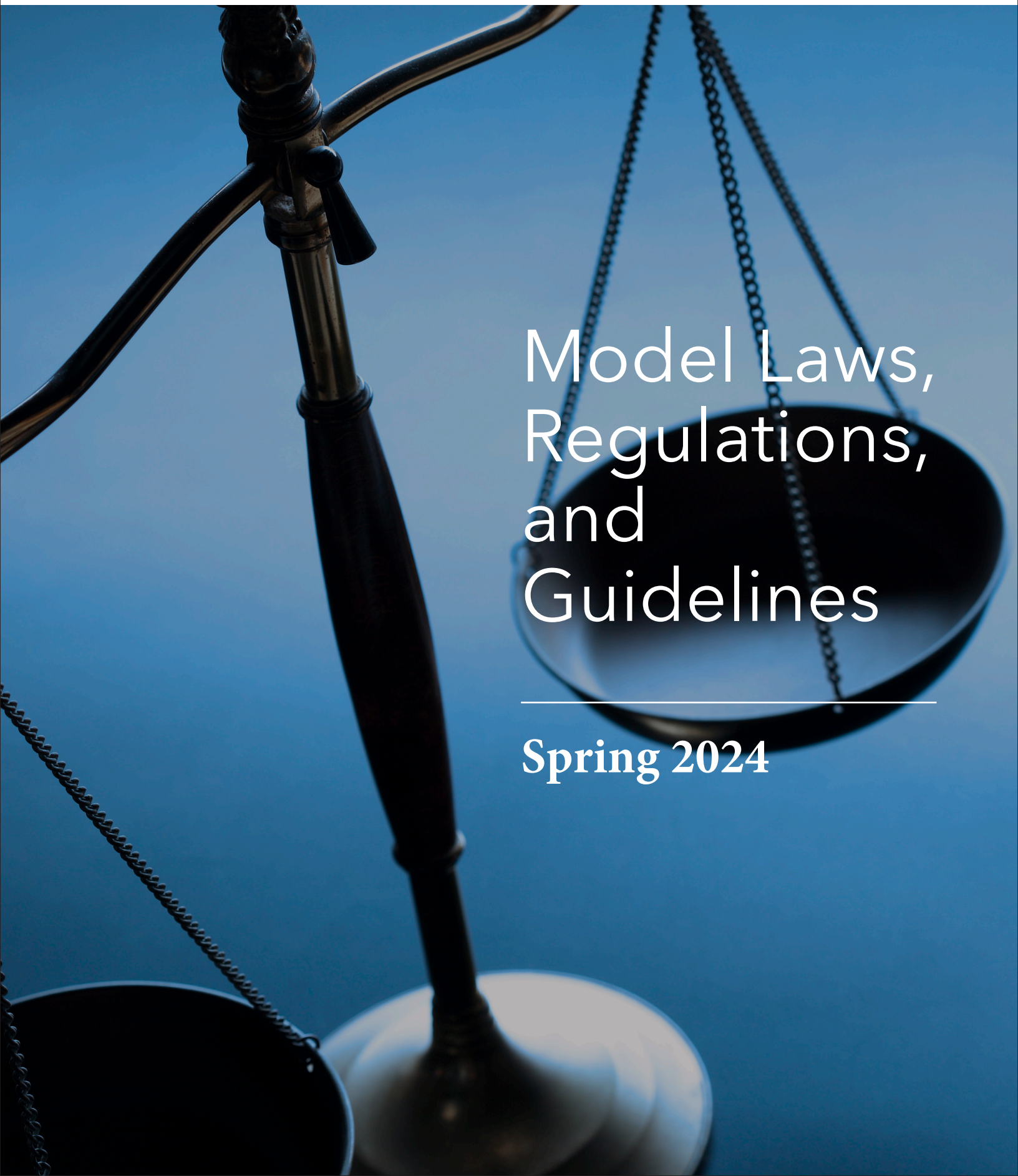
NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS



Model Laws, Regulations, and Guidelines

Spring 2024

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

Accounting & Reporting
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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

NAIC Model Laws, Regulations, Guidelines and Other Resources

Update #141

Spring 2024

Enclosed, please find the *Model Laws, Regulations, Guidelines and Other Resources* Update #141 Spring 2024. This update includes recent changes to state law and the most recent amendments to the *Unfair Trade Practices Act* (#880).

Please note: Updated model law charts will be released in May 2024. The reference page (pg. 3) in this Model Law Publication will be updated with a list of these charts at that time.

If you have questions about this publication, including questions about copyright issues, please contact an NAIC representative at (816) 783-8300 or prodserv@naic.org.

Sincerely,

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NAIC MODEL LAWS, REGULATIONS, GUIDELINES AND OTHER RESOURCES

Reference
Spring 2024—Update #141

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In addition, the following **charts** of **State Laws on Insurance Topics** have been updated and can be downloaded from Account Manager. Regulators may download charts from StateNet.

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A searchable index of the NAIC's Model Laws, Regulations, Guidelines and Other Resources can be accessed on the NAIC website at: www.naic.org/documents/committees_models_table_of_contents.pdf

ACCIDENT AND HEALTH INSURANCE

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
10	**Health Insurance Reserves Model Regulation**	This model regulation implements the NAIC Standard Valuation Law (MDL-820). It defines categories of reserves and sets forth the minimum claim, premium and contract reserve requirements. The regulation provides for gross premium valuation to evaluate adequacy of reserves.	
22	**Health Carrier Prescription Drug Benefit Management Model Act**	This model act provides standards for the establishment, maintenance and management of prescription drug formularies and other pharmaceutical benefit management procedures used by health carriers that provide prescription drug benefits.	
26	**Individual Market Health Insurance Coverage Model Regulation**	This model regulation implements the NAIC Individual Market Health Insurance Coverage Model Act (MDL-36).	
30	**Standardized Health Claim Form Model Regulation**	This model regulation standardizes the forms used in the billing and reimbursement of health care, reduces the number of forms utilized, increases efficiency in the reimbursement of health care and encourages the use of and prescribes a timetable for the implementation of electronic data interchange of health care expenses and reimbursement.	
32	**Health Carrier Claim Audit Guidelines Model Act**	This model act provides for the reasonable standardization of claim audit guidelines of health care bills to determine whether data in a health care record is supported by services listed on the claim for payment of an insured or an institutional provider.	
36	**Individual Market Health Insurance Coverage Model Act**	This model act sets out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provides for the establishment of coverage and other benefit requirements in the individual market.	HB-15 - Mandated Benefits - Women's Health, Pregnancy, Fertility, Preventative Care HB-16 - Mandated Benefits - Women's Health HB-25 - Mandated Benefits - Mental Health HB-27 - Mandated Benefits - Substance Abuse and Addiction HB-50 - Genetic Testing for Insurance Coverage

ACCIDENT AND HEALTH INSURANCE CONSUMER PROTECTION

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
40	**Advertisements of Accident and Sickness Insurance Model Regulation**	This model regulation establishes minimum criteria to ensure proper and accurate description and to protect prospective purchasers with respect to the advertisement of health insurance. This regulation applies to group and blanket, as well as individual accident and sickness insurance.	
42	**Prohibition on the Use of Discretionary Clauses Model Act**	This model act helps ensure that health insurance benefits and disability-income protection coverage are contractually guaranteed and helps avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due.	

ACCIDENT AND HEALTH INSURANCE DELIVERY SYSTEMS

68	**Prepaid Limited Health Service Organization Model Act**	This model act provides the means to regulate limited health service plans and to avoid unnecessary duplication of regulation for other entities that currently are authorized to provide limited health services on a prepayment or other basis or to indemnify for such services.	
70	**Health Care Professional Credentialing Verification Model Act**	This model act requires a health carrier to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification.	
71	**Quality Assessment and Improvement Model Act**	This model act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans and for the quality improvement activities of health carriers issuing closed plans or combination plans that have a closed component.	
72	**Health Carrier Grievance Procedure Model Act**	This model act provides standards for the establishment and maintenance of procedures by health carriers to ensure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this model.	
73	**Utilization Review and Benefit Determination Model Act**	This model act establishes standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.	
74	**Health Benefit Plan Network Access and Adequacy Model Act**	This model act establishes standards for the creation and maintenance of networks by health carriers to ensure the adequacy, accessibility and quality of health care services offered under a managed care plan. It establishes requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.	

ACCIDENT AND HEALTH INSURANCE DELIVERY SYSTEMS (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
75	**Health Carrier External Review Model Act**	This model act provides standards for the establishment and maintenance of external review procedures to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this act.	
76	**Uniform Health Carrier External Review Model Act**	The purpose of this model act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination.	
77	**Medical Professional Liability Closed Claim Reporting Model Law**	This act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.	
78	**The Single Health Care Voluntary Purchasing Alliance Model Act**	This model act helps improve fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than a specified number of employees. This model also provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws.	HG-30 - Health Insurance Purchasing Alliances
80	**The Regional Health Care Voluntary Purchasing Alliance Model Act**	This model act helps improve fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than a specified number of employees. It also provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws.	HG-30 - Health Insurance Purchasing Alliances
82	**The Private Health Care Voluntary Purchasing Alliance Model Act**	This model act helps improve fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than a specified number of employees. It also provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws.	HG-30 - Health Insurance Purchasing Alliances
85	**Model Health Plan for Uninsurable Individuals Act**	This model act establishes guidelines for a health plan for uninsurable individuals. The mechanics of the plan and its operations and functions must all be established under a plan of operation approved by the commissioner.	
92	**Stop Loss Insurance Model Act**	This model act establishes criteria for the issuance of stop-loss insurance policies. This model does not impose any requirement or duty on any person other than an insurer or as treating any stop-loss policy as a direct policy of health insurance.	HA-90 - Stop Loss Coverage
98	**Discount Medical Plan Organization Model Act**	This model act helps promote the public interest by establishing standards for discount medical plan organizations to protect consumers from unfair or deceptive marketing, sales or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.	

ACCIDENT AND HEALTH INSURANCE GROUP REGULATION

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
100	**Group Health Insurance Standards Model Act**	This model act establishes the definition of group health insurance and sets forth the requirements of a group health policy. It also delineates group health insurance standard provisions.	HA-10 - Filing Requirements Health Insurance Forms and Rates
105	**Group Health Insurance Mandatory Conversion Privilege Model Act**	This model act specifies when an employee or member of a group health plan is entitled to have a converted policy issued to him/her, without evidence of insurability, subject to the provisions of this model.	
106	**Small Group Market Health Insurance Coverage Model Act**	This model act sets out the requirements for guaranteed availability, guaranteed renewability and premium rating in the small group market and provides for the establishment of coverage and other benefit requirements in the small group market.	HB-15 - Mandated Benefits - Women's Health, Pregnancy, Fertility, Preventative Care HB-16 - Mandated Benefits - Women's Health HB-25 - Mandated Benefits - Mental Health HB-27 Mandated Benefits - Substance Abuse and Addiction HB-50 - Genetic Testing for Insurance Coverage
107	**Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation**	This model regulation incorporates the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations. It prohibits carriers providing health insurance coverage under a health benefit plan in the group market from discriminating against individual participants or beneficiaries in these plans with respect to plan eligibility and in setting premium and contribution rates based on any health factor of the participants or beneficiaries.	
110	**Group Coverage Discontinuance and Replacement Model Regulation**	This model regulation is applicable to all insurance policies and subscriber contracts issued or provided by a carrier on a group or group-type basis covering persons as employees of employers or as members of unions or associations.	
120	**Coordination of Benefits Model Regulation**	This model regulation establishes a uniform order of benefit determination under which plans pay claims; reduces duplication of benefits; and provides greater efficiency in the processing of claims when a person is covered under more than one plan.	HA-40 - Coordination of Benefits Provisions
126	**Small Group Market Health Insurance Coverage Model Regulation**	This model regulation implements the NAIC Small Group Market Health Insurance Coverage Model Regulation (MDL-106).	

ACCIDENT AND HEALTH INSURANCE RATE AND POLICY STANDARDS

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
134	**Guidelines for Filing of Rates for Individual Health Insurance Forms**	This guideline provides guidance for the submission and filing of individual health insurance rates and establishes standards for determining the reasonableness of the relationship of benefits to premiums.	HA-10 - Filing Requirements Health Insurance Forms and Rates
139	**Noncancellable and Guaranteed Renewable Terminology Defined**	This model defines the terms "non-cancellable" or "non-cancellable and guaranteed renewable," establishing recommended limiting ages in an effort to make the language conform as closely as possible with existing language.	
148	**Off-Label Drug Use Model Act**	This model act sets standards for payments for drugs that have been approved for indications other than those stated in the labeling approved by the FDA.	HB-10 - Mandated Benefits - Other
155	**Newborn and Adopted Children Coverage Model Act**	This model act provides for uniformity of coverage requirements for newborn and newly adopted children and children placed for adoption under both group and individual health benefit plans.	
165	**Health Policy Rate and Form Filing Model [Act] [Regulation]**	The purpose of this model act is to provide a uniform standard for processing of accident and health carrier policy rate and form filings.	HA-10 - Filing Requirements Health Insurance Forms and Rates
170	**Supplementary and Short-Term Health Insurance Minimum Standards Model Act**	Along with its corresponding regulation (MDL-171), this model act standardizes the terms and coverage of individual and group health insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.	
171	**Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act**	This model regulation implements the NAIC Accident and Sickness Insurance Minimum Standards Model Act (MDL-170).	
180	**Uniform Individual Accident and Sickness Policy Provision Law (UPPL)**	This model law establishes a uniform individual accident and sickness policy. It sets forth the definition of "policy of accident and sickness insurance" and establishes the requirements for the form of a policy, specifies particular provisions to be included, and provides for judicial review.	
185	**Restatement of UPPL in Simplified Language**	This restatement of the required and most often used optional provisions of the Uniform Policy Provision Law (MDL-180) in simplified language is intended as a guideline for the submission and approval of individual accident and sickness policies written in simplified language. The restated provisions are intended to most accurately reflect the original intent of the UPPL and to duplicate its substantive requirements.	MC-25 - Readability Requirements
190	**Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio (MLR)**	The purpose of this model is to promulgate uniform definitions and a standardized methodology for calculating the medical loss ratio, as legislated by Section 2718 (b) of the Public Health Service Act and the Patient Protection and Affordable Care Act. This model was incorporated into a federal regulation during 2010.	

ACCOUNTING

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
200	**Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts Model Regulation**	This model regulation prescribes rules for separate accounts that fund guaranteed minimum benefits under group contracts. It also sets out the procedures for establishing and maintaining these separate accounts and the reserve requirements for these accounts.	LI-20 - Form Filing Requirements Life Insurance Policies
205	**Annual Financial Reporting Model Regulation**	This model regulation helps improve the surveillance of the financial condition of insurers by requiring: 1) annual audit of financial statements; 2) communication of internal control-related matters noted in an audit; and 3) managements report of internal control over financial reporting.	CA-10 - Annual and Quarterly Financial Reporting Requirements

AGENTS/BROKERS/PRODUCERS

218	**Producer Licensing Model Act**	This model act governs the qualifications and procedures for the licensing of insurance producers. This model does not apply to surplus lines agents and brokers licensed pursuant to excess and surplus lines statutes, except as provided in this model.	PR-15 - Compensation Disclosure Requirements for Producers PR-20 - Producer Education and Examination Requirements PR-30 - Fingerprint Requirements for Licensing PR-60 - Producers' Fiduciary Responsibilities—Premiums PR-70 - Producers' Ability to Charge Fees and Collect Commissions
220	**Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation**	This model regulation helps prevent the operation of illegal multiple employer welfare arrangements (MEWAs). This regulation establishes specific standards for persons and licensees who become aware of, or are asked to assist, such an operation.	PR-20 - Producer Education and Examination Requirements HA-95 - MEWAs and METs Provisions
222	**Authorization for Criminal History Record Check Model Act**	This model act sets forth requirements for the states to obtain access to the FBI Criminal Justice Information Services Division's criminal history record information and secure such information or reports.	PR-30 - Fingerprint Requirements for Licensing
225	**Managing General Agents Act**	This model act governs the qualifications and procedures for a resident or non-resident producer acquiring the status as a managing general agent. Its provisions cover licensure, required contract provisions, duties of insurers, examination authority, penalties and liabilities.	
228	**Public Adjuster Licensing Model Act**	This model act governs the qualifications and procedures for the licensing of public adjusters. It specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first-party claims.	PR-20 - Producer Education and Examination Requirements PR-30 - Fingerprint Requirements for Licensing PL-40 - Adjuster Licensing Requirements MC-90 - State Laws on Records Maintenance
230	**Title Insurance Agent Model Act**	This model act provides for the effective regulation and supervision of title insurance agents. It should be adopted concurrently with the Title Insurers Model Act (MDL-628), because the two models contain complementary provisions and both are required to provide sufficient regulation of title insurance.	

ANNUITIES/VARIABLE CONTRACTS

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
235	**Interest-Indexed Annuity Contracts Model Regulation**	This model regulation establishes the initial filing requirements for interest-indexed annuity contracts. It also contains additional filing requirements, valuation requirements, and a Statement of Actuarial Opinion for Interest-Indexed Annuity Contracts. This regulation applies only to individual annuity contracts. This regulation currently addresses only the indexing of interest credits.	
240	**Charitable Gift Annuities Model Act**	This model act defines charitable gift annuities and contains requirements related to certificate of authority requirements, surplus and reserve standards, investments, examinations, annual reports and disclosure.	
241	**Charitable Gift Annuities Exemption Model Act**	This model act specifies that annuities that qualify as charitable gift annuities do not constitute engaging in the business of insurance.	
245	**Annuity Disclosure Model Regulation**	This model regulation provides standards for the disclosure of information about annuity contracts in order to protect consumers and foster consumer education.	LI-35 - Annuity Disclosure Provisions
250	**Variable Annuity Model Regulation**	This model regulation specifies the qualifications required of insurers to offer, and agents to sell, variable annuities. It also stipulates the manner in which variable benefits are to be calculated and how separate account categories are to be maintained.	
255	**Modified Guaranteed Annuity Regulation**	This model regulation provides rules for modified guaranteed annuities. It establishes the qualifications of agents and insurers; the required contract form and provisions; and the manner in which separate account assets are to be maintained and reported.	LI-20 - Form Filing Requirements Life Insurance Policies
260	**Variable Contract Model Law**	This model law establishes guidelines for variable contracts. It includes requirements pertaining to contract statements and licensing, and clarifies the powers of the commissioner with respect to variable contracts.	
270	**Variable Life Insurance Model Regulation (includes commentary)**	This model regulation establishes parameters for the issuance of variable life insurance. It outlines insurer qualifications, insurance policy requirements, reserve liabilities, separate accounts; information furnished to applicants, reports to policyholders, foreign companies and agent qualifications.	LI-20 - Form Filing Requirements Life Insurance Policies
275	**Suitability in Annuity Transactions Model Regulation**	This model regulation requires producers to act in the best interest of the consumer when making a recommendation of an annuity and requires insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively addressed.	PR-20 - Producer Education and Examination Requirements LI-35 - Annuity Disclosure Provisions LI-55 - Suitability of Sales of Life Insurance and Annuities
278	**Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the State of Life Insurance and Annuities**	The purpose of this model regulation is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.	

COMPANY ORGANIZATION, MANAGEMENT, SECURITIES

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
280	**Investments of Insurers Model Act (Defined Limits Version)**	This model act helps protects the interests of insureds by promoting insurer solvency and financial strength. It is, however, not considered by the NAIC to exhaust regulatory methods to address the regulation of investments of insurers.	CF-50 - Limitations on Insurers' Investments
282	**Derivative Instruments Model Regulation**	This model regulation sets standards for the prudent use of derivative instruments in accordance with the Investments of Insurers Model Act (MDL-280).	CF-50 - Limitations on Insurers' Investments
283	**Investments of Insurers Model Act (Defined Standards Version)**	This model act helps protect and further the interests of insureds, creditors and the general public by providing prudent standards for the development and administration of insurer investment programs.	CF-50 - Limitations on Insurers' Investments
285	**Disclosure of Material Transactions Model Act**	This model act establishes requirements for disclosing material transactions. It provides guidelines pertaining to the content of the report containing material transactions, the process for acquisition and disposition of assets, transaction exceptions to the reporting requirement and confidentiality.	
290	**Protected Cell Company Model Act**	This model act provides a basis for the creation of protected cells by a domestic insurer as one means of accessing alternative sources of capital and achieving the benefits of insurance securitization.	CA-80 - Captive Insurance Company Laws
295	**Model Act on Custodial Agreements and the Use of Clearing Corporations**	This model act authorizes domestic insurance companies to use modern systems for holding and transferring securities, subject to appropriate regulations. Its corresponding model regulation is MDL-298.	
298	**Model Regulation on Custodial Agreements and the Use of Clearing Corporations**	This model regulation establishes requirements for custody agreements and deposits with affiliates. Its corresponding model act is MDL-295.	
305	**Corporate Governance Annual Disclosure Model Act**	This model act permits the Commissioner to collect information related to an insurer or insurance group's corporate governance structure, policies and practices. The model provides that this information will be kept confidential. (Also refer to MDL-306.)	
306	**Corporate Governance Annual Disclosure Model Regulation**	This model regulation sets forth rules and procedural requirements necessary to carry out the provisions of the Corporate Governance Annual Disclosure Model Act (MDL-305).	
312	**Risk-Based Capital (RBC) Model Act**	This model act establishes RBC requirements and outlines the reporting requirements for insurers. The hearing process and confidentiality concerns are addressed. It also includes provisions for exemptions, foreign insurers and immunity.	CF-20 - Capital and Surplus Requirements on Risks
315	**Risk-Based Capital (RBC) for Health Organizations Model Act**	This model act establishes RBC requirements and outlines the reporting requirements for health organizations. The hearing process and confidentiality concerns are addressed. It also includes provisions for exemptions, foreign health organizations and immunity.	CF-20 - Capital and Surplus Requirements on Risks

COMPANY ORGANIZATION, MANAGEMENT, SECURITIES (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
325	**Business Transacted with Producer Controlled Property/Casualty Insurer Act**	This model act sets forth guidelines for business between controlled insurers and controlling producers. It contains specific contract provisions to be contained in controlling producer/controlled insurer contracts.	
340	**Investments in Medium Grade and Lower Grade Obligations Model Regulation**	This model regulation helps protect the insurance-buying public by establishing limitations on the concentration of medium-grade and lower-grade obligations in which a domestic insurer can invest.	I-CF-50 - Limitations on Insurers' Investments
350	**Redomestication Model Bill**	This model provides a means whereby any insurer organized under the laws of another state may become a domestic insurer; to provide a means for any domestic insurer to transfer its domicile to another state; and to provide a means for the continuation of a certificate of authority and other approvals pertaining to a foreign insurer that transfers its corporate domicile to another state by merger or consolidation or any other lawful method.	
356	**Model Indemnity Contracts Act**	This model act regulates certain classes of indemnity contracts empowering corporations to make such contracts and fixing certain fees, and includes penalty provisions.	

CREDIT INSURANCE

360	**Consumer Credit Insurance Model Act**	This model act helps promote the public welfare by regulating consumer credit insurance.	
365	**Credit Personal Property Insurance Model Act**	This model act 1) Promotes the public welfare by regulating credit personal property insurance; 2) Creates a legal framework within which credit personal property insurance may be written in this state; 3) Helps maintain the separation between creditors and insurers; 4) Minimizes the possibilities of unfair competitive practices in the sale of credit personal property insurance; and 5) Addresses the problems arising from reverse competition in credit insurance markets.	
370	**Consumer Credit Insurance Model Regulation**	This model regulation helps protect the interests of debtors and the public by providing a system of rate, policy form and operating standards for the transaction of credit life, credit accident and health, and credit unemployment insurance.	PC-50 - Terrorism and War Risks Exclusion

EXAMINATIONS

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
385	**Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition**	This model regulation sets forth standards for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.	
390	**Model Law on Examinations**	This model law helps provide an effective, efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance.	CF-40 - Financial Examinations Standards for Insurers
395	**Participation in the NAIC Insurance Regulatory Information System (IRIS) Model Act**	This model act sets forth the requirements for participating in the NAIC Insurance Regulatory Information System (IRIS). It requires annual statement filing for each domestic, foreign and alien insurer that is authorized to transact insurance in the respective jurisdiction.	

HEALTH MAINTENANCE ORGANIZATIONS

430	**Health Maintenance Organization Model Act**	This model act provides for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations.	HM-10 - Departmental Regulation of HMOs HM-20 - Open Enrollment Periods for HMOs HM-30 - HMO Net Worth and Deposit Requirements
432	**Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organizations**	This model regulation implements the NAIC Health Maintenance Organization Act (MDL-430). It ensures the availability, accessibility and quality of services provided by HMOs and to provide reasonable standards for terms and provisions contained in HMO group and individual contracts and evidences of coverage.	HM-10 - Departmental Regulation of HMOs HM-20 - Open Enrollment Periods for HMOs HM-30 - HMO Net Worth and Deposit Requirements

HOLDING COMPANIES

440	**Insurance Holding Company System Regulatory Act**	This model act includes requirements pertaining to holding companies. (Also refer to MDL-450). It pertains to subsidiaries of insurers, acquisition of control of or merger with domestic insurers, acquisitions involving insurers not otherwise covered, registration of insurers, and standards and management of an insurer within a holding company system.	
450	**Insurance Holding Company System Model Regulation with Reporting Forms and Instructions**	This model regulation sets forth rules and procedural requirements necessary to carry out the provisions of the NAIC Insurance Holding Company System Regulatory Act (MDL-440).	

INSIDER TRADING AND PROXIES

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
460	**An Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities**	This model act includes provisions concerning the unfair use of information, sales of equity security, exceptions, definitions and forfeiture. Its corresponding model regulation is MDL-480.	
480	**Regulations Adopted Pursuant to an Act Concerning the Insider Trading of Domestic Stock Insurance Company Equity Securities**	This model regulation contains definitions and other detailed guidelines to evaluate compliance with the provisions set forth in the NAIC Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities (MDL-460).	
490	**Regulation Regarding Proxies, Consents and Authorizations of Domestic Stock Insurers**	This model regulation provides proxy requirements, filing requirements. securities solicitations, information to be provided to securities holders, consent and authorization, communications with securities holders, proposals, false and misleading statements, and special provisions related to election contests.	
500	**Stockholders Information Supplement Schedule SIS**	This model contains general instructions, information regarding financial reporting to stockholders, information and instructions regarding management and directors, and instructions for statement of beneficial ownership of securities.	

INSOLVENCY

505	**Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act**	This model act establishes the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA). It addresses exemptions, confidentiality and sanctions.	
520	**Life and Health Insurance Guaranty Association Model Act**	This model act protects against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts because of the impairment or insolvency of the member insurer that issued the policies or contracts.	IN-10 - Life and Health Guaranty Fund Laws IN-15 - Life and Health Guaranty Funds Triggering Provisions IN-50 - Health Maintenance Organization Coverage by Guaranty Associations TX-60 - Premium Tax Credits for Guaranty Association Assessments
540	**Property and Casualty Insurance Guaranty Association Model Act**	This model act provides a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.	IN-30 - Property and Casualty Guaranty Fund Laws IN-35 - Property and Casualty Guaranty Triggering Provisions TX-60 - Premium Tax Credits for Guaranty Association Assessments
555	**Insurer Receivership Model Act**	This model act helps protect the interests of insureds, claimants, creditors and the public generally through early detection of a potentially hazardous financial condition of an insurer and enhanced efficiency in liquidation to conserve the assets of the insurer.	
558	**Administrative Supervision Model Act**	This model act outlines the parameters under which administrative supervision of an insurance company takes effect. It addresses failure to comply, confidentiality, prohibited acts, immunity, and administrative election of proceedings.	

LIFE INSURANCE

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
565	**Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act**	This model act sets forth group life insurance standard provisions. It defines group life insurance and contains provisions relating to limits of group life insurance, notice of compensation, dependent coverage, standard provisions, and a supplementary provision relating to conversion privileges.	
568	**Military Sales Practices Model Regulation**	The purpose of this model regulation is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair. This regulation shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States Armed Forces.	PC-50 - Terrorism and War Risks Exclusion
570	**Advertisements of Life Insurance and Annuities Model Regulation**	This model regulation sets forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.	LI-30 - Life Insurance Disclosure Provisions
575	**Life and Health Insurance Policy Language Simplification Model Act**	This model act establishes minimum standards for language used in policies, contracts and certificates of life insurance, health insurance, credit life insurance and credit health insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds. Policy forms must meet certain standards in regard to readability, type size and format.	LI-20 - Form Filing Requirements Life Insurance Policies LI-30 - Life Insurance Disclosure Provisions MC-25 - Readability Requirements
580	**Life Insurance Disclosure Model Regulation**	This model regulation requires insurers to provide information to purchasers of life insurance that will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs and improve the buyer's understanding of the basic features of the policy that has been purchased or is under consideration.	LI-30 - Life Insurance Disclosure Provisions LI-35 - Annuity Disclosure Provisions
582	**Life Insurance Illustrations Model Regulation**	This model regulation provides rules for life insurance policy illustrations that will help protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations.	LI-30 - Life Insurance Disclosure Provisions
585	**Universal Life Insurance Model Regulation**	This model regulation supplements existing regulations on life insurance policies in order to accommodate the development and issuance of universal life insurance plans.	
590	**Model Policy Loan Interest Rate Bill (An Act to Regulate Interest Rates on Life Insurance Policy Loans)**	This model act sets guidelines for life insurers to include a provision for periodic adjustment of policy loan interest rates.	
601	**Guidelines on Gifts of Life Insurance to Charitable Institutions**	This guideline contains guidance for states in a question-and-answer format, explaining the main features of gifts of life insurance to charities.	
602	**Guidelines on Corporate Owned Life Insurance**	This guideline includes key elements that should be included in state laws regarding corporate-owned life insurance.	
605	**Disclosure for Small Face Amount Life Insurance Policies Model Act**	This model act helps ensure that meaningful information is provided to the purchasers of small face amount policies. Disclosure requirements are listed and insurer duties explained.	

LIFE INSURANCE (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
613	**Life Insurance and Annuities Replacement Model Regulation**	This model regulation sets forth standards for the activities of insurers and producers with respect to the replacement of existing life insurance and annuities. It helps protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions.	
615	**Life Insurance Multiple Policy Model Regulation**	The purpose of this model regulation is to set forth guidelines for insurers to utilize to search for additional policies or insurance coverages on the life of an insured upon notification of death of the insured.	
620	**Accelerated Benefits Model Regulation**	This model regulation regulates accelerated benefit provisions of individual and group life insurance policies and provides required standards of disclosure. It applies to all accelerated benefits provisions not subject to the Long-Term Care Insurance Model Act (MDL-640).	

LIMITED LINES

628	**Title Insurers Model Act**	This model act provides for the effective regulation and supervision of title insurance and title insurers. It should be adopted concurrently with the Title Insurance Agent Model Act (MDL-230), because the two models contain complementary provisions and both are required to provide sufficient regulation of title insurance.	CF-90 - Reserve Requirements for Title Insurers MC-90 - State Laws on Records Maintenance
630	**Mortgage Guaranty Insurance Model Act**	This model act defines terminology related to mortgage guaranty insurance and contains provisions pertaining to capital and surplus, the insurer's authority to transact business, geographic concentration, advertising, investment limitation, underwriting discrimination, mortgage guaranty insurance as monocline, policy and premium rate filings, outstanding total liabilities, rebates, commissions and charges, prohibition of compensating balances, reserves, and conflicts of interest.	
631	**Real Property Lender-Placed Insurance Model Act**	This model act promotes the public welfare by creating a legal framework within which lender-placed insurance on real property may be written. The model helps to maintain the separation between lenders and servicers and insurers and insurance producers, while minimizing the possibilities of unfair competitive practices in the sale, placement, solicitation, and negotiation of lender-placed insurance.	
632	**Travel Insurance Model Act**	This model act promotes the public welfare by creating a comprehensive legal framework within which travel insurance may be sold.	
633	**Pet Insurance Model Act**	This model act promotes the public welfare by creating a comprehensive legal framework within which Pet Insurance may be sold.	

LONG-TERM CARE INSURANCE

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
640	**Long-Term Care Insurance Model Act**	This model act establishes standards for long-term care insurance and facilitates flexibility and innovation in the development of long-term care insurance coverage. Its corresponding regulation is MDL-641.	HS-10 - Long-Term Care Insurance Act Provisions HS-15 - Long-Term Care Insurance Regulation Provisions
641	**Long-Term Care Insurance Model Regulation**	This model regulation implements the NAIC Long-Term Care Insurance Model Act (MDL-640). It sets standards for rates, non-forfeiture values and suitability. Requirements for advertising and marketing are also detailed. Several forms are included.	HS-10 - Long-Term Care Insurance Act Provisions HS-15 - Long-Term Care Insurance Regulation Provisions PC-50 - Terrorism and War Risks Exclusion
642	**Limited Long-Term Care Insurance Model Act**	This model act promotes the public interest, promotes the availability of limited long-term care insurance policies, protects applicants for limited long-term care insurance from unfair or deceptive sales or enrollment practices, establishes standards for limited long-term care insurance, facilitates public understanding and comparison of limited long-term care insurance policies, and facilitates flexibility and innovation in the development of limited long-term care insurance coverage.	
643	**Limited Long-Term Care Insurance Model Regulation**	This model regulation implements the NAIC *Limited Long-Term Care Insurance Model Act* (MDL-642).	

MEDICARE SUPPLEMENT INSURANCE

650	**Medicare Supplement Insurance Minimum Standards Model Act**	This model act applies to all Medicare supplement policies and certificates issued under group Medicare supplement policies. It includes loss ratio standards and authority to promulgate regulations. Its corresponding model regulation is MDL-651.	
651	**Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act**	This model regulation implements the NAIC Medicare Supplement Insurance Minimum Standards Model Act (MDL-650). It provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; facilitates public understanding and comparison of such policies; eliminates provisions contained in such policies that may be misleading or confusing; and provides for full disclosures in the sale of health insurance coverage to persons eligible for Medicare.	HB-50 - Genetic Testing for Insurance Coverage
660	**NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines**	This model helps provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance; and ensures the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance.	

MISCELLANEOUS

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
668	**Insurance Data Security Model Law**	This model act establishes standards for data security and standards for the investigation of and notification to the Commissioner of a Cybersecurity Event applicable to Licensees.	MC-30 - Insurance Privacy Protection in Response to the Gramm-Leach-Bliley Act RE-40 - General State Privacy Breach/Consumer Protection Laws
670	**NAIC Insurance Information and Privacy Protection Model Act**	This model act establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance support organizations.	MC-30 - Insurance Privacy Protection in Response to the Gramm-Leach-Bliley Act
672	**Privacy of Consumer Financial and Health Information Regulation**	This model aligns with the requirements set forth in Title V of the Gramm-Leach-Bliley Act related to the privacy of consumer financial and health information.	MC-30 - Insurance Privacy Protection in Response to the Gramm-Leach-Bliley Act
673	**Standards for Safeguarding Customer Information Model Regulation**	This model regulation establishes standards for developing and implementing administrative, technical and physical safeguards to protect the security, confidentiality and integrity of customer information, pursuant to the Gramm-Leach-Bliley Act.	MC-30 - Insurance Privacy Protection in Response to the Gramm-Leach-Bliley Act RE-40 - General State Privacy Breach/Consumer Protection Laws
675	**Uniform Fraternal Code**	This model defines fraternal benefit societies, lodge systems, representative form of government and sets forth an organizational footprint for a fraternal benefit society. It addresses conversion of fraternal benefit societies into mutual life insurance companies, includes qualifications for membership, articles of incorporation, constitution, laws and amendments, as well as a provision regarding operation of institutions.	
680	**Insurance Fraud Prevention Model Act**	This model act helps state insurance regulators investigate and discover fraudulent insurance acts more effectively, halt fraudulent acts, and assist and receive assistance from state, local and federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts.	CA-90 - Statutes Making the Unauthorized Transaction of Insurance a Criminal Act MC-10 - Insurance Fraud Prevention Laws
685	**Service Contracts Model Act**	This model act creates a legal framework within which service contracts may be sold; encourages innovation in the marketing and development of more economical and effective means of providing services under service contracts; and encourages fair and effective competition among different systems of providing and paying for these services.	PA-60 - Service Contracts, Motor Clubs and Other Extended Warranties
692	**Interstate Insurance Product Regulation Compact**	This model establishes a compact for the purpose of approving forms for life, annuity, disability income and long-term care insurance. The compact also has authority to review and approve rates for disability income and long-term care, as well as advertising for long-term care insurance.	
693	**Market Conduct Surveillance Model Law**	This model law establishes a framework for market conduct actions, including processes and systems for identifying, assessing and prioritizing market conduct problems; actions by a commissioner to substantiate market conduct problems and a means to remedy significant market conduct problems; and procedures to communicate and coordinate market conduct actions among jurisdictions to foster the most efficient, effective use of resources.	
695	**Synthetic Guaranteed Investment Contracts Model Regulation**	This model regulation prescribes the terms and conditions under which life insurance companies may issue group annuity contracts and other agreements that establish the insurer's obligation by reference to a segregated portfolio of assets that is not owned by the insurer; the essential operational features of the segregated portfolio of assets; and the reserve requirements for these group annuity contracts and agreements.	

MISCELLANEOUS (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
697	**Viatical Settlements Model Act**	This model act contains provisions for regulating viatical settlements. (Its corresponding model regulation is MDL-698). This Act includes definitions, licensing requirements, contract statement requirements, reporting requirements and privacy, examinations and investigations, disclosure, general rules, prohibited practices, advertising requirements, fraud prevention and control, penalties for failure to comply, and unfair trade practices.	MC-90 - State Laws on Records Maintenance
698	**Viatical Settlements Model Regulation**	This model regulation sets forth requirements related to the NAIC Viatical Settlements Model Act (MDL-697).	

PROPERTY AND CASUALTY INSURANCE

700	**Insurance Statute—Atomic Energy Exclusion**	This model offers an exclusion authorizing insurers to exempt from coverage loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.	
701	**Nationwide Inland Marine Definition**	This model defines the kinds of risks and coverage that may be classified under state insurance laws as marine, inland marine or transportation insurance.	
705	**Model Risk Retention Act**	This model act regulates the formation and operation of risk retention groups and purchasing groups formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (LRRA).	CA-80 - Captive Insurance Company Laws
710	**Mass Marketing of Property and Liability Insurance Model Regulation**	This model regulation prescribes rules to prevent abuses in connection with the sale of property-liability insurance pursuant to mass marketing plans, while preserving for consumers the potential benefits of this form of marketing.	
745	**Property and Casualty Actuarial Opinion Model Law**	This model law outlines the requirements for property/casualty insurers to obtain annual actuarial opinions of reserves. It details the requirements for the actuarial opinion summary and the actuarial report. The model also contains a provision pertaining to confidentiality.	
751	**Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies**	This model regulation sets forth the manner of reporting data by insurers to statistical agents; prescribes reports to be submitted by statistical agents; and prescribes certain conduct in connection therewith. This regulation does not apply to data reported directly by insurers to the commissioner.	

PROPERTY AND CASUALTY INSURANCE RATING LAWS

777	**Property and Casualty Commercial Rate and Policy Form Model Law (Condensed)**	This model law is not intended to be a stand-alone model. Its provisions are intended to replace comparable provisions in current state rate and policy form regulatory laws. Regulatory laws relating to definitions, rate and form standards, disapprovals, advisory organizations, etc., are to be preserved.	PA-10 - Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title PA-15 - Form Filing Methods for Property/Casualty

REINSURANCE

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
785	**Credit for Reinsurance Model Law**	This model law helps ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. Also refer to the corresponding model regulation (MDL-786).	
786	**Credit for Reinsurance Model Regulation**	This model regulation sets forth rules and procedural requirements necessary to carry out the provisions of the NAIC Credit for Reinsurance Model Law (MDL-785). A certification form is included.	
787	**Term and Universal Life Insurance Reserve Financing Model Regulation**	This model regulation establishes uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees.	
789	**Special Purpose Reinsurance Vehicle Model Act**	This model act provides for the creation of Special Purpose Reinsurance Vehicles (SPRVs) exclusively to facilitate the securitization of one or more ceding insurers' risk as a means of accessing alternative sources of capital and achieving the benefits of securitization.	
790	**Reinsurance Intermediary Model Act**	This model act applies to reinsurance intermediary-brokers and reinsurance intermediary-managers. It establishes required contract provisions, book and record documentation, prohibited acts, duties of reinsurers, examination authority, prohibited acts, licensure provisions, examination authority, penalties and liability and reciprocity provisions related to reinsurance intermediary-brokers and intermediary-managers.	PR-20 - Producer Education and Examination Requirements MC-90 - State Laws on Records Maintenance
791	**Life and Health Reinsurance Agreements Model Regulation**	This model regulation addresses the situation where a licensed insurer, in the capacity of ceding insurer, enters into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. Accounting requirements for these transactions are included.	
803	**Assumption Reinsurance Model Act**	This model act provides for the regulation of the transfer and innovation of contracts of insurance by way of assumption reinsurance. It defines assumption reinsurance and establishes notice and disclosure requirements which protect and define the rights and obligations of policyholders, regulators and the parties to assumption reinsurance agreements.	

STANDARD NONFORFEITURE AND VALUATION

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
805	**Standard Nonforfeiture Law for Individual Deferred Annuities**	This model provides guidance as to non-forfeiture requirements, minimum values, present value computation, calculation of cash-surrender values, paid-up annuity benefits, maturity date, disclosure of limited death benefits, inclusion of lapse of time considerations, proration of values and additional benefits for individual deferred annuities.	
806	**Annuity Nonforfeiture Model Regulation**	This model regulation implements the provisions added in 2003 to Section 4 of the NAIC Standard Non-forfeiture Law for Individual Deferred Annuities (MDL-805) and describes the calculations needed for redetermination of non-forfeiture rates. The requirements for equity-indexed annuities are also described.	
808	**Standard Nonforfeiture Law for Life Insurance**	This model provides guidance as to non-forfeiture benefits for life insurance. It includes provisions pertaining to the computation of cash surrender value, paid-up non-forfeiture benefits computations, adjusted premium calculations, proration of values, net value or paid up additions, consistency of progression of cash surrender values and applicable exceptions.	
811	**NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables**	This model permits individual life insurance policies to provide the same cash values and paid-up non-forfeiture benefits to men and women.	
812	**NAIC Model Rule Permitting Smoker/Nonsmoker Mortality Tables for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits**	This model permits the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.	
814	**Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits Model Regulation**	This model regulation prescribes the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with the NAIC Standard Valuation Law (MDL-820) and the NAIC Standard Non-forfeiture Law for Life Insurance (MDL-808).	
815	**Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities**	This model regulation recognizes permits and prescribes the use of mortality tables that reflect the differences in mortality between preferred and standard lives in determining minimum reserve liabilities.	
817	**Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Model Regulation**	The purpose of this model regulation is to establish for preneed insurance products minimum mortality standards for reserves and non-forfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard non-forfeiture values for preneed insurance products.	
818	**Determining Reserve Liabilities for Credit Life Insurance Model Regulation**	This model regulation recognizes the 2001 CSO Male Composite Ultimate Mortality Table for use in determining the minimum standard of valuation and specifies the interest rate and method to be used in determining the minimum standard of valuation for credit life insurance.	

STANDARD NONFORFEITURE AND VALUATION (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
820	**Standard Valuation Law**	The model law establishes standards for reserve liabilities valuation for all outstanding life insurance policies and annuity and pure endowment contracts. It requires actuarial opinion of reserves and contains provisions detailing the computation of minimum standard, reserve valuation, minimum reserves, optional reserves and minimum standards of valuation for health plans.	
821	**NAIC Model Rule for Recognizing a New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities**	This model regulation recognizes the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a," the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, the 2012 Individual Annuity Reserving (2012 IAR) Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.	
822	**Actuarial Opinion and Memorandum Regulation**	This model regulation prescribes requirements for statements of actuarial opinion submitted in accordance with the NAIC Standard Valuation Law (MDL-820) and for memoranda in support of the opinion.	
830	**Valuation of Life Insurance Policies Model Regulation**	This model regulation provides tables of select mortality factors and rules for their use; rules concerning a minimum standard for the valuation of plans with non-level premiums or benefits; and rules concerning a minimum standard for the valuation of plans with secondary guarantees. It is also referred to as Actuarial Guideline XXX.	

UNAUTHORIZED INSURANCE

840	**Unauthorized Insurers False Advertising Process Act**	This model act gives the commissioners jurisdiction to take action against unauthorized insurers that distribute false advertising in their respective states, according to the parameters outlined in the Unfair Trade Practices Act (MDL-880).	
850	**Unauthorized Insurers Process Act**	This model act subjects certain insurers to the jurisdiction of the respective state court in suits by or on behalf of insureds or beneficiaries under insurance contracts.	
870	**Nonadmitted Insurance Model Act**	The majority of this statute is devoted to the requirements for conducting surplus lines insurance business. Requirements for taxation of independently procured insurance are included, as well as procedures for actions by and against unauthorized insurers.	CF-30 - Capital and Surplus and Deposit Requirements for Surplus Lines Companies TX-55 - Direct Procurement Tax Rates

UNFAIR TRADE PRACTICES

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
880	**Unfair Trade Practices Act**	This model act regulates insurance trade practices by defining or providing for the determination of and prohibiting all such practices that constitutes unfair methods of competition or unfair or deceptive acts or practices.	PR-70 - Producers' Ability to Charge Fees and Collect Commissions MC-20 - Use of Credit Reports/Scoring in Underwriting MC-40 - Domestic Violence Laws MC-45 - Prohibitions Against Redlining and Other Geographic Discrimination
884	**Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act**	This model regulation implements provisions of the NAIC Unfair Trade Practices Act (MDL-880) regarding complaint recordkeeping.	
887	**Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment**	This model regulation identifies specific acts or practices in life and health insurance that are prohibited by the NAIC Unfair Trade Practices Act (MDL-880). The main purpose of this model is to make clear that life and health insurers cannot classify individuals without a rational basis for each decision.	
888	**Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness**	This model regulation is promulgated pursuant to the authority granted by the NAIC Unfair Trade Practices Act (MDL-880). It classifies failure to insure an individual because of blindness as an unfair trade practice.	
890	**Unauthorized Transaction of Insurance Criminal Model Act**	This model act prescribes penalties for those engaging in the unauthorized transaction of insurance or health coverage. It also sets out penalties for assisting an unauthorized insurer, as well as for engaging in repeated violations of this act.	CA-90 - Statutes Making the Unauthorized Transaction of Insurance a Criminal Act
891	**After Market Parts Model Regulation**	This model regulation regulates the use of after-market parts in automobile damage repairs that insurers pay for on their insured's vehicle. The regulation requires disclosure when any use is proposed of a non-original manufacturer part. It also requires that all after-market parts, as defined in the regulation, be identified and be of the same quality as the original part.	
895	**Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act**	This model act prohibits unfair discrimination by health carriers and insurance professionals on the basis of abuse status.	MC-40 - Domestic Violence Laws
896	**Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act**	This model act prohibits unfair discrimination by life insurers and insurance professionals on the basis of abuse status.	MC-40 - Domestic Violence Laws
897	**Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act**	This model act prohibits unfair discrimination by disability income insurers and insurance professionals on the basis of abuse status.	MC-40 - Domestic Violence Laws
898	**Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance**	This model prohibits unfair discrimination by property and casualty insurers and insurance professionals on the basis of abuse status.	MC-40 - Domestic Violence Laws
900	**Unfair Claims Settlement Practices Act**	This model act sets forth standards for the investigation and disposition of insurance claims. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance.	MC-50 - Claims Settlement Provisions MC-55 - Private Rights of Action for Unfair Claims Settlement Practices

UNFAIR TRADE PRACTICES (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
902	**Unfair Property/Casualty Claims Settlement Practices Model Regulation**	This model regulation sets forth minimum standards for the investigation and disposition of property and casualty claims. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. It is not intended to cover claims involving workers' compensation, fidelity, surety or boiler and machinery insurance.	MC-50 - Claims Settlement Provisions MC-55 - Private Rights of Action for Unfair Claims Settlement Practices
903	**Unfair Life, Accident and Health Claims Settlement Practices Model Regulation**	This model regulation sets forth minimum standards for the investigation and disposition of life, accident and health claims. The various provisions of this regulation are intended to define procedures and practices that constitute unfair claims practices. It is not intended to cover claims involving workers' compensation insurance.	MC-50 - Claims Settlement Provisions MC-55 - Private Rights of Action for Unfair Claims Settlement Practices
910	**Market Conduct Record Retention and Production Model Regulation**	This model regulation implements provision of the NAIC Unfair Trade Practices Model Act (MDL-880), the NAIC Unfair Claims Settlement Practices Model Act (MDL-900) and/or state examination authority statute regarding the retention and maintenance of records required for market conduct purposes.	MC-90 - State Laws on Records Maintenance
915	**Improper Termination Practices Model Act**	This model act helps protect policyholders from improper terminations of insurance coverage and sets forth standards for the regulation and disposition of terminations of policies or certificates of insurance.	
920	**Home Service Disclosure Model Act**	This model act establishes rules that ensure meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.	

HEALTH CARE REFORM

929	**American Health Benefit Exchange Model Act**	This model act provides for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market.	

NAIC GUIDELINES (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
1077	**Guideline for Implementation of Medical Professional Liability Closed Claim Reporting**	This guideline establishes detailed reporting requirements that are consistent with the NAIC Medical Professional Liability Closed Claim Reporting Model Law.	
1090	**Registration and Regulation of Third-Party Administrators (TPAs)**	This guideline establishes the status of a third-party administrator, providing definitions and guidance as to the authority and obligations of a third-party administrator.	CA-10 - Annual and Quarterly Financial Reporting Requirements PL-20 - Third Party Administrator Licensure and Bond Requirements MC-90 - State Laws on Records Maintenance
1224	**Independent Adjuster Licensing Guideline**	This guideline governs the qualifications and procedures for licensing independent adjusters. It specifies the duties of and places restrictions on independent adjusters.	PL-40 - Adjuster Licensing Requirements
1525	**Notice of Protection Provided by [State] Life and Health Insurance Guaranty Association**	This guideline is designed to help states proceed with revisions to Section 19: Prohibited Advertisement of Insurance Guaranty Association Act in Insurance Sales; Notice to Policy Owners in the Life and Health Insurance Guaranty Association Model Act – Model # 520. This guideline updates the general notice on guaranty association coverage required to be provided under Section 19 of the Model Act.	
1556	**Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts**	This guideline provides states with language for a stay provision similar to the Federal Deposit Insurance Act with respect to an insurer in insolvency. The stay provision would give the receiver 24 hours to transfer qualified financial contracts by the receiver to another entity before contract termination.	
1600	**Guideline for Payment of Interest to Receiver on Overdue Reinsurance Recoverables**	This guideline governs the payment of interest on reinsurance recoverables held by insurers in receivership.	
1626	**Financial Guaranty Insurance Guideline**	The purpose of this guideline is to set requirements for monoline financial guaranty insurers.	
1650	**Title Agent Statistical Data Plan Implementation Guideline**	The purpose of this guideline is to provide useful information to state regulators about the business of title insurance at the agency level.	
1690	**Antifraud Plan Guideline**	The purpose of this guideline is to establish standards for state fraud bureaus, insurance company SIUs and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements for submitting a plan with a state Department of Insurance.	
1694	**Automobile Insurance Fraud Guideline**	This guideline relates to the use of runners, cappers, or steerers and police accident reports in solicitation schemes and attempts to fraudulently assert a claim against an insured or an insurance carrier.	
1700	**Guideline for Implementation of State Orderly Liquidation Authority**	This guideline is intended as a for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal Dodd-Frank Wall Street Reform and Consumer Protection Act.	

NAIC GUIDELINES (cont.)

Model #	Title of Model	Description	Related Charts: State Laws on Insurance Topics
1750	**Title Insurance Consumer Protection Fund Guideline**	This guideline provides a mechanism for continuation of coverage; provides payment of covered claims under certain insurance policies; prevents excessive delay in payment; prevents financial loss to policyholders because of the insolvency of a title insurer; and provides an Association to assess the costs of such protection.	
1775	**Property and Casualty Model Rating Law (File and Use Version)**	This guideline sets rate standards for a competitive marketplace. Procedures for rate filings and disapproval of those filings are included.	PA-10 - Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title
1776	**Property and Casualty Model Rate and Policy Form Law Guideline**	The purpose of this guideline is: (1) to prohibit price fixing agreements and other anticompetitive behavior by insurers; (2) to protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates; (3) to promote beneficially competitive markets and to protect insurance consumers from the absence of beneficially competitive markets; among other things.	PA-10 - Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title PA-15 - Form Filing Methods for Property/Casualty
1780	**Property and Casualty Model Rating Law (Prior Approval Version)**	The purpose of this guideline is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate limited cooperative action among insurers in ratemaking-related activities and in other matters within the scope of the guideline.	PA-10 - Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title
1781	**Property and Casualty Model Rate and Policy Form Regulation Guideline**	This guideline provides for exemptions for insurers from rate and form regulation sales made to "exempt commercial policyholders" (large, sophisticated commercial risks).	PA-10 - Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title PA-15 - Form Filing Methods for Property/Casualty
1860	**Guideline on Nonadmitted Accident and Health Coverages**	This guideline provides assistance to states updating laws and establishing procedures for allowing accident and health coverage to be procured in the nonadmitted market either independently or through surplus lines brokers.	
1950	**Guidelines for Regulation and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements**	The purpose of this guideline is to ensure that: (1) PEOs and their clients properly obtain workers' compensation insurance coverage; (2) premiums paid are commensurate with anticipated claims experience; (3) coverage is obtained for all employees, including direct hire employees and persons employed under PEO agreements.; and (4) there are appropriate procedural frameworks for the inception, continuation, and termination of coverage.	
1970	**Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (Large Deductible Filing Guidelines)**	The purpose of this guideline is to provide suggestions for approval of large deductible policies and programs that are consistent with the NAIC/IAIABC white paper, Workers' Compensation Large Deductible Study.	
1980	**Guideline for Administration of Large Deductible Policies in Receivership**	The purpose of this Guideline is to provide alternative model language for administration of large deductible workers' compensation policies in receivership.	
1985	**Guideline for Definition of Reciprocal State in Receivership Laws**	The purpose of this guideline is to define "Reciprocal State" for receivership laws.	

HEALTH INSURANCE RESERVES MODEL REGULATION

TABLE OF CONTENTS

Section 1. Introduction

A. Purpose and Scope

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Standard Valuation Law].

These standards apply to all individual and group health [accident and sickness] insurance coverages including single premium credit disability insurance. All other credit insurance is not subject to this regulation.

When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

B. Categories of Reserves

The following sections set forth minimum standards for three categories of health insurance reserves:

Section 2. Claim Reserves
Section 3. Premium Reserves
Section 4. Contract Reserves

Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

C. Appendices

These standards contain two appendices which are an integral part of the standards, and one additional "supplementary" appendix which is not part of the standards as such, but is included for explanatory and illustrative purposes only.

Appendix A. Specific minimum standards with respect to morbidity, mortality and interest, which apply to claim reserves according to year of incurral and to contract reserves according to year of issue.

Appendix B. Glossary of Technical Terms Used.

Appendix C. (Supplementary) Reserves for Waiver of Premium.

Section 2. Claim Reserves

A. General

(1) Claim reserves are required for all incurred but unpaid claims on all health insurance policies. For contracts with an elimination period, the duration of disablement shall be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(3) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

(4) For claim reserves on policies that require contract reserves, the claim incurral date is to be considered the "issue date" for determining the table and interest rate to be used for claim reserves.

(5) The maximum interest rate for claim reserves is specified in Appendix A.

(6) With respect to claim reserves for policies issued before the operative date of the Valuation Manual, the requirements for claim reserves on claims incurred after that date shall be as described in the Valuation Manual based on the incurred date of the claim.

Drafting Note: The historical application of new requirements for claim reserves has been the incurred date of the claim. The 2009 changes to the Standard Valuation Law apply new requirements provided through the Valuation Manual **only to policies** issued after the effective date of the changes and the Valuation Manual. This addition makes new requirements for claim reserves applicable based on the incurred date irrespective of the policy issue date – *i.e.* consistent with historical practice.

B. Minimum Morbidity Standards for Individual Disability Income Claim Reserves

(1) For claims incurred prior to [January 1, 2005], each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(a) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(b) The standards as defined in Section 2B(2) or (3) applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in either Section 2B(2) or (3), all future valuations must be on that basis.

(2) For claims incurred on or after [January 1, 2005] and prior to the effective date for the company as determined in Section 2B(5), the minimum standards with respect to morbidity are those specified in Appendix A, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(3) For claims incurred on or after January 1, 2020, the minimum standards are those specified in Appendix A, including (as derived in accordance with Actuarial Guideline L):

(a) The use of the insurer's own experience;

(b) An adjustment to include an own experience measurement margin; and

(c) The application of a credibility factor.

(4) In determining the minimum reserves in accordance with Section 2B(3), the provisions in Section 2B(3)(a), (b) and (c) are not required if:

(a) The insurer meets the Own Experience Measurement Exemption provided in Actuarial Guideline L; or

(b) For worksite disability policies with benefit periods of up to two years, at the option of the insurer, disabled life reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(5) An insurer may begin to use the minimum reserve standards in Section 2B(3) above at a date earlier than January 1, 2020, but not prior to January 1, 2017.

(6) An insurer may, within three years of January 1, 2020, (or such earlier date it elects under Section 2B(5)) to apply the new standards in Section 2B(3) to all open claims incurred prior to the effective date for Section 2B(3) for the insurer. Once an insurer elects to calculate reserves for all open claims based on Section 2B(3), all future valuations must be on that basis.

Drafting Note: The 2013 Table requires additional information that was not required to determine claim reserves under prior tables. The three-year period is a period after the date a company starts using the 2013 Table for new claims to allow the company to update its claims data to use the 2013 Table for claims incurred prior to that date. For example, if a company begins to use the 2013 Table on January 1, 2020, for claims incurred after that date, it does not need to immediately convert all existing claims. This provision allows for the run-off of existing claims until December 31, 2022. As of that date (or an earlier date), the company must either continue use of the existing tables applicable to these claims or may convert all still open claims to the 2013 Table (adding the necessary data only for the remaining open claims).

C. Minimum Morbidity Standards for Group Disability Income Claim Reserves

(1) For claims incurred prior to [January 1, 2005], each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(a) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(b) After the effective date selected by the company in Section 2C(2), the standards as defined in Section 2C(2), applied to all open group long term disability income claims, or

(c) The standards as defined in Section 2C, (3), applied to all open group disability income claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(2) For group long-term disability income claims incurred on or after [January 1, 2005], but before the effective date selected by the company in Section 2C(3), and group disability income claims incurred on or after [January 1, 2005], that are not group long-term disability income, the minimum standards with respect to morbidity are those specified in Appendix A except that, at the option of the insurer:

(b) Assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) Assumptions regarding claim termination rates for the period two (2) or more years but less than five (5) years from the date of disablement may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(i) An analysis of the credibility of the experience;

(ii) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(iii) A description and quantification of the margins to be included;

(iv) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(v) A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) Any other information deemed necessary by the commissioner.

(d) Each insurer may elect which of the following to use as the minimum morbidity standard for group long-term disability income claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(ii) The standards as defined in Section 2C(3), applied to all open claims.

Once an insurer elects to calculate reserves for all open claims on a more recent standard, then all future valuations must be on that basis.

(3) For group long-term disability income claims incurred on or after January 1, 2017, the minimum standards with respect to morbidity shall be based on the 2012 GLTD termination table or subsequent table with considerations of:

(a) The insurer's own experience computed in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*, and

(b) An adjustment to include an own experience measurement margin derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*, and

(c) A credibility factor derived in accordance with Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*.

(4) An insurer may begin to use the minimum reserve standards in Section 2C(3) above at a date earlier than January 1, 2017, but not prior to October 1, 2014. An insurer may apply the standards in Section 2C (3) to all open claims incurred prior to the effective date for Section 2C(3) for the insurer. Once an insurer elects to calculate reserves for all open claims based on Section 2C(3), all future valuations must be on that basis.

Drafting Note: For experience to be considered credible for purposes of Paragraph (2), the company should be able to provide claim termination patterns over no more than six (6) years reflecting at least 5,000 claims terminations during the third through fifth claims durations on reasonably similar applicable policy forms.

For claim reserves to reflect "sound values" and reasonable margins, reserve tables based on credible experience should be adjusted regularly to maintain reasonable margins. Demonstrations may be required by the commissioner of the state of domicile based on published literature (e.g., Goldman, TSA XLII).

Drafting Note: The 2012 GLTD Valuation Table is based on experience for claims with maximum benefit periods in excess of two years. The 2012 Table (or any single morbidity table) may not be appropriate for claims with maximum benefit periods less than or equal to two years (i.e., STD or GSTD) for the following reasons: 1) benefit designs, definitions of disability and markets vary much more widely between companies for GSTD than for GLTD; 2) as a result, termination experience varies significantly and a single morbidity standard would not be achievable; 3) most companies' book of GSTD business would be fully credible; 4) calculating tabular claim reserves for GSTD claims would not result in an appreciably more adequate claim reserving method (e.g., claim triangles) with margins; 5) it has been common industry practice to use aggregate methods as the basis for GSTD claim reserves.

D. Minimum Morbidity Standard for Other Health Insurance Claim Reserves

The reserve should be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

E. Claim Reserve Methods Generally

A generally accepted actuarial reserving method or other reasonable method, if, after a public hearing, the method is approved by the commissioner prior to the statement date, or a combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

Section 3. Premium Reserves

A. General

(1) Except as noted in Paragraph (2), unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) Single premium credit disability insurance, both individual and group, is excluded from unearned premium reserve requirements of this Section 3.

(3) If premiums due and unpaid are carried as an asset, the premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes and the cost of collection associated with due and unpaid premiums shall be carried as an offsetting liability.

(4) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

B. Minimum Standards for Unearned Premium Reserves

(1) The minimum unearned premium reserve with respect to a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of:

(a) The valuation net modal premium on the contract reserve basis applying to the contract; or

(b) The gross modal premium for the contract if no contract reserve applies.

(2) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. The reserve shall never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

Drafting Note: States should be aware that while single premium credit disability insurance is excluded from unearned premium reserve requirements, there may be requirements elsewhere in statutory accounting to test reserves against the premium refund net liability.

C. Premium Reserve Methods Generally

The insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages and aggregate estimation; in computing premium reserves. Approximations or estimates should be tested periodically to determine their continuing adequacy and reliability.

Section 4. Contract Reserves

A. General

(1) Contract reserves are required, unless otherwise specified in Section 4A(2) for:

(a) All individual and group contracts with which level premiums are used; or

(b) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in this subparagraph shall be determined on the basis specified in Subsection B of this section.

Drafting Note: Language permitting a rating block test was added because a concern arose that the existing minimum reserve standards could be interpreted as requiring contract reserves on a per contract basis for products that are community rated or that use other rating methodology based on cross-subsidies among contracts within the block. If rates are determined such that each year's premium is intended to cover that year's cost, the rating block approach results in no contract reserves unless required by Subsection D. If rates are designed to prefund future years' costs, contract reserves will be required.

(2) Contracts not requiring a contract reserve are:

(a) Contracts that cannot be continued after one year from issue; or

(b) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(3) The contract reserve is in addition to claim reserves and premium reserves.

(4) The methods and procedures for contract reserves shall be consistent with those for claim reserves for a contract, or else appropriate adjustment shall be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral shall be the same in both determinations.

(5) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

B. Minimum Standards for Contract Reserves

(1) Basis

(a) Morbidity or Other Contingency. Minimum standards with respect to morbidity are those set forth in Appendix A. Valuation net premiums used under each contract shall have a structure consistent with the gross premium structure at issue of the contract as this relates to the advancing age of insured, contract duration and period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in Appendix A shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner. The morbidity tables shall contain a pattern of incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

Drafting Note: Section 4B(1)(a) only applies to the premium structure applicable to each contract. The relationship among gross premiums for different contracts (e.g., variations by age) has no bearing on the net premium structure. If for a policy form there is no gross premium variation by age, the valuation net premiums will nonetheless vary based on age at issue for each contract since at issue the present value of valuation net premiums for a contract must equal the present value of tabular claim costs.

(i) In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

Drafting Note: The last sentence is intended to provide allowances for a known event, such as a new drug release, but at the time of this writing, there are no specific examples that could be pointed to in the recent past that would have met this standard. This is intended to be an extremely rare event.

(ii) Business in force as of the effective date of Section 4B(1)(c)(iii) may be permitted to retain the original reserve basis which may not meet the provisions of Item (i) above, subject to the acceptability to the commissioner.

Drafting Note: The consistency between the gross premium structure and the valuation net premium is required only at issue, because the impact on such consistency after issue of regulatory restrictions on premium rate increases is still under study.

(b) Interest. The maximum interest rate is specified in Appendix A.

(c) Termination Rates. Termination rates used in the computation of reserves shall be on the basis of a mortality table as specified in Appendix A except as noted in the following items:

(i) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(I) Eighty percent of the total termination rate used in the calculation of the gross premiums, or

(II) Eight percent;

(ii) For long-term care individual policies or group certificates issued after January 1, [1997], the contract reserve may be established on a basis of separate:

(I) Mortality (as specified in Appendix A); and

(II) Terminations other than mortality, where the terminations are not to exceed:

- For policy years one (1) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and eight percent (8%);
- For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%).

(iii) For long-term care individual policies or group certificates issued on or after January 1, [2005], the contract reserve shall be established on the basis of:

(I) Mortality (as specified in Appendix A); and

(II) Terminations other than mortality, where the terminations are not to exceed:

- For policy year one, the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and six percent (6%);
- For policy years two (2) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%); and
- For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and two percent (2%), except for group insurance as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act, i.e., employer groups] where the 2% shall be three percent (3%).

(iv) Where a morbidity standard specified in Appendix A is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the commissioner.

(2) Reserve Method.

(a) For insurance except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(b) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(i) For individual policies and group certificates issued on or before December 31, [1991], reserves calculated on the two-year full preliminary term method;

(ii) For individual policies and group certificates issued on or after January 1, [1992], reserves calculated on the one-year full preliminary term method.

(c) (i) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(I) On the one year preliminary term method if the benefits are provided at any time before the twentieth anniversary;

(II) On the two year preliminary term method if the benefits are only provided on or after the twentieth anniversary.

(ii) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(3) Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(4) Nonforfeiture Benefits for Long-Term Care Insurance. The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

Drafting Note: While the above consideration for nonforfeiture benefits is specific to long-term care insurance, it should not be interpreted to mean that similar consideration may not be applicable for other lines of business.

C. Alternative Valuation Methods and Assumptions Generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

D. Tests for Adequacy and Reasonableness of Contract Reserves

Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of Section 4B.

In the event a company has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

Section 5. Reinsurance

Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

Section 6. Effective Date

The regulation shall be effective on [insert date].

APPENDIX A. SPECIFIC STANDARDS FOR MORBIDITY, INTEREST AND MORTALITY

I. MORBIDITY

A. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 1965, and prior to January 1, [YEAR 1]:

The 1964 Commissioners Disability Table (64 CDT).

Contracts issued on or after January 1, [YEAR 1] and before January 1, 2020:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Contracts issued during [YEAR 1 or YEARS]:

Optional use of either the 1964 Table or the 1985 Tables.

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

Contracts issued on or after January 1, 2020:

The 2013 IDI Valuation Table with modifiers as described in Actuarial Guideline L.

An insurer may begin to use the 2013 IDI Valuation Table with modifiers at a date earlier than January 1, 2020, but not prior to January 1, 2017.

Within three years of 2020, or the earlier date an insurer begins to use the 2013 IDI Valuation Table, the insurer may elect to apply that morbidity standard for all policies issued subject to other valuation tables. This may be done if the following conditions are met:

(i) The insurer must apply the morbidity standard to all inforce policies and incurred claims;

(ii) The insurer elects or has elected to apply the 2013 IDI Valuation Table to all claims incurred regardless of incurred date;

(iii) The insurer maintains adequate policy records on policies issued prior to 2020, that allow the insurer to apply the 2013 IDI Valuation Table appropriately;

(iv) Once an insurer elects to calculate reserves for all inforce policies based on the current morbidity standard, all future valuations must be on that basis.

Drafting Note: As an example of the [YEAR] values to be used by a state, the following would be the actual "year" values if a state were to have adopted these changes effective January 1, 2010 (with optional early use from January 1, 2007 through December 31, 2009):

Contract Reserves –

- Contracts issued on or after January 1, 1965 and prior to January 1, 2007: The 1964 Commissioners Disability Table (64 CDT).
- Contracts issued during 2007, 2008 or 2009: Optional use of either the 1964 Table or the 1985 Tables.
- Contracts issued on or after January 1, 2010 and before January 1, 2017:
    - The 1985 Commissioners Individual Disability Tables A (85CIDA); or
    - The 1985 Commissioners Individual Disability Tables B (85CIDB).
- Contracts issued during 2017, 2018 or 2019: Optional use of either the 1985 Tables (as previously used) or the 2013 IDI Table.
- Contracts issued on or after January 1, 2020: The 2013 IDI Table.

(b) Claim Reserves:

(i) For claims incurred on or after [effective date of this amendment] and prior to 2020:

The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

Duration	Adjustment Factor	Adjusted Termination Rates*
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448

Duration	Adjustment Factor	Adjusted Termination Rates*
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (*Transactions of the Society of Actuaries* (TSA) XXXVII, pp. 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

** Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pp. 462-463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 Commissioners Individual Disability Table C).

For claims incurred on or after 2020, the 2013 IDI Valuation Table with modifiers and adjustments for company experience as prescribed in the Actuarial Guideline L, except for worksite disability policies with benefit periods of 24 months or less.

(ii) For worksite disability policies, claim reserves may be calculated using claim run-out analysis or claim triangles, or other methods that place a sound value on the reserves that are appropriate for the business and risks involved.

(iii) For claims incurred prior to [effective date of this amendment]:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to [effective date of this amendment]:

(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred, or

(II) The standard as defined in Appendix A, Section I.A(1)(b)(i) or (ii), applied to all open non-worksite claims, provided the insurer maintains adequate claim records to allow the insurer to apply the standard defined in Appendix A, Section I.A(1)(b)(i) or (ii) appropriately. Once an insurer elects to calculate reserves for all open claims on the standard defined in Appendix A, Section I.A.(1)(b)(i) or (ii), all future valuations must be on that basis. This option, with respect to Appendix A, Section I.A.(1)(b)(ii), may be selected only if the insurer maintains adequate claim records for all claims incurred to use the 2013 IDI Valuation Table appropriately.

(2) Hospital Benefits, Surgical Benefits and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

(a) Contract Reserves:

Contracts issued on or after January 1, 1955, and before January 1, 1982:

The 1956 Intercompany Hospital-Surgical Tables.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, *Transactions of the Society of Actuaries*, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(b) Claim Reserves:

No specific standard. See (6).

(3) Cancer Expense Benefits.

(a) Contract Reserves:

(i) Contracts issued on or after January 1, 1986 and before January 1, 2019:

The 1985 NAIC Cancer Claim Cost Tables (1985 CCCT).

(ii) Contracts issued on or after January 1, 2019:

(I) For first occurrence and hospitalization benefits:

The 2016 Cancer Claim Cost Valuation Tables (2016 CCCVT); https://content.naic.org/sites/default/files/actuary-01-naic-2017-cancer-claim-cost-valuation-table.xlsx

(II) For all other benefits:

Assumptions based on company experience, relevant industry experience, and actuarial judgement. Such assumptions should be appropriate for valuation which considers margin for adverse experience.

(iii) For contracts issued on or after January 1, 2018, and before January 1, 2019, a company may elect to use morbidity basis described in Item (ii) above. Once a company begins use of the 2016 CCCVT for new issues, it may not revert to the 1985 CCCT.

(b) Claim Reserves:

No specific standard. See (6).

(4) Accidental Death Benefits.

(a) Contract Reserves:

Contracts issued on or after January 1, 1965:

The 1959 Accidental Death Benefits Table.

(b) Claim Reserves:

Actual amount incurred.

(5) Single Premium Credit Disability.

(a) Contract Reserves:

(i) For contracts issued on or after [effective date of this amendment]:

(I) For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).

(II) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in Subitem (I).

(ii) For contracts issued prior to [effective date of this amendment], each insurer may elect either Subitem (I) or (II) to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Item (i), all future valuations must be on that basis.

(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

Drafting Note: If the state does not have a minimum morbidity standard in effect for contract reserves on currently issued contracts, the state shall accept the methodology approved by the commissioner in the state of domicile.

(II) The standard as defined in Item (i), applied to all contracts.

(b) Claim Reserves:

Claim reserves are to be determined as provided in Section 2E.

(6) Other Individual Contract Benefits.

(a) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in the standards.

B. Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness, where the Model references this Appendix; otherwise Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual*.

(a) Contract Reserves:

Contracts issued prior to January 1, [YEAR]:

The same basis, if any, as that employed by the insurer as of January 1, [SAME YEAR];

Contracts issued on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim Reserves:

For claims incurred on or after January 1, [YEAR]:

The 1987 Commissioners Group Disability Income Table (87CGDT);

For claims incurred prior to January 1, [YEAR]:

Use of the 87CGDT is optional.

(2) Single Premium Credit Disability

(a) Contract Reserves:

(i) For contracts issued on or after [effective date of this amendment]:

(I) For plans having less than a thirty-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by twelve percent (12%).

(II) For plans having a thirty-day and greater elimination period, the 85CIDA for a fourteen-day elimination period with the adjustment in item (I).

(ii) For contracts issued prior to [effective date of this amendment], each insurer may elect either Item (I) or (II) to use as the minimum standard. Once an insurer elects to calculate reserves for all contracts on the standard defined in Item (i), all future valuations must be on that basis.

(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the contract was issued, or

(II) The standard as defined in Item (i), applied to all contracts.

(b) Claim Reserves:
Claim reserves are to be determined as provided in Section 2C.

(3) Other Group Contract Benefits.

(a) Contract Reserves:
For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

(b) Claim Reserves:
For all benefits other than disability, claim reserves are to be determined as provided in the standards.

II. INTEREST

A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

III. MORTALITY

A. Unless Subsection B or C applies, the mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued before [January 1, 1997, or the effective date set in state regulations, whichever is later] shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after [January 1, 1997, or the effective date set in state regulations, whichever is later], the mortality basis used shall be the 1983 Group Annuity Mortality Table without projection. For long-term care insurance individual policies or group certificates issued on or after the effective date of Section 4B(1)(c)(iii), the mortality basis used shall be the 1994 Group Annuity Mortality Static Table.

B. Other mortality tables adopted by the NAIC and promulgated by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for approval shall include the proposed mortality table and the reason that the

standard specified in Subsection A is inappropriate.

C. For single premium credit insurance using the 85CIDA table, no separate mortality shall be assumed.

APPENDIX B. GLOSSARY OF TECHNICAL TERMS USED

As used in this valuation standard, the following terms have the following meaning:

ANNUAL-CLAIM COST. The net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

CLAIMS ACCRUED. That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

CLAIMS REPORTED. When an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

CLAIMS UNACCRUED. That portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

CLAIMS UNREPORTED. When an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

DATE OF DISABLEMENT. The earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

ELIMINATION PERIOD. A specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

GROSS PREMIUM. The amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit or contingencies.

GROUP INSURANCE. The term group insurance includes blanket insurance and franchise insurance and any other forms of group insurance.

GROUP LONG-TERM DISABILITY INCOME. The term "group long-term disability income" includes group contracts providing group disability income coverage with a maximum benefit duration longer than two years. Group long-term disability income contracts are based on a group pricing structure. The term "group long-term disability" does not include group short-term disability (coverage with benefit periods of two years or less in maximum duration). It also does not include voluntary group disability income coverage that is priced on an individual risk structure and generally sold in the workplace.

LEVEL PREMIUM. A premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

LONG-TERM CARE INSURANCE. Any insurance policy or rider advertised, marketed, offered or designed to provide coverage

for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

MODAL PREMIUM. This refers to the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

NEGATIVE RESERVE. Normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

PRELIMINARY TERM RESERVE METHOD. Under this method of valuation the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

PRESENT VALUE OF AMOUNTS NOT YET DUE ON CLAIMS. The reserve for "claims unaccrued" (see definition), which may be discounted at interest.

RATING BLOCK. "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics filed with the commissioner, such as a policy form or forms having similar benefit designs.

RESERVE. The term "reserve" is used to include all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

TERMINAL RESERVE. This is the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

UNEARNED PREMIUM RESERVE. This reserve values that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

VALUATION NET MODAL PREMIUM. This is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

WORKSITE DISABILITY POLICIES. The term worksite disability policy refers to individual short-term disability policies that are sold at the worksite through employer-sponsored enrollment, cover normal pregnancy, and that have benefit periods up to 24 months. Worksite disability policies do not include personal disability policies sold to an individual and not associated with employer-sponsored enrollment. They also do not include business overhead expense, disability buyout, or key person policies, in whatever manner those policies are sold.

APPENDIX C. RESERVES FOR WAIVER OF PREMIUM
(Supplementary explanatory material)

Waiver of premium reserves involve several special considerations. First, the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are NOT reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1989 Proc. I 9, 23-25, 651-658, 705 (adopted new model).
1989 Proc. II 13, 23-24, 467, 875 (adopted technical amendment).
1991 Proc. II 25, 58, 719, 1257-1264 (amended and reprinted).
1993 Proc. I 8, 136, 820, 1460-1462 (amended).
1993 Proc. 1st Quarter 3, 34, 266, 438-446 (amended and reprinted).
1996 Proc. 2nd Quarter 10, 30, 732, 960, 961-964 (amended).
1997 Proc. 4th Quarter 1175-1188 (model adopted later is printed here).
1998 Proc. 1st Quarter 15, 17, 770, 1000, 1056-1057 (amended).
2000 Proc. 2nd Quarter 21, 22, 163-164, 166-168, 1098, 1112 (amended).
2001 Proc. 2nd Quarter 12, 14, 112-113, 991, 1130, 1132-1137 (amended).
2003 Proc. 3rd Quarter 217, 1006, 1013, (amended, adopted by parent committee).
2003 Proc. 4th Quarter 16 (Adopted by Plenary).
2003 Proc. 4th Quarter 390, 2059, 2065, 2116-2121 (amended, further amendments adopted by parent committee).
2004 Proc. 1st Quarter Vol. I 53 (adopted by Plenary).
2014 Proc. 1st Quarter, Vol. I 120-121, 133-136, 196-221, 280, 859, 914, 1019, 1036 (amended).
2016 Proc. 2nd Quarter, Vol. I 113, 137-141, 295-321, 501, 517 (amended).
2017 Spring National Meeting (amended).
2023 technical edit

Chronological Summary of Action (all references are to the Proceedings of the NAIC) (cont.)

The following has been superseded by the model above:

Reserve Standards for Individual Health Insurance Policies

1941 Proc. 160-162 (adopted).
1957 Proc. I 75, 77, 78-85, 107 (amended).
1959 Proc. I 90 (reaffirmed).
1965 Proc. I 71, 73-86, 88 (adopted 1964 Commissioners Disability Table).
1981 Proc. II 27, 35, 558, 561, 778, 781, 823-826 (amended).
1985 Proc. II 11, 23, 564, 567-569, 609-612 (cancer tables added).
1986 Proc. I 601-605 (Contains amendments adopted in June 1985 but omitted from that Proceedings).
1986 Proc. I 9, 23, 547, 557-558, 666 (Appendix A amended).

HEALTH INSURANCE RESERVES MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH INSURANCE RESERVES MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE. r. 482-1-134-.01 to 482-1-134-.06 (2005).	ALA. CODE §§ 27-36-1 to 27-36-6 (1971/2017).
Alaska		ALASKA STAT. §§ 21.18.080 to 21.18.086 (1966/1997).	
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-501 to 20-509 (2001).
Arkansas		ARK. ADMIN. CODE. § 054.00.22 (1976/1999).	
California		CAL. CODE REGS. tit.10, §§ 2310 to 2315 (1994/2005).	CAL. INS. CODE § 997 (1959/1984).
Colorado		3 COLO. CODE REGS. § 702-3:3-1-9 (1993/2013).	
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-11 to 38a-78-16 (1993/2018).		
Delaware			DEL. CODE ANN. tit. 18, § 1108 (1953/1968).
District of Columbia	NO CURRENT ACTIVITY		

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida		FLA. ADMIN. CODE ANN. r. 69O-154.201 to 69O-154.210 (1999/2016).	
Georgia			GA. CODE ANN. § 33-10-8 (1960/1985).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAWAII REV. STAT. §§ 431:5-301 to 431:5-306 (1955/1987).
Idaho	NO CURRENT ACTIVITY		
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2004.20 to 2004.50 (1965/2017).	215 ILL. COMP. STAT. ANN. 5/353a (1937/1965).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas		KAN. ADMIN. REGS. § 40-4-21 (1968/1986).	
Kentucky			KY. REV. STAT. ANN. § 304.6-070 (1970/2010).
Louisiana			LA. REV. STAT. ANN. § 22:761; § 22:764 (1968/2009).
Maine		02-031 ME. CODE R. § 130 (1991/2006).	
Maryland			MD. CODE ANN. INS. § 5-203 (1963/1997).
Massachusetts	NO CURRENT ACTIVITY		
Michigan		MICH. COMP. LAWS ANN. §§ 500.701 to 500.737 (1994).	
Minnesota		MINN. STAT. §§ 60A.760 to 60A.768 (2004).	

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi			MISS. CODE ANN. § 83-9-106 (1992) (authority to adopt regulation).
Missouri			MO. CODE REGS. ANN. tit. 20, § 200-1.140 (1969/2001).
Montana			MONT. CODE ANN. § 33-2-514 (1959/1997).
Nebraska			NEB. REV. STAT. § 44-409 (1913/2005).
Nevada			NEV. REV. STAT. § 681B.080 (1971).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey		N.J. ADMIN. CODE §§ 11:4-6.1 to 11:4-6.18 (1965/2017).	
New Mexico		N.M. CODE R. §§ 13.10.14.1 to 13.10.14.26 (1997/2003).	
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 94.1 to 94.11 (1971/2017) (Regulation 56).		
North Carolina		11 N.C. ADMIN. CODE 11F §§ 0201 to 0208 (1994/2004).	
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE § 3901-3-13 (1996/1996).	
Oklahoma			OKLA. STAT. tit. 36, § 1508 (1957).
Oregon	OR. ADMIN. R. 836-031-0200 to 836-031-0300 (1995/2018).		OR. REV. STAT. § 733.080 (1967/1971).
Pennsylvania		31 PA. CODE §§ 84a.1 to 84a.8 (1993/2007).	NOTICE 7-15-2006 (#2) (2006).

HEALTH INSURANCE RESERVES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 516 to 524 (1966/2008).
Rhode Island		230 R.I. CODE. R §§ 20-30-3.1 to 20-30-3.10 (1996/2001).	
South Carolina		S.C. CODE ANN. REGS. 69-7 (1991/1997).	
South Dakota			S.D. CODIFIED LAWS § 58-26-30 (1966).
Tennessee		TENN. COMP. R. & REGS. 0780-01-69 (1998/2018).	
Texas		28 TEX. ADMIN. CODE §§ 3.7001 to 3.7010 (1992/2018).	
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		14 VA. ADMIN. CODE §§ 5-320-10 to 5-320-70 (1979/1994).	
Washington		WASH. ADMIN. CODE §§ 284-16-400 to 284-16-540 (1992).	
West Virginia		W. VA. CODE R. §§ 114-44-1 to 114-44-10 (1996).	W. VA. CODE ANN. § 33-7-7 (1957/1969).
Wisconsin		WIS. ADMIN. CODE 3.17 (1989/1992).	
Wyoming			WYO. STAT. § 26-6-107 (1967/1983).

PROJECT HISTORY - 2016

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2016 Cancer Claim Cost Valuation Tables)

1. Description of the Project, Issues Addressed, etc.

The 2016 Cancer Claim Cost Valuation Tables (2016 CCCVT) were proposed by the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Cancer Claim Cost Tables Work Group as the basis for a new minimum valuation standard for cancer insurance contracts issued on or after Jan. 1, 2019, to replace the current 1985 NAIC Cancer Claim Cost Tables. To do so, Model #10 had to be amended to make reference to the new tables.

2. Name of Group Responsible for Drafting the Model and States Participating

The Cancer Claims Cost Table (B) Subgroup—comprising regulator representatives from California, Georgia, Nebraska, New York and Utah—oversaw the drafting of the proposed amendments to Model #10.

3. Project Authorized by What Charge and Date First Given to the Group

In May 2004, the Accident and Health Working Group of the Life and Health Actuarial Task Force (predecessor of the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force) charged the Academy and the SOA with developing tables to replace the 1985 NAIC Cancer Claim Cost Tables for active life reserves associated with contracts issued past a date to be specified later. As the Academy neared completion of its charge to develop the tables, the Health Actuarial (B) Task Force appointed the Cancer Claims Cost Table (B) Subgroup. The Subgroup was charged with overseeing the addition of references to the table to Model #10, and collaborating with the Statutory Accounting Principles (E) Working Group to add references to the table in the *Accounting Practices and Procedures Manual*.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to Model #10 was provided to the Cancer Claims Cost Table (B) Subgroup by America's Health Insurance Plans (AHIP). The draft was discussed and modified, with input from interested regulators and the industry, on an open conference call of the Subgroup held Dec. 22, 2016. The final version of the proposed amendments to Model #10 was adopted by the Subgroup on a conference call held Feb. 8, 2017. The Health Actuarial (B) Task Force adopted the proposed amendments to Model #10 on a conference call held Feb. 24, 2017. The Health Insurance and Managed Care (B) Committee adopted the proposed amendments to Model #10 on a conference call held March 16, 2017.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force voted at the 2016 Summer National Meeting to expose the 2016 CCCVT for a public comment period ending Oct. 6, 2016. Several comments from regulators and the industry were received concerning how to compute reserves for benefits other than those addressed by the two CCCVT tables, first occurrence and hospitalization. Regulators, the industry and the Academy participated in drafting amendments to Model #10 to incorporate the 2016 CCCVT, and to address the valuation of benefits not covered by the two tables. The final version of the proposed amendments to Model #10 was adopted by the Cancer Claims Cost Table (B) Subgroup, the Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee (please see item #4 for the dates of adoption by each group).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see item #5.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2016

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2013 IDI Valuation Table)

1. Description of the Project, Issues Addressed, etc.

The 2013 Individual Disability Income (IDI) Valuation Table was proposed by the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Individual Disability Tables Work Group as the basis for a new minimum reserve valuation standard for IDI claims incurred and contracts issued on or after Jan. 1, 2020, to replace the current standard and its 1985 Commissioners Individual Disability A (CIDA) and 1985 Commissioners Individual Disability C (CIDC) Tables. Model #10 needs to be amended to make reference to the new table and the actuarial guideline that gives detailed instructions for its application.

2. Name of Group Responsible for Drafting the Model and States Participating

The Individual Disability Valuation Table Implementation (B) Subgroup, comprising regulator representatives from Alabama, California, Florida, Kansas, Nebraska, New York and Texas oversaw the drafting of the proposed amendments to the model and the associated actuarial guideline. The Subgroup was directed by the Health Actuarial (B) Task Force to coordinate and oversee the drafting of both of these.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Actuarial (B) Task Force charged the Academy at the 2012 Fall National Meeting with developing a table to replace the 1985 CIDA and CIDC for claims incurred and contracts issued past a date to be specified later. As the Academy neared completion of its charge to develop the table, the Task Force formed the Individual Disability Income Valuation Table Implementation (B) Subgroup during its Aug., 1, 2014, conference call. The Subgroup was charged with overseeing addition of references to the table to Model #10, developing an actuarial guideline to implement use of the table and methodologies for its use, and collaborating with the Statutory Accounting Principles (E) Working Group to add references to the table in the *Accounting Practices and Procedures Manual* (AP&P Manual).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to the model and the actuarial guideline were provided to the Subgroup by America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI). The draft was discussed and modified with input from interested regulators, industry and Academy participants on open conference calls of the Subgroup on April 1, 2015, Sept. 24, 2015, and Feb. 12, 2016. The final version of the proposed amendments to the model and the actuarial guideline were adopted by the Subgroup during its April. 14, 2016, conference call. The Health Actuarial (B) Task Force adopted the proposed amendments and the actuarial guideline during its April 14, 2016, conference call, as did the Health Insurance and Managed Care (B) Committee on its May 16 conference call.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force voted at the 2013 Fall National Meeting to expose the 2013 IDI Valuation Table, proposed amendments to the model and the actuarial guideline to implement the table for a public comment period ending June 30, 2014. Several comments from regulators and industry concerning the complexity of the table relative to the 1985 CIDA and CIDC tables, the need for sub-tables for more than one medical occupation class, and the need for separate claim incidence modifiers for each of voluntary and mandatory employer-sponsored policies were received. Regulators, industry and the Academy participated in revising the table implementation methodology, and the final version of the proposed amendments to the model and the guideline were adopted by the Subgroup, the Health Actuarial (B) Task Force, and the Health Insurance and Managed Care (B) Committee. (Please see 4. for dates of adoption by each group.)

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see 5.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2012

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Referencing 2012 GLTD Valuation Table and Associated Actuarial Guideline)

1. Description of the Project, Issues Addressed, etc.

The 2012 Group-Long Term Disability (GLTD) Valuation Table was proposed by the American Academy of Actuaries (AAA)/Society of Actuaries (SOA) Group Long-Term Disability Work Group as the basis for a new minimum reserve valuation standard for GLTD claims incurred on or after Oct. 1, 2016, to replace the current standard and its 1987 Commissioners Group Disability Table (CGDT). The *Health Insurance Reserves Model Regulation* (#10) needs to be amended to make reference to the new table and the actuarial guideline that gives detailed instructions for its application.

2. Name of Group Responsible for Drafting the Model and States Participating

The Group Long-Term Disability Valuation Table Implementation (B) Subgroup—composed of regulator representatives from Kansas, Nebraska, New Jersey and New York—oversaw the drafting of the proposed amendments to the model and the drafting of the associated actuarial guideline. The Subgroup was directed by the Health Actuarial (B) Task Force to coordinate and oversee the drafting of both of these.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Actuarial (B) Task Force charged the AAA with developing a table to replace the 1987 CGDT for claims incurred past a date to be specified later at the NAIC Spring National Meeting on March 25, 2011. As the AAA neared completion of its charge to develop the table, the Task Force charged the Group Long-Term Disability Valuation Table Implementation (B) Subgroup with the following at the NAIC Summer National Meeting on Aug, 10, 2012:

> The Subgroup, upon NAIC Executive (EX) Committee favorable consideration of the model regulation request, shall develop revisions to the *Health Insurance Reserves Model Regulation* (#10) to implement changes to:
>
> 1. Add reference to the 2012 GLTD Valuation Table for GLTD reserves.
> 2. Clarify distinction between group LTD and other group disability products.
> 3. Replace use of own experience with a credibility blending approach.
>
> Further, the Subgroup shall develop an Actuarial Guideline to implement these changes to the model regulation, taking into consideration elements discussed in the American Academy of Actuaries' Aug. 10, 2012, letter to the Health Actuarial (B) Task Force. The Subgroup will also draft appropriate changes to Statement of Statutory Accounting Practices (SSAP) No. 54—*Individual and Group Accident and Health Contracts* and Appendix A-010 of the *Accounting Practices and Procedures Manual*.
>
> The Subgroup will attempt to provide the above documents to the Task Force by Oct. 1, 2012, for its consideration and subsequent exposure.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The initial draft of the amendments to the model and the draft actuarial guideline were provided to the Subgroup by America's Health Insurance Plans and the American Council of Life Insurers. The draft was discussed and modified with input from interested regulators, industry and AAA participants on open conference calls of the Subgroup held June 5, July 10, Nov. 15 and Dec. 4, 2013. The final version of the proposed amendments to the model and the final actuarial guideline were adopted by the Subgroup during its Dec. 4 call. The Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee both adopted the proposed amendments and the actuarial guideline during the 2013 NAIC Fall National Meeting.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The 2012 GLTD Valuation Table, proposed amendments to the model, and the actuarial guideline to implement the table were exposed Sept. 12, 2012, for a 30-day public comment period. Many industry commenters felt that 30 days was not enough time to evaluate the tables and how they would be implemented through instructions in the actuarial guideline, and the exposure period was extended to May 31, 2013. Several comments from regulators and industry concerning the methodology for applying credibility to company experience used in modifying the tables and the effective date for use of the new table were received. Regulators, industry, and the AAA participated in revising the implementation methodology in the actuarial guideline, and the final versions of the proposed amendments to the model and the guideline were adopted by the Subgroup, the Health Actuarial (B) Task Force and the Health Insurance and Managed Care (B) Committee. Please see item #4 above for dates of adoption by each group.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Please see the response to item #5 above.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Long-Term Care Insurance Contract Reserve Requirements)

Description of Project and Issues Intended to be Addressed

Regulators have expressed concern that current minimum contract reserve standards for long-term care insurance may be inadequate given the recent incidence of rate increases and the new rate stability standards of the NAIC Long-Term Care Insurance Model Regulation requiring provision for moderately adverse deviation. Conversely, industry has expressed concern that contract reserve requirements for long-term care insurance generate excessive reserves and thus adversely affect insurance carrier returns, premium rates charged to consumers and future product availability. In response, the Accident and Health Working Group of the Life and Health Actuarial Task Force formed a subgroup in June 2002 to study the issue of minimum standards for long-term care insurance contract reserves. Long-term and short-term issues were identified. Noting a desire to quickly act on those issues that are immediately identifiable, a decision was made to address contract reserve valuation assumptions contained in the model regulation, while deferring overall contract reserve methodology review to a later date. The subgroup quickly narrowed the focus of the valuation assumption review to three major issues:

1. Prohibiting the use of assumed improvement in valuation morbidity tables beyond the valuation date for contracts for which tabular morbidity tables are not specified in the model regulation.
2. The need to add explicit levels of conservatism in morbidity assumptions.
3. Possible reduction in maximum allowable mortality and voluntary termination rates to reflect developing experience.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas, and Vermont.

Charge Authorizing Project

One of the 2003 charges of the task force is, "Study the methodology currently applicable to statutory reserves for long-term care insurance. Make recommendations for appropriate changes no later than the Winter National Meeting."

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested Parties Were Provided An Opportunity to Comment During the Drafting Process

A subgroup of the Accident and Health Working Group of the Life and Health Actuarial Task Force was formed in June 2002 to study the issue of minimum valuation standards for long-term care insurance contract reserves. This matter was included as a specific agenda item at each quarterly meeting of the working group from June 2002 through December 2003, and correspondence was included in numerous mailings of the *Life and Health Actuarial Subscription* over that time period. In addition, five interim conference calls were conducted by the subgroup or the working group to discuss this topic. Industry representatives were invited to participate in the conference calls, and a number of verbal and written comments were received, including ones from the American Council of Life Insurers and the Health Insurance Association of America.

During the course of the drafting process, three separate drafts of proposed changes to the Health Insurance Reserves Model Regulation were prepared by the subgroup and released by the Accident and Health Working Group for comment, the latest following the October 23, 2003 interim conference call. These drafts were posted on the NAIC website and included in mailings of the *Life and Health Actuarial Subscription.* At the 2003 Winter National Meeting the working group recommended the proposed language be forwarded to the Life and Health Actuarial Task Force. At this same meeting the task force voted to recommend that the Health Insurance and Managed Care (B) Committee adopt the amendments, which it did.

Significant Issues Raised During the Due Process and Group's Response

An issue of concern to some regulators was the uncertainty of the financial impact of the proposed changes on carriers. In response to this concern the support of the American Academy of Actuaries Long-Term Care Reserving Work Group was enlisted to prepare for regulators an impact study on contract reserves of various changes being considered.

Regulators and interested parties also expressed other concerns, and the American Academy of Actuaries work group provided input to help regulators make informed decisions on many of these as well. One concern was the limited amount of actual lapse and mortality experience available for use in accurately revising the maximum allowable termination assumptions in the minimum contract reserves standards. Acknowledging the limited nature of available experience, regulators compromised by agreeing on amendments containing greater maximum allowable mortality and voluntary lapse rate standards than proposed in the initial drafts.

Regulators also considered requiring an explicit load for conservatism in the morbidity table used for calculating contract reserves. Regulators agreed to remove this provision based on arguments from interested parties that it may be overly conservative. However, a general provision was added to the contract reserve section requiring the total contract reserve established for all health insurance products incorporate provisions for moderately adverse deviation.

Industry groups were supportive of the restriction on use of future morbidity improvement after compromise language was developed preventing unintended consequences identified by them, and so long as it was not retroactive. The proposed changes allow in force business as of the effective date of the amendment to retain the original reserve morbidity basis, which may have included future improvement in morbidity, so long as it is acceptable to the commissioner.

Implications of this Project for Accreditation and Codification

This change has no impact on Accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Single Premium Credit Disability Minimum Reserve Requirements)

Description of Project and Issues Intended to be Addressed

The Health Insurance Reserves Model Regulation was amended in June 2001 implementing inclusion of single premium credit disability insurance. Specific valuation morbidity tables were added as minimum standards for determining contract reserves for individual and group single premium credit disability insurance.

Most states currently require entities to hold the gross unearned premium reserve as the minimum contract reserve. The intent of the June 2001 amendment was to establish, following the effective date of the amendment, the minimum standard for contract reserves using a defined morbidity table, and to replace the gross unearned premium as the minimum reserve standard. However, the amendment did not clearly exclude single premium credit disability insurance from unearned premium reserve requirements included in the HIRMR. Therefore, some readers might interpret the existing language to require an insurer to hold both unearned premium and morbidity-based contract reserves. In addition, a reserve test requiring the sum of unearned premium reserves and contract reserves be no less than the gross modal unearned premium reserve could also increase the reserve held for single premium credit disability above the morbidity-based contract reserve.

Since the intent of the June 2001 amendment was that an unearned premium reserve not be required for single premium credit disability insurance after implementation of the valuation morbidity tables, an amendment to exclude single premium credit disability from all unearned premium reserve requirements has been proposed to clarify the intent of the 2001 amendment.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas and Vermont.

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested parties Were Provided An Opportunity to comment During the Drafting Process

Interested parties, Chris Hause (Hause Actuarial), Bob Butler (Assurant Group) and Steve Ostlund (Protective Life Corp.) brought this issue to the attention of the working group in March 2003. They noted that the legislature of the state of Ohio was considering a revision to the June 2001 amendments to the model, similar to the one proposed here, prior to adopting it.

At the 2003 Summer National Meeting, the working group reviewed language proposed by Mr. Hause to amend the model. Following discussion, the working group agreed immediate action was desirable and recommended the proposed language be released for comment. The June 2003 draft was posted on the NAIC website and was included in the June mailing of the *Life and Health Actuarial Subscription*. This matter was included as a specific agenda item at the June 2003 and September 2003 quarterly meetings of the working group.

Significant Issues Raised During the Due Process and Group's Response

No comments were received on the proposed language during the three-month comment period. At the 2003 Fall National Meeting the working group recommended adoption of the draft language released for exposure, but with a slight change in wording and the addition of a drafting note to further clarify the intent. The Life and Health Actuarial Task Force agreed with the working group recommendation to adopt the amendment.

Implications of this Project for Accreditation and Codification

This change has no impact on accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* (APPM) contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2003

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)
(Disability Income Insurance Claim Reserve Requirements)

Description of Project and Issues Intended to be Addressed

The issue concerns interpretation of the proper length of the period for use of a company's own claim experience in determining morbidity assumptions used in setting disability income insurance claim reserves.

The Health Insurance Reserves Model Regulation provides, "For claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities." Furthermore, "For group disability income claims with a duration from date of disablement of more than two (2) years but less than five (5) years, reserves may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control."

There are two competing interpretations of this language. Some argue that for claims with duration less than two or five years for individual and group policies respectively that the model allows the claim reserve to be based entirely on the company's morbidity experience. Others maintain that company morbidity experience may only be used in setting that portion of claim reserve for benefits payable in the first two or five durations from date of disablement with tabular morbidity rates as specified in the model to be used to set the portion of claim reserve for benefits payable beyond duration two or five from date of disablement.

The first interpretation can produce a substantial increase in the claim reserve following duration two or five if the insurer's own morbidity assumption was used to set the entire reserve and that assumption varies to a great extent from the tabular morbidity assumption required to be used to set the reserve once the duration from date of disablement is beyond durations two or five. In an effort to promote consistency of interpretation and to eliminate substantial reserve increases, an amendment to the model language reflecting the second interpretation has been proposed.

States That Participated in Drafting the Amendment to the Model

Member states of the Accident and Health Working Group of the Life and Health Actuarial Task Force are New Mexico (Chair), Alaska, Arkansas, Connecticut, Florida, Illinois, Maine, Minnesota, Nebraska, New York, Oklahoma, Texas and Vermont.

Procedure Followed in Drafting the Amendment to the Model Including Efforts Made to Assure All Interested Parties Were Provided An Opportunity to Comment During the Drafting Process

A subgroup of the working group was formed in March 2002 to gather and review additional information on this issue. In addition to conducting a survey of the reserving methods used by major disability income carriers and a survey of state regulators as to how the model is interpreted in their state, several conference calls were also conducted by the subgroup. Industry representatives were invited to participate in the conference calls and the subgroup received a number of verbal and written comments. This matter was included as a specific agenda item at each quarterly meeting of the working group from March 2002 through September 2003, and correspondence was included in numerous mailings of the *Life and Health Actuarial Subscription* over that time period.

At the 2003 Summer National Meeting, the working group reviewed language to amend the model. Following discussion, the working group recommended the proposed language be released for comment. The June 2003 draft was posted on the NAIC website and was included in the June mailing of the *Life and Health Actuarial Subscription*. A conference call of the working group was held in August 2003 to discuss comments received on the draft.

Significant Issues Raised During the Due Process and Group's Response

Initial comments from the industry noted a concern with clarity and potential for continued varying interpretations of the language originally considered as the proposed revision to the model. Industry also suggested a survey be taken of the methods being used to develop disability claim reserves during the initial two- or five-year period. In response the subgroup surveyed, with industry input on survey development, major disability income insurance writers on methods used to calculate claim reserves. A survey was also made of state regulators on their interpretation of current model language. During its

review, the subgroup considered alternative solutions for addressing the issue including taking no action to amend the model and revising the *Health Reserve Guidance Manual* to indicate the need for asset adequacy analysis to consider this issue. The working group agreed amending the model to be the best course of action.

Another issue was the effective date of the amendment and whether it was to be prospective only. The subgroup proposed a January 1, 2005, effective date that allows reasonable time for states to enact the amendment. In addition, the date will be bracketed so states can choose an alternative date to accommodate timing issues. They also agreed the revisions shall apply only to claims incurred on or after the effective date in recognition of the fact the change could have significant impact on carriers that used a varying interpretation of the current model language. However, the language allows carriers to select the amended method for all prior claims if they so desire.

Some comments received during the comment period pertained to portions of Section 2 – Claim Reserves other than those to which amendments are being proposed. The working group noted that these comments deserve consideration and discussion, however, since they broaden the scope of this particular issue, a decision was made to defer such consideration to such time a more thorough review of the model is undertaken.

Over the course of due process, the draft language was revised on multiple occasions in an effort to better reflect the intent of the proposed amendment and remove potential ambiguity. Ultimately, industry representatives offered their support to the final draft language.

At the 2003 Fall National Meeting the working group recommended adoption, without change, of the draft language released for exposure, and the Life and Health Actuarial Task Force also recommended adoption of the amendment to the model.

Implications of this Project for Accreditation and Codification

This change has no impact on accreditation.

Appendix A- Volume I of the *Accounting Practices and Procedures Manual* contains document No. A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, which is referenced by several Statements of Statutory Accounting Principles. No. A-010 is a virtual copy of the Health Insurance Reserves Model Regulation to which this amendment applies.

PROJECT HISTORY - 2001

HEALTH INSURANCE RESERVES MODEL REGULATION (#10)

Project Description: Review recommendations from the Society of Actuaries (SOA) relative to revisions concerning current minimum morbidity valuation standards for single premium credit disability insurance, and if appropriate, propose revisions.

Drafting group: Accident and Health Working Group (A&HWG) of the Life and Health Actuarial Task Force member states are: Minnesota, Chair, Alaska, Arkansas, Connecticut, Florida, Illinois, Kansas, Maine, Michigan, New Hampshire, Nebraska, New Mexico, Oklahoma, South Carolina, Texas.

Charge authorizing project: 2000 Charge for the Life and Health Actuarial Task Force: Continue discussions on the recommendations from the Society of Actuaries regarding revisions to the Health Insurance Reserves Model Regulation concerning single premium credit disability income valuation tables. Report recommendations as to whether changes to the model regulation should be made no later than the Winter National Meeting

Drafting process: Proposed revisions to the model were drafted by the A&HWG and revised based on comments from working group members and interested parties.

Due process:

National Meeting Date	Description of Activity
May, 2000	As agreed upon at the 2000 Spring National Meeting, the working group sent a letter to the Society of Actuaries (SOA) requesting that they review current minimum morbidity valuation standards for single premium credit disability insurance, and to recommend, as appropriate, valuation morbidity tables. The Society of Actuaries (SOA) established the Task Force to Recommend Morbidity Standards for Valuation of Credit Disability Benefits.
Nov., 2000	The A&HWG received the final report of the SOA's Task Force at the 2000 Winter National Meeting.
March, 2001	At the 2001 Spring National Meeting, the working group discussed a draft of the Health Insurance Reserves Model Regulation that incorporated the SOA recommendations. Immediately following the national meeting, a March 28, 2000 draft was exposed that incorporated revisions based upon all of the comments from regulators and interested parties that had been received to-date.
June, 2001	At the Summer National Meeting, the A&HWG, the Life and Health Actuarial Task Force, and the Health Insurance and Managed Care (B) Committee adopted the March 28, 2000 draft of the model with two revisions for clarification, and forward it to the Executive (EX) Committee with a recommendation for adoption.

Significant issues:
States have historically required unearned premium reserves as the standard method for determining policy reserves. The adoption of this model could cause an estimated overall reduction in policy reserves for single premium credit disability insurance of 25% to 30%.

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Carrier Prescription Drug Benefit Management Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide standards for the establishment, maintenance and management of prescription drug formularies and other pharmaceutical benefit management procedures used by health carriers that provide prescription drug benefits.

Drafting Note: This Act is not intended to address the off-label use of prescription drugs. The "off-label use" of a prescription drug occurs when a prescription drug that has been approved by the federal Food and Drug Administration (FDA) for one or more indications, but the prescription drug is used for indications or in doses other than those stated in the labeling approved by the FDA. Many states have enacted "off-label use" laws or regulations to address this situation. States that have enacted "off-label use" laws or regulations should review the provisions of this Act to determine whether any provisions of this Act should be modified or clarified in light of those laws or regulations.

Drafting Note: This Act also is not intended to address prescription drug formularies and other pharmaceutical benefit management procedures health carriers or their designees may use for purposes of workers' compensation. States typically regulate workers' compensation under an independent, standalone law, which will include provisions, if the state has determined they are appropriate, concerning prescription drug formulary criteria and other related requirements specifically related to workers' compensation.

Section 3. Definitions

For purposes of this Act:

A. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person for the purpose of filing a medical exceptions request under Section 7 of this Act;

(2) A person authorized by law to provide substituted consent for a covered person;

(3) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person; or

(4) For the purpose of filing a medical exceptions request under Section 7 of this Act on behalf of a covered person, the covered person's prescribing, treating or dispensing provider.

B. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocol and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

C. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

D. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of the health benefit plan.

E. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

F. (1) "Dose restriction" means imposing a restriction on the number of doses of a prescription drug that will be covered during a specific time period.

(2) "Dose restriction" does not include:

(a) A restriction set forth in the terms of coverage under a health carrier's health benefit plan for prescription drug benefits that limits the number of doses of a prescription drug that will be covered during a specific time period; or

(b) A restriction on the number of doses when the prescription drug that is subject to the restriction cannot be supplied by or has been withdrawn from the market by the drug's manufacturer.

G. "Drug substitution" means:

(1) For generics, the substitution of a generic version of a brand name drug that the U.S. Food and Drug Administration (FDA) in its publication *Approved Drug Products with Therapeutic Equivalence Evaluations*, also known as the FDA *Orange Book*, has determined to be a therapeutic equivalent; or

(2) For biologics, the substitution of an interchangeable biosimilar product, which is a biosimilar product, as that term is defined in 42 USC §262(i), the FDA has determined to be interchangeable in accordance with the standards set forth in 42 USC §262(k)(4) and listed as such in the latest edition of or supplement to the FDA *Lists of Licensed Biological Products with Reference to Product Exclusivity and Biosimilarity or Interchangeability Evaluations*, also known as the *Purple Book*.

Drafting Note: Subsection G defines the term "drug substitution" for use in Section 6C of this Act. States should review the language of this definition and the use of this defined term in Section 6C of this Act to determine whether the language of this definition needs to be modified or clarified in light of any other existing state law regulating drug substitution. In addition, states should review whether the definition of "drug" in relevant state law includes biologics.

H. "Facility" means an institution providing [physical, mental or behavioral] health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

I. "FDA" means the U.S. Food and Drug Administration.

J. "Formulary" means a list of prescription drugs that has been developed by a health carrier or its designee, which the health carrier or its designee references in determining applicable coverage and benefit levels.

K. "Grievance" means a complaint submitted by or on behalf of a covered person regarding:

(1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

L. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

M. "Health care professional" means a physician, pharmacist or other health care practitioner who is licensed, accredited or certified to perform specified [physical, mental or behavioral] health care services consistent with state law.

Drafting Note: States may wish to specify the health care professionals to whom this definition may apply (e.g. physicians, pharmacists, psychologists, nurse practitioners, etc.). This definition applies to individual health care professionals, not corporate "persons."

N. "Health care provider" or "provider" means a health care professional or a facility.

O. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance abuse disorders.

P. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the PHSA defines the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" above is consistent with the definition of "health insurance issuer" in Section 2791(b)(2) of the PHSA.

Q. "Medical and scientific evidence" means evidence found in the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline), and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) The following standard reference compendia:

(a) The American Hospital Formulary Service–Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia–National Formulary;

(5) Peer-reviewed or expert consensus findings, including the studies or research used to reach the findings, developed by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) The federal Agency for Healthcare Research and Quality;

(b) The National Institutes of Health;

(c) The National Cancer Institute;

(d) The National Academy of Sciences;

(e) The federal Centers for Medicare & Medicaid Services;

(f) The FDA;

(g) The federal Centers for Disease Control and Prevention;

(h) The U.S. Preventive Services Task Force;

(i) The U.S. Health Resources & Services Administration; and

(j) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) Any other relevant data that is comparable to the sources listed in Paragraphs (1) through (5).

Drafting Note: States should note that in some limited instances, guidelines developed by the federal government or national specialty medical organizations that are nationally recognized as setting the standard of care for a condition (*e.g.* U.S. Department of Health and Human Services (HHS) antiretroviral treatment guidelines and the hepatitis C recommendations developed by the American Association of the Study of Liver Diseases and the Infectious Diseases Society of America) may initially lack broad expert consensus or peer-review because of an urgent need to make drugs that improve or maintain critical life functions available as they are approved and/or treatment data is released. Such information can be helpful to the P&T committee as it determines coverage updates and/or changes.

R. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

S. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, and any entity or any combination of the foregoing.

T. "Pharmaceutical benefit management procedure" or "PBMP" includes any of the following that is used to manage prescription drug benefits:

(1) A formulary;

(2) The grouping of drugs into different categories;

(3) Dose restrictions;

(4) Prior authorization requirements; or

(5) Step therapy requirements.

Drafting Note: The definition of "pharmaceutical benefit management procedure" refers to commonly used utilization management criteria. It is possible that a health benefit plan may utilize new or different utilization management criteria. States should consider whether additional utilization management criteria should be included in the definition of "pharmaceutical benefit management procedure."

U. "Pharmacy and Therapeutics committee" or "P&T committee" means an advisory committee or committees or equivalent body or bodies that have current knowledge and expertise in:

(1) Clinically appropriate prescribing, dispensing and monitoring of outpatient prescription drugs; and

(2) Drug use review, evaluation and intervention.

Drafting Note: Although this definition is broad, states should take note of the federal rules implementing the federal Affordable Care Act (ACA) effective January 1, 2017, which will require health carriers providing essential health benefits in the individual and small group markets to meet a range of requirements related to the use of a P&T committee (see Title 45 CFR – Subpart B – Essential Health Benefits, Section 156.122(a)(3).

V. "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

W. "Prescription drug" means a drug that has been approved or is regulated and for which marketing is permitted by the federal Food and Drug Administration and that can, under federal and state law, be dispensed only pursuant to a prescription drug order from a licensed, certified or otherwise legally authorized prescriber.

Drafting Note: States with laws that mandate coverage for patient costs associated with clinical trials and laws that mandate coverage for the off-label use of prescription drugs should review those laws to determine what impact, if any, this definition of "prescription drug" has on those laws. This reference was included in order to exclude coverage under this Act for treatment investigational new drugs (INDs). States should note that under Section 2709 of the Public Health Service Act, as added by the ACA, a health carrier, (1) is prohibited from denying a qualified individual from participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial.

X. "Prescription drug order" means an order from a prescriber or the prescriber's designated agent to a pharmacist for a prescription drug to be dispensed.

Y. "Prior authorization" means the process of obtaining prior approval for coverage of a prescription drug.

Z. "Step therapy" means a type of protocol or program the health carrier utilizes that establishes a sequence of covered prescription drugs for a given medical condition.

Section 4. Applicability and Scope

This Act shall apply to health carriers that provide benefits for outpatient prescription drugs under a health benefit plan issued by the health carrier where the health carrier or its designee administers coverage for this benefit through the use of a formulary or through the application of any other pharmaceutical benefit management procedure.

Drafting Note: The provisions of Section 4 above should not be construed to have this Act: 1) apply to a health benefit plan that does not cover outpatient prescription drugs; 2) require coverage of a prescription drug for a medical condition that is not covered under the health benefit plan; or 3) require coverage of a prescription drug categorically excluded from coverage under a health benefit plan unless an express exception is made pursuant to Section 7 of this Act.

Drafting Note: The reference to "designee" in Section 4 is intended to be construed broadly to apply to any person or entity the health carrier contracts with to perform, or carry out on its behalf, specified activities required under this Act or applicable regulations, such as pharmacy benefit manager (PBM). Section 10 of this Act provides that the health carrier is responsible for monitoring all of activities carried out by, or on behalf, of the health carrier by a designee that the health carrier has contracted with to perform that activity and ensuring that the designee is complying with the requirements of this Act and any applicable regulations related to that activity. If a state has enacted or intends to enact a specific law or regulation directly regulating certain persons or entities that may be designees under this Act, such as PBMs, those states should review the provisions of this Act, such as Section 10 of this Act, to determine whether any provisions of this Act should be modified or clarified to encompass such persons or entities in light of that law or regulation.

Section 5. Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures

A. Each health carrier that provides coverage for prescription drugs and manages this benefit through the use of a formulary or other PBMP shall establish, or have established, one or more P&T committees meeting the requirements of this section.

B. (1) Any P&T committee established under Subsection A shall include members the health carrier considers appropriate who represent a sufficient number of clinical specialties to adequately meet the needs of covered persons, the majority of which are practicing physicians, practicing pharmacists and other practicing health care professionals licensed to prescribe prescription drugs, to develop and maintain formularies or any other PBMP in accordance with the requirements of this section.

(2) A P&T committee established under Subsection A shall seek outside expert advice, as appropriate, to develop and maintain formularies or any other PBMP in accordance with the requirements of this section.

(3) The health carrier shall ensure that any P&T committee established under Subsection A has the following policies and disclosure requirements in place that address potential conflicts of interest that members of a P&T committee may have with the carrier and any pharmaceutical developer or manufacturer:

(a) At least 20% of the P&T committee membership has no conflict of interest with respect to the health carrier and any pharmaceutical developer or manufacturer;

(b) Prohibits any P&T committee member with a conflict of interest with respect to the health carrier or a pharmaceutical developer or manufacturer from voting on decisions with regard to a particular prescription drug or class of prescription drugs for which the conflict exists; and

(c) Each P&T committee member, and any individual who advises the P&T committee, signs a conflict of interest statement, which reveals any economic or other relationships the P&T committee member, or other individual advising the P&T committee, has with any person affected by drug coverage decisions that could influence P&T committee decisions.

(4) (a) Each P&T committee shall establish procedures outlining its conflict of interest standards for its members and any individuals providing expert advice to the P&T committee, which, at a minimum, are consistent with Paragraph (3).

(b) The procedures shall require the P&T committee to have a system in place to maintain the signed conflict of interest statements described in Paragraph (3)(c) and to document any P&T committee member recusals from voting.

(c) The procedures and information under Subparagraph (b) of this paragraph shall be available for regulatory review and provided to the commissioner upon request.

Drafting Note: State regulators should be aware that any conflict of interest standards a P&T committee establishes might need to permit the P&T committee to receive information from a non-voting individual who may have significant conflicts of interest with the health carrier or a pharmaceutical developer or manufacturer because the individual has special information, knowledge, or expertise related to the particular prescription drug or class of prescription drugs under consideration.

(5) The P&T committee shall meet at least quarterly and shall maintain documentation of its rationale for all decisions regarding formulary drug list development or revision.

C. Each health carrier that offers coverage for prescription drugs shall ensure that it offers a formulary based on the recommendations of the carrier's P&T committee and covers at least the greater of:

(1) One drug in every United States Pharmacopeia (USP) category and class; or

(2) The same number of prescription drugs in each category and class as the essential health benefits (EHB)-benchmark plan.

Drafting Note: States should be aware the provisions of Subsection C above are a requirement under federal regulations implementing the ACA for plans providing essential health benefits (EHBs) in the individual and small group markets (Title 45 CFR – Subpart B – Essential Health Benefits Package Section 156.122(a) (Prescription Drug Benefits)).

D. (1) The health carrier shall ensure that any P&T committee established in accordance with Subsection A has and uses a process and documents and procedures to base clinical decisions on the strength of:

(a) Medical and scientific evidence concerning the safety and effectiveness of prescription drugs, including the FDA label indications of the prescription drug and available comparative information on clinically similar prescription drugs, when deciding what prescription drugs to review and include on a formulary; and

Drafting Note: Any P&T committee shall base formulary decisions, in part, on whether prescription drugs included for a therapeutic category or class are effective for all populations, including racial and ethnic minorities, and shall consider whether the formulary includes prescription drugs that have proven efficacy in all patient subgroups, including racial and ethnic minority populations. In making these considerations, the P&T committee shall consider medical and scientific evidence, as well as medical treatment guidelines developed or endorsed by specialty organizations.

(b) Applicable medical and scientific evidence concerning the safety and effectiveness of prescription drugs and the therapeutic advantages of prescription drugs when developing any PBMP.

(2) In the case of rare or ultra-rare diseases, the P&T committee process under Paragraph (1) shall include the review, as the P&T committee considers appropriate and necessary, of clinically appropriate and relevant information when there is no or limited medical and scientific evidence concerning the safety and effectiveness of prescription drugs or drug classes used to treat rare and ultra-rare diseases.

Drafting Note: Paragraph (2) above is meant to require the P&T committee, when deciding what prescription drugs to review and include on a formulary or when developing any PBMP, to have as part of this review process procedures in place to review the best available and appropriate information at the time concerning a prescription drug or drugs to include on a formulary that may be used to treat rare or ultra-rare diseases. Such diseases have been described as from a population of one million people, 650 have a rare disease and fewer than 20 have an ultra-rare disease.

(3) The health carrier shall ensure that any P&T committee maintains documentation of the process required under Paragraph (1) to ensure appropriate prescription drug review and inclusion and makes any records and documents relating to the process available, upon request, to the health carrier for record keeping purposes under Section 9 of this Act.

E. (1) The health carrier shall ensure that any P&T committee established in accordance with Subsection A has and uses a process to enable it, in a timely manner, but at least annually, to consider the need for and implement appropriate updates and changes to the formulary or other PBMPs based on:

(a) Newly available scientific and medical evidence or other information concerning prescription drugs currently listed on the formulary or subject to any other PBMP and scientific and medical evidence or other information on new FDA-approved prescription drugs and other prescription drugs not currently listed on the formulary or subject to any other PBMP to determine whether a change to the formulary or PBMP should be made;

(b) The strength of medical and scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data and other such information the P&T committee considers appropriate;

(c) Information received from the health carrier with respect to medical exception requests made under Section 7 of this Act to enable the P&T committee to evaluate whether the prescription drugs currently listed on the formulary or subject to any other PBMP are meeting the health care service needs of covered persons; and

(d) Information relating to the safety and effectiveness of a prescription drug currently listed on the formulary or subject to any other PBMP or relating to clinically similar prescription drugs not currently listed on the formulary or subject to any other PBMP from the health carrier's quality assurance activities or claims data that was received since the date of the P&T committee's most recent review of that prescription drug.

(2) The P&T committee also shall:

(a) Review and approve appropriate updates and guidance related to the medical exceptions process under Section 7 of this Act and other utilization management processes, including any PBMP requirements such as drug utilization review, quantity limits and therapeutic interchange;

(b) Review and approve appropriate updates and changes to all clinical prior authorization criteria, step therapy protocols and quantity limit restrictions applied to each covered prescription drug; and

(c) Review new FDA-approved prescription drugs and new uses for existing prescription drugs.

Drafting Note: A health carrier's P&T committee also should ensure the health carrier's formulary drug list covers a range of prescription drugs across a broad distribution of therapeutic categories and classes and recommend prescription drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of covered persons, and provides appropriate access to prescription drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

F. (1) A health carrier shall allow covered persons to access outpatient prescription drug benefits at in-network retail or mail order pharmacies, unless:

(a) The drug is subject to restricted distribution by the FDA; or

(b) The drug requires special handling, provider coordination or patient education that a retail pharmacy cannot provide.

(2) The health carrier may charge covered persons different cost-sharing amounts based on the distribution method used to obtain the covered prescription drug. All in-network cost-sharing amounts paid shall count towards the health benefit plan's annual limit on cost-sharing paid by the covered person and shall be included in the actuarial value calculated for that plan.

G. Subject to Section 10 of this Act, a health carrier may contract with another person to perform the functions of a P&T committee as described in this section.

Section 6. Information to Prescribers, Pharmacies, Covered Persons and Prospective Covered Persons

A. (1) (a) Except as provided in Paragraph (6), a health carrier shall display on its website in plain language the prescription drug benefit information required in this subsection.

(b) For a health benefit plan providing group market health insurance coverage, a health carrier may require:

(i) A covered person to create or access an account or enter a plan or contract number to access the plan's formulary list and other prescription drug benefit information; and

(ii) A prospective covered person to access a plan's formulary list and other prescription drug benefit information by searching by plan name or contract number.

(c) For a health benefit plan providing individual market health insurance coverage, a health carrier may not require a covered person or prospective covered person to create or access an account or enter a plan or policy number to access a plan's formulary list or other prescription drug benefit information, but may require a covered person or prospective covered person to access a plan's formulary list and other prescription drug benefit information by searching, as appropriate, by plan name.

(2) (a) (i) The health carrier's formulary list(s) shall include each prescription drug covered under the carrier's plan(s) prescription drug benefit and outpatient medical benefit, which are prescription drugs administered by a health care professional or under the professional's direct supervision in an outpatient setting.

(ii) The health carrier may provide the information pertaining to prescription drugs covered under a plan's outpatient medical benefit as an addendum or link to the formulary, if applicable, provided the information is prominently displayed.

(b) The formulary shall be electronically searchable by drug name and any other means required by the commissioner.

Drafting Note: States should be aware that organizing formularies also by major therapeutic class can be helpful to consumers when determining whether the formulary offered under the health benefit plan is robust with respect to a specific disease or medical condition.

(c) The prescription drug benefit information shall include a notice for any individual reviewing the information that the inclusion of a prescription drug on a health benefit plan's formulary does not mean that a prescriber will prescribe that drug for the individual's specific medical condition.

(d) Except for a health carrier that satisfies the requirements of Section 7G or H of this Act, a health carrier shall include in the prescription drug benefit information how and what written documentation is required to be submitted in order for a covered person or the covered person's authorized representative to file a request under the health carrier's medical exceptions process established pursuant to Section 7 of this Act.

(3) The health carrier shall include in the prescription drug benefit information a description in plain language of how an individual can access the following benefit information:

(a) An indication of whether the drug is preferred, if applicable, under the plan;

(b) A disclosure of any prior authorization, step therapy, quantity limits, pharmacy restrictions or other PBMP requirement; and

(c) The specific tier the drug falls under, if the plan uses a tiered formulary.

(4) (a) The health carrier shall include in the prescription drug benefit information a description in plain language of how an individual may find the benefit cost-sharing information for the prescription drugs on a formulary list that includes:

(i) Whether the prescription drug is subject to a deductible, and if so, the amount of the deductible;

(ii) The amount of the prescription drug copayment;

(iii) The amount of the prescription drug coinsurance; and

(iv) The amount of any cost-sharing difference between the days' supply of the prescription drug.

(b) For a health benefit plan providing individual market health insurance coverage, a health carrier may meet the requirements set forth in Subparagraph (a) of this paragraph by referring the individual to a summary of the plan's benefits and coverage displayed or linked to a place elsewhere on the carrier's website, provided that a covered person or prospective covered person is not required to create or access an account or enter a policy or plan number to access this information.

Drafting Note: States may want to look at the prescription drug benefit information that is to be provided to consumers in accordance with the requirements of this paragraph to see if that information can be easily found and is clear and understandable.

(5) A health carrier shall provide, upon request, a print copy of specifically requested prescription drug benefit information of a carrier's current, accurate and complete formulary.

(6) A health carrier may make available the prescription drug benefit information required in this subsection using electronic links associated with the specific health benefit plan for which the information applies.

(7) A health carrier shall ensure a formulary list(s), whether in electronic or print format, shall accommodate individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(8) A health carrier shall ensure the formulary list itself:

(a) Is accurate;

(b) Updated, as needed, to reflect changes in a health benefit plan's covered prescription drugs; and

(c) Includes the date it was last updated.

Drafting Note: Health carriers are required to maintain accurate formulary lists for their health benefit plans. State insurance regulators may want to closely monitor consumer complaints received to determine if there is a problem or pattern of complaints that might indicate a problem with the formulary list.

B. Whenever the health carrier makes or approves a change in a formulary that causes a particular prescription drug not to be covered, applies a new or revised dose restriction that causes a prescription for a particular prescription drug not to be covered for the number of doses prescribed, or applies a new or revised step therapy or prior authorization requirement that causes a particular prescription drug not to be covered until the requirements of that PBMP have been met, unless the change is being made for safety reasons or because the prescription drug cannot be supplied by or has been withdrawn from the market by the drug's manufacturer, the health carrier or its designee shall provide notice of that change to:

(1) Prescribers at least sixty (60) days prior to the effective date of the change; and

(2) Pharmacies participating in the health carrier's network prior to the effective date of the change.

C. (1) Whenever a health carrier makes or approves a change in a formulary impacting prescription drug benefit coverage or PBMP administration, including, but not limited to, co-payment amounts, co-insurance percentage level, step therapy, drug substitution and mandatory generics, the health carrier or its designee shall do one of the following:

(a) At least sixty (60) days prior to its effective date, the health carrier or its designee shall notify covered persons impacted by the change currently receiving benefits for the drug of the change; or

(b) The health carrier or its designee shall cover a refill of a drug impacted by the change for any covered person currently receiving benefits for the drug on the same terms as covered previously so long as the drug continues to be prescribed for the covered person and notify the covered person or the covered person's authorized representative at the time of the refill of the change.

Drafting Note: State insurance regulators should keep in mind that under certain circumstances notices to covered persons under this paragraph may not be needed if the health carrier decides to continue coverage of the prescription drug on the same terms and conditions as covered previously for covered persons currently receiving coverage for that drug as long as the drug continues to be prescribed for the covered person and the covered person is covered under the health benefit plan.

Drafting Note: State insurance regulators should be aware Paragraph (1) above does not obviate the requirement that the carrier or its designee provide a minimum 60-day advance notice before the effective date of a formulary change to consumers in order to provide sufficient time for consumers to discuss alternatives to the prescription drug impacted by the change with their physician or prescriber or file a request for approval of an exception under the health carrier's medical exceptions process.

(2) (a) As part of the information to be provided in a notice pursuant to Paragraph (1)(a) or Paragraph (1)(b), the health carrier or its designee shall include information on any available alternatives to the prescription drug impacted by the formulary change and direct the covered person to speak with the prescriber.

(b) Except for a health carrier that satisfies the requirements of Section 7G or H of this Act, the notice provided pursuant to Paragraph (1)(a) or Paragraph (1)(b) shall include information on how and what written documentation is required to be submitted for the covered person or the covered person's authorized representative to file a medical exceptions request in accordance with the health carrier's medical exceptions process set forth in Section 7 of this Act.

(3) A health carrier or its designee shall not be required to cover a refill of a prescription drug pursuant to Paragraph (1)(b) whenever:

(a) The prescription drug is being discontinued from coverage on the formulary for safety reasons;

(b) The prescription drug is not available because the drug's manufacturer no longer supplies the drug or has withdrawn the drug from the market; or

(c) The change in or a new PBMP for the prescription drug is for safety reasons.

D. In addition to the information to be provided under Subsection A, a health carrier or its designee electronically or in writing, upon request, shall include in any notice provided under Subsection C information explaining in plain language that:

(1) Any formulary change impacting prescription drug benefit coverage or PBMP administration could impact the covered person's out-of-pocket costs and the covered person may want to consider contacting his or her prescribing provider to determine whether continuation of that particular prescription drug impacted by the change is appropriate or whether there is an acceptable alternative prescription drug that can be used to treat the covered person's disease or medical condition;

(2) The covered person may want to review the health benefit plan's formulary from time-to-time or contact the health carrier or its designee to obtain any updated formulary information prior to obtaining a refill for a particular prescription drug the covered person is currently using to find out if there has been any change in the requirements for obtaining coverage for the drug or if there has been a change in the covered person's out-of-pocket costs for the drug and include the telephone number or electronic link that covered persons can use to contact the health carrier or its designee to obtain this information; and

(3) The amount the covered person may be required to pay out-of-pocket for a particular prescription drug may change from time-to-time.

Section 7. Medical Exceptions Approval Process Requirements and Procedures

A. Each health carrier that provides prescription drug benefits and manages this benefit through the use of a formulary or through the application of a dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed or step therapy requirement that causes a particular drug not be covered until the requirements of that PBMP have been met shall establish and maintain a medical exceptions process that allows covered persons or covered persons' authorized representatives to request approval for:

(1) Coverage of a prescription drug that is not covered based on the health carrier's formulary;

(2) Continued coverage of a particular prescription drug that the health carrier is discontinuing coverage on the formulary except when coverage for the drug is being discontinued for safety reasons or because the drug's manufacturer is no longer supplying the prescription drug or the drug's manufacturer has withdrawn the prescription drug from the market; or

(3) An exception to a PBMP that causes a prescription drug to not be covered until the step therapy requirement is satisfied or not be covered at the prescribed number of doses.

Drafting Note: States should ensure that health benefit plans have a process in place to address issues that may not fall under this section as a formulary exception, but would be considered a benefit exception.

Drafting Note: This section is not intended to apply to requests for an exception to a pharmaceutical benefit management procedure (PBMP) involving a prior authorization requirement. Those types of requests for benefits for which a health carrier requires prior authorization are to be resolved under a health carrier's utilization review process.

Drafting Note: This section also is not intended to apply to situations where the consumer may have issues with pharmacy access, such as an in-network pharmacy being too far from a covered person's home address or when a prescription drug a covered person is currently using changes from being available through a range of pharmacy options to mail order pharmacy only. In these situations, states should review the network access requirements in state law or regulation similar to the requirements in the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

B. (1) A covered person or the covered person's authorized representative may file, and the health carrier shall review, a request under Subsection A only if the covered person's prescribing provider has determined that the requested prescription drug is medically necessary to treat the covered person's disease or medical condition because:

(a) There is not a prescription drug listed on the formulary to treat the covered person's disease or medical condition that is an acceptable clinical alternative;

(b) The prescription drug alternative listed on the formulary or required to be used in accordance with step therapy requirements:

(i) Has been ineffective in the treatment of the covered person's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance;

(ii) Is contraindicated; or

(iii) Has caused or based on sound clinical evidence and medical and scientific evidence is likely to cause an adverse reaction or other harm to the covered person in the prescriber's clinical judgment;

Drafting Note: States should be aware that this Act does not contemplate covered persons using the medical exceptions process established under this section to request a change in benefits, which, in some cases, could impact potential medical exception requests involving step therapy requirements. This Act contemplates benefit exception requests would be handled under a different state law or regulations related to utilization review or grievance processes. Given this, states should review their existing state laws for consistency when considering adoption of this section.

(c) The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the covered person's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

(d) The covered person's condition and function are stable and based on the covered person's medical history a change in prescription drug would have the potential for adverse consequences or other risks.

(2) (a) A health carrier may require the covered person or the covered person's authorized representative upon request to provide a written certification from the covered person's prescribing provider of the determination made under Paragraph (1).

(b) The health carrier may require the written certification to include any of, but no more than, the following information:

(i) The patient's name, group or contract number, subscriber number or other information necessary to identify the covered person;

(ii) Patient history;

(iii) The primary diagnosis related to the requested prescription drug that is the subject of the medical exceptions request;

(iv) Based on Paragraph (1)(a), (b) or (c), the reason:

(I) Why the formulary drug is not acceptable for the individual patient;

(II) If the medical exceptions request involves a step therapy requirement, why the prescription drug required to be used is not acceptable for the individual patient; or

(III) If the medical exceptions request involves a dose restriction, why the available number of doses for the prescription drug is not acceptable for the individual patient;

(v) The reason why the prescription drug that is the subject of the medical exceptions request is needed for the individual patient or, if the medical exceptions request involves a dose restriction, why an exception to the dose restriction is needed for the individual patient; and

(vi) Any other information reasonably necessary to evaluate the medical necessity of the medical exceptions request.

(c) A prescriber may submit additional information the prescriber deems necessary to establish medical necessity for purposes of the medical exceptions request.

(3) Participation by a provider on behalf of a covered person in the medical exceptions process established under this section shall be construed as being the same as a provider's advocating on behalf of a covered person within the utilization review process established by the health carrier for purposes of [insert reference to state law equivalent to Section 6J of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74)].

Drafting Note: Section 6J of the NAIC *Health Benefit Plan Network Access and Adequacy Model Act* (#74) provides that a health carrier may not prohibit a participating provider from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier. The medical exceptions process established under this section for the review of requests for approval for exceptions to a formulary or being subject to a dose restriction or step therapy requirement is similar to the expedited utilization review process that health carriers may be required to establish for the review of health care service benefit requests. Paragraph (3) is intended to ensure that providers participating in the medical exceptions process established under this section have the same protections given to participating providers under Section 6J of the NAIC *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

C. (1) Upon receipt of a request made pursuant to Subsection A, the health carrier shall ensure that the request is reviewed by appropriate health care professionals who, in reaching a decision on the request, shall take into account the specific facts and circumstances that apply to the covered person for whom the request has been made using documented clinical review criteria that:

(a) Are based on sound clinical evidence and medical and scientific evidence; and

(b) If available, appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, practice guidelines developed by the health carrier's P&T committee or any other practice guidelines developed by the federal government, national or professional medical or pharmacist societies, boards and associations.

(2) The health care professional or professionals designated by the health carrier to review the request under Paragraph (1) shall ensure that the decision reached on the request is consistent with the benefits and exclusions under the covered person's health benefit plan with the health carrier.

D. (1) (a) Except as provided in Subparagraph (b) of this paragraph, the medical exceptions process under this section shall require the health carrier to make a decision on a request made pursuant to Subsection A and provide notice of the decision to the covered person or the covered person's authorized representative as quickly as the covered person's particular medical condition requires, but in no event later than seventy-two (72) hours after the later of the date of receipt of the request or, if required by the health carrier, the date of receipt of the certification under Subsection B(2).

(b) (i) A health carrier shall include in its medical exceptions process required under Subsection A an expedited medical exceptions review based on exigent circumstances.

(ii) Exigent circumstances exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health, or ability to regain maximum function.

Drafting Note: Item (ii) above also is intended to apply when an infant's or a child's health condition may seriously jeopardize their ability to develop maximum function.

(iii) A health carrier shall make a decision on an expedited medical exceptions review request based on exigent circumstances made pursuant to Subsection A and notify the covered person or the covered person's authorized representative of its coverage decision no later than [24] hours following receipt of the request.

(2) (a) If the health carrier fails to make a decision on the request and provide notice of the decision within the time frame required under Paragraph (1)(a) or Paragraph (1)(b):

(i) The covered person shall be entitled to have coverage for, up to one month's supply of the prescription drug that is the subject of the request; and

(ii) The health carrier shall make a decision on the request prior to the covered person's completion of the supply provided in Item (i).

(b) If the health carrier fails to make a decision on the request and provide notice of the decision prior to the covered person's completion of the supply provided for in Subparagraph (a) of this paragraph, the health carrier shall maintain coverage, as specified in Subparagraph (a) of this paragraph, on the same terms on an ongoing basis, as long as the prescription drug continues to be prescribed for that covered person and is considered safe for the treatment of the covered person's disease or medical condition until a decision is made on the request and notice of that decision is provided, unless there is a material change in the covered person's terms of coverage or the applicable benefit limits have been exhausted.

E. (1) Whenever a request made under this section is approved, the health carrier shall not require the covered person to request approval under this section for a refill, or a new prescription to continue using the prescription drug after the refills for the initial prescription have been exhausted, for the same prescription drug that was previously approved under this section for coverage or continued coverage or that was previously approved under this section as an exception to the health carrier's PBMP for that drug, subject to the terms of coverage under the health carrier's health benefit plan for prescription drug benefits as long as:

(a) The covered person's prescribing provider continues to prescribe the prescription drug to treat the same disease or medical condition of the covered person; and

(b) The prescription drug continues to be considered safe for treating the covered person's disease or medical condition.

(2) In addition to Paragraph (1), whenever a request made under this section is approved, the health carrier shall provide coverage for the approved prescription drug [and count the covered person's in-network cost-sharing for the drug toward the covered person's annual limitation on cost-sharing].

Drafting Note: States should be aware that the bracketed language above is a requirement under federal regulations implementing the ACA for plans providing essential health benefits (EHBs) in the individual and small group markets (see Title 45 CFR – Subpart B – Essential Health Benefits Package Section 156.122(c) (Prescription Drug Benefits)). As such, states will need to consider whether to include the bracketed language where it could have a broader application.

(3) A health carrier shall not establish a special formulary tier or co-payment or other cost-sharing requirement that is applicable only to prescription drugs approved for coverage under this section.

Drafting Note: A state that requires health carriers to establish specific formulary tiers with specific cost-sharing requirements for each tier should modify the language in Paragraph (3) to take into account the requirements of its law.

F. (1) Any denial by a health carrier of a request made under Subsection A:

(a) Shall be provided to the covered person or, if applicable, the covered person's authorized representative in writing or, if the covered person has agreed to receive information in this manner, electronically;

(b) Shall be provided electronically to the covered person's prescribing provider or, upon request, in writing; and

(c) May be appealed by filing a grievance pursuant to [insert reference in state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)].

(2) The denial shall, in plain language, set forth:

(a) The specific reason or reasons for the denial;

(b) A reference to the evidence or documentation, including the clinical review criteria, including practice guidelines, and clinical evidence and medical and scientific evidence considered in reaching the decision to deny the request;

(c) Instructions for requesting, a written statement of the clinical and medical or scientific rationale for the denial; and

(d) A description of the process and procedures that must be followed for filing a grievance to appeal the denial pursuant to [insert reference in state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)], including any time limits applicable to those procedures.

G. A health carrier that permits a covered person's prescriber to make formulary and other PBMP exceptions without having to obtain authorization from the carrier and that maintains on an ongoing basis in its administrative systems information about the exception status of a particular prescription drug for a particular covered person shall not be required to establish a medical exceptions process in accordance with Subsection A or required to comply with the provisions of Subsections B, C, D, E(1) and (2) and F with respect to the prescription drug orders of these prescribing participating providers.

Drafting Note: Subsection G above is intended to apply to carriers that are organized and operated as integrated care systems, such as a staff model HMO, where health care providers manage and provide covered health care services to covered persons without having to seek specific authorization from the carrier for the provision of those specific services.

H. A health carrier shall not be required to establish a medical exceptions process in accordance with Subsection A or required to comply with the provisions of Subsections B, C, D, E(1) and (2) and F if the health carrier:

(1) Has an expedited utilization review process as set forth in [insert reference in state law equivalent to Section 10 of the *Utilization Review and Benefit Determination Model Act* (#73)]; and

(2) Allows covered persons or their authorized representatives to use this process to seek approval for coverage of a prescription drug that is not otherwise covered because of the health carrier's formulary or because of any other PBMP requirement that restricts coverage of the prescription drug until the PBMP requirement has been met.

I. A covered person may not use the process established under this section to request coverage for: (1) an investigational or a non-FDA-approved prescription drug; or (2) a prescription drug for a specifically excluded benefit under the covered person's health benefit plan.

Drafting Note: Subsection I reflects that health benefit plans exclude certain benefits from coverage by listing non-covered benefits, but do not exclude specific medical conditions from coverage.

Drafting Note: Also, with respect to Subsection I, states should be aware that an issue could arise in situations where an application for new drug approval has been submitted to the FDA, but, at the time a covered person submits a medical exceptions request for coverage of that prescription drug, the drug has not received FDA-approval.

Section 8. Nondiscrimination in Prescription Drug Benefit Design

A health carrier or its designee shall not adopt or implement a formulary or prescription drug benefit design that is discriminatory in violation of state or federal law.

Drafting Note: State insurance regulators should consider federal nondiscrimination laws and regulations requiring health carriers in the individual and small group health insurance markets to meet a range of requirements related to prescription drug benefit coverage, including nondiscrimination in prescription drug benefit design.

Drafting Note: State insurance regulators should consider the nondiscrimination provisions contained in state laws based on the *Individual Market Health Insurance Coverage Model Act* (#36), the *Small Group Market Health Insurance Coverage Model Act* (#106); or the *Unfair Trade Practices Act* (#880).

Drafting Note: State insurance regulators should pay particular attention to the formulary and prescription drug benefit notices and disclosures health carriers are required under this Act to provide to covered persons to ensure that these notices and disclosures, whether provided electronically or in print, accommodate individuals with disabilities and individuals with limited English proficiency.

Section 9. Record Keeping and Reporting Requirements

A. (1) Each health carrier shall maintain written or electronic records sufficient to demonstrate compliance with this Act, including records documenting the application of a process for making decisions on formularies and other PBMPs that is required under Section 5 of this Act and, except for a health carrier that satisfies the requirements of Section 7G or H of this Act, records documenting the application of the medical exceptions process that is required under Section 7 of this Act.

(2) The records shall be maintained for period of three (3) years or until the completion of the health carrier's next market conduct examination, whichever is later, and shall be made available to the commissioner upon request by the commissioner.

B. Except for a health carrier that satisfies the requirements of Section 7G or H of this Act, each health carrier shall maintain data on and, upon request, make available to the commissioner the following information with respect to medical exceptions requests made under Section 7 of this Act:

(1) The total number of medical exceptions requests;

(2) From the total number of medical exceptions requests provided under Paragraph (1):

(a) The number of requests made for coverage of a nonformulary prescription drug;

(b) The number of requests made for continuing coverage of a prescription drug that the health carrier was discontinuing from coverage on the formulary for reasons other than safety or because the drug cannot be supplied by or has been withdrawn from the market by the drug's manufacturer; and

(c) The number of requests made for an exception to being subject to a PBMP;

(3) The number of medical exceptions requests approved and denied;

[(4) The changes to its formulary or prescription drug benefit information made after the start of the plan year;] and

(5) Any other information the commissioner may request.

Section 10. Oversight and Contracting Responsibilities

A. A health carrier shall be responsible for monitoring all activities carried out by, or on behalf, of the health carrier under this Act and for ensuring that all requirements of this Act and applicable regulations are met.

B. Whenever a health carrier contracts with another person to perform activities required under this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of that person with which the health carrier contracts and for ensuring that the requirements of this Act and applicable regulations with respect to that activity are met.

Section 11. Disclosure Requirements

A. Each health carrier that uses a formulary or any other PBMP shall in the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons:

(1) Disclose the existence of the formulary and any other PBMP and that there may be other plan restrictions or requirements that may affect the specific prescription drugs that will be covered and where to find more specific information;

(2) Except for a health carrier that satisfies the requirements of Section 7G or H of this Act, describe the medical exceptions process that may be used to request coverage of nonformulary prescription drugs or to obtain an exception to being subject to any PBMP requirement; and

(3) If applicable, describe the process for filing a grievance as set forth in [insert reference in state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)] to appeal a denial of a medical exceptions request.

B. (1) In addition to Subsection A, the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons shall explain in plain language information on the health carrier's formulary and other prescription drug benefit information as provided in Section 6A and state where the information is available electronically and a print copy of the formulary list and specific prescription drug information can be provided to a covered person by the health carrier or its designee on request.

(2) In addition to the information explained under Paragraph (1), a health carrier shall explain in plain language in a separate document or other attachment to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage that:

(a) Any formulary change impacting prescription drug benefit coverage or PBMP administration could impact the covered person's out-of-pocket costs and the covered person may want to consider contacting his or her prescribing provider to determine whether continuation of that particular prescription drug impacted by the change is appropriate or whether there is an acceptable alternative prescription drug that can be used to treat the covered person's disease or medical condition;

(b) The covered person may want to review the health benefit plan's formulary from time-to-time or contact the health carrier or its designee to obtain any updated formulary information prior to obtaining a refill for a particular prescription drug the covered person is currently using to find out if there has been any change in the requirements for obtaining coverage for the drug or if there has been a change in the covered person's out-of-pocket costs for the drug and include the telephone number or electronic link that covered persons can use to contact the health carrier or its designee to obtain this information; and

(c) The amount that the covered person may be required to pay out-of-pocket for a particular prescription drug may change from time-to-time;

Section 12. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 13. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 14. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other that those to which it is held invalid, shall not be affected.

Section 15. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2002 Proc. 4th Quarter 279, 323-333 (adopted by task force).
2003 Proc. 1st Quarter 175 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 16 (adopted by Plenary).
2018 Proc. 1st Quarter (amendments adopted by Plenary).

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1057.02 (2000/2015).
Arkansas			ARK. CODE ANN. § 23-79-159 (2014) (notification of drug formulary changes).
California			CAL. HEALTH & SAFETY § 1367.241 (2016); CAL INS. CODE §§ 10123.192 to 10123.193 (2015); § 10123.201 (2015).
Colorado			COLO. REV. STAT. § 10-16-124.5 (2018).
Connecticut			CONN. GEN. STAT. § 38a-477d (2016/2017); CONN. AGENCIES REGS. § 38A-481-13 (2018).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:10A-140 (2015/2019).
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/155.37 (2001/2002) (notice).
Indiana			IND. CODE ANN. § 27-8-5-31.5 (2020).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.17C-030 (2002/2010) (disclosure).
Louisiana			LA. REV. STAT. ANN. § 22:1060.2 (2011).
Maine			ME. REV. STAT. ANN. tit. 24, §§ 4347 to 4350-E (2019).
Maryland			MD. CODE. ANN. INS. §§ 15-1613 to 15-1619 (2000/2008) (P&T Committees).
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. COMP. LAWS § 333.9705 (2004); § 500.3406o (1999/2016).
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. § 376.392 (2007).
Montana	NO CURRENT ACTIVITY		

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. § 689C.281 (2001); § 689B.0283 (2001).
New Hampshire			N.H. REV. STAT. ANN. § 420-J:7-b (2000/2019).
New Jersey			N.J. ADMIN. CODE § 11:22-5.9 (2006/2010).
New Mexico			N.M. STAT. ANN. § 13-7-15 (2013).
New York			N.Y. INS. LAW § 3217-a (1996/2019) (disclosure).
North Carolina			N.C. GEN. STAT. § 58-3-221 (1999).
North Dakota			N.D. CENT. CODE § 26.1-36-03.1 (1999).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 1753.21 (1997).
Oklahoma			OKLA. STAT. tit. 36, § 6850.1 (2013).
Oregon			OR. ADMIN. R. § 836-053-1020 (1998).
Pennsylvania			40 PA. CONS. STAT. § 991.2136 (1998/1999) (disclosure).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 9041 to 9052 (2011/2013).	
Rhode Island			R.I. GEN. LAWS §§ 27-20.8-1 to 27-20.8-2 (2004/2008).
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS §§ 58-29E-1 to 58-29E-15 (2004/2019).

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee			TENN. CODE ANN. § 56-57-104 (2005) (disclosure).
Texas			TEX. INS. CODE ANN. §§ 1369.051 to 1369.057 (2003/2017).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. 38.2-3407.9:01 (1999/2014).
Washington			WASH. REV. CODE § 48.43.510 (2000/2019).
West Virginia			W. VA. CODE § 33-50-2 (2015).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2018

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT (#22)

1. Description of the Project, Issues Addressed, etc.

In 2013, the Regulatory Framework (B) Task Force was charged to review NAIC existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, the Task Force decided that revising the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) was a priority for state insurance regulators, carriers and consumers given the expanded role state insurance regulators were given in overseeing prescription drug formulary issues under federal regulations implementing the provisions of the ACA. In addition, in November 2015, the Health Insurance and Managed Care (B) Committee adopted a 2016 charge directing the Regulatory Framework (B) Task Force to review and, if necessary, consider revisions to Model #22 to address issues related to: 1) transparency, accuracy and disclosure regarding prescription drug formularies and formulary changes during a policy year; 2) accessibility of prescription drug benefits using a variety of pharmacy options; and 3) tiered prescription drug formularies and discriminatory benefit design.

In February 2016, the Regulatory Framework (B) Task Force established the Model #22 (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #22. In April 2016, the Subgroup began meeting every other week to review and discuss the comments received on Model #22 by the Jan. 22, 2016, public comment deadline. During its conference calls, the Subgroup discussed a myriad of issues, including the model's application and scope, Pharmacy and Therapeutics (P&T) committee conflict of interest requirements, consumer disclosures, mid-year formulary changes, and nondiscrimination formulary and prescription drug benefit design. The Subgroup finished its review of the comments in September 2017 and released a second draft of proposed revisions to Model #22 with a Oct. 17, 2017, comment deadline. The Subgroup held three conference calls to discuss the comments received. The Subgroup adopted the proposed revisions to Model #22 on Nov. 7, 2017, via conference call and submitted the draft to the Regulatory Framework (B) Task Force for its consideration. The Regulatory Framework (B) Task Force adopted the proposed revisions on Dec. 2, 2017. The Health Insurance and Managed Care (B) Committee adopted the revisions on Dec. 3, 2017.

The proposed revisions to Model #22 include a number of enhancements, including more specific requirements in Section 5—Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures concerning P&T committee establishment and how it develops and manages a health carrier's formulary and pharmacy benefit management procedures (PBMPs). The revisions also enhance provisions concerning a P&T committee's conflict of interest policies and procedures. The proposed revisions to Model #22 also enhance and clarify requirements in Section 6—Information to Prescribers, Pharmacies, Covered Persons and Prospective Covered Persons regarding the information consumers must be provided concerning a health carrier's formulary and other prescription drug benefit information. The revisions to this section also enhance consumer disclosure requirements whenever a health carrier makes or approves a change in a formulary or PBMP administration. Additional revisions to Model #22 include revisions to Section 7—Medical Exceptions Approval Process Requirements and Procedures adding an expedited medical exceptions process and adding a new section—Section 8—Nondiscrimination in Prescription Drug Benefit Design.

2. Name of Group Responsible for Drafting the Model and States Participating

The Model #22 (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed revisions to Model #22. The members of the Subgroup were: Wisconsin, Chair; Alaska; California; Florida; Iowa; Missouri; Nebraska; New Mexico; Oklahoma; Oregon; Rhode Island; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

Based on the 2016 charge below from the Health Insurance and Managed Care (B) Committee, the Regulatory Framework (B) Task Force established the Model #22 (B) Subgroup in February 2016 to consider revisions to Model #22.

"Utilize the Regulatory Framework (B) Task Force to review and, if necessary, consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) to address issues related to: 1) transparency, accuracy and disclosure regarding prescription drug formularies and formulary changes during a policy year; 2) accessibility of prescription drug benefits using a variety of pharmacy options; and 3) tiered prescription drug formularies and discriminatory benefit design.—*Important*"

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2016 and ending in November 2017, the Subgroup reviewed and discussed all of the comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call every other week and sometimes weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2016 and ending in November 2017, the Subgroup reviewed and discussed all of the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions with public comment deadlines was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call twice weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

A number of significant issues were raised and addressed, including a provision on nondiscrimination requirements in formulary benefit design, prohibition on mid-year formulary changes and whether to apply certain provisions to qualified health plans (QHPs) only or to any health benefit plan providing prescription drug benefits.

With respect to the nondiscrimination in formulary benefit design provision, the Subgroup considered three options: 1) not include nondiscrimination language because it exists in other models; 2) include general nondiscrimination language that state insurance regulators may want to reference to ensure things are nondiscriminatory; or 3) include a more extensive proposal along the lines of the proposed draft language. After extension discussion, as reflected in Section 8, the Subgroup decided: 1) the model should include a nondiscrimination section containing some general language to allow state insurance regulators to look at PBMPs and formulary structural issues to make sure they are not discriminatory; 2) there should be a reference to federal nondiscrimination provisions that may apply; and 3) there should be a reference to existing NAIC models with nondiscrimination language that states may want to consider if developing implementing regulations to this model.

Another issue the Subgroup discussed extensively was whether to include language in the revisions prohibiting health carriers from making mid-year formulary changes. Interested parties advocating for such language said allowing health carriers to make mid-year formulary changes means that consumers who enrolled in a plan based on the formulary will not be getting the benefits they thought they would be receiving at the time of plan enrollment. The Subgroup acknowledged those concerns, but because the model applies to all markets—individual market, small group market and large group market—implementing such a provision would be administratively complex. The Subgroup also felt that other revisions to the model, including additional consumer disclosure requirements on this issue and enhanced medical exceptions process provisions, addressed the issue.

Another issue the Subgroup discussed was whether to apply certain provisions to QHPs only or apply to any health benefit plan providing prescription drug benefits. The Subgroup decided not to make such a distinction in the model and instead make decisions on the revisions based on policy.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

Section-by-Section Summary of Proposed Revisions

Section 1. Short Title

The proposed revisions to Model #22 make no changes to this section.

Section 2. Purpose and Intent

The proposed revisions to Model #22 make no substantive changes to this section, but add a drafting note clarifying that Model #22 is not intended to address prescription drug formularies and other PBMPs that health carriers or their designees may use for the purpose of workers' compensation.

Section 3. Definitions

The proposed revisions to Model #22 add, revise and delete definitions to reflect the substantive changes made in the other sections of the Act. In addition, some of the definitions in this section have been revised for consistency with the revisions to the same terms used in the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). The proposed revisions add one new definition for the term "drug substitution" and revise several definitions, including definitions for the terms "authorized representative," "medical and scientific evidence," "pharmaceutical benefit management procedure," "Pharmacy and Therapeutics committee," "prescription drug," and "step therapy." The proposed revisions to Model #22 delete definitions for the terms "generic substitution" and "health maintenance organization."

Section 4. Applicability and Scope

The proposed revisions to Model #22 revise this section substantively for clarity as to the model's application to prescription drugs categorically or contractually excluded from coverage under a covered person's health benefit plan. The proposed revisions add a drafting note on the issue. The proposed revisions also add another drafting note clarifying that the reference to "designee" in this section is intended to be construed broadly to any person or entity a health carrier contracts with to perform, or carry out on its behalf, specified activities required under the Act or applicable regulations.

Section 5. Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures

The proposed revisions to Model #22 enhance the existing provisions of this section to more clearly establish the responsibilities and duties of any P&T committee a health carrier uses to develop and maintain its prescription drug formulary and implement its PBMPs. The proposed revisions also include additional P&T committee member conflict of interest requirements. The proposed revisions also include a provision requiring health carriers to allow covered persons access to prescription drug benefits at in-network retail or mail order pharmacies, except under specified circumstances.

Section 6. Information to Prescribers, Pharmacies, Covered Persons and Prospective Covered Persons

The proposed revisions to Model #22 clarify and enhance the provisions in this section concerning disclosures, particularly consumer disclosures, related to formulary and prescription drug benefit information and changes to that information. The proposed revisions also specifically require health carriers to provide a 60-day notice or take other specific action whenever the health carrier makes or approves a change in a formulary affecting prescription drug benefit coverage or PBMP administration, including, but not limited to, co-payment amounts, co-insurance percentage level, step therapy, drug substitution and mandatory generics.

Section 7. Medical Exceptions Approval Process Requirements and Procedures

The proposed revisions to Model #22 clarify the provisions in this section related to the medical exceptions process. The proposed revisions also add an expedited medical exceptions process.

Section 8. Nondiscrimination in Prescription Drug Benefit Design

The proposed revisions to Model #22 add this section. This section prohibits a health carrier or its designee from adopting or implementing a formulary or prescription drug benefit design that is discriminatory in violation of state or federal law. The revisions also add three drafting notes to provide guidance to state insurance regulators in implementing this section. One drafting note references existing NAIC models with nondiscrimination language that states may want to consider if developing implementing regulations to this model.

Section 9. Recordkeeping and Reporting Requirements

The proposed revisions to Model #22 make one substantive revision to this section. The revisions require a health carrier to also maintain data on and, upon request, make available to the commissioner information on the changes to its formulary or prescription drug benefit information made after the state of a plan year. This revision is optional for a state to include when adopting the revisions.

Section 10. Oversight and Contracting Responsibilities

The proposed revisions to Model #22 make no changes to this section.

Section 11. Disclosure Requirements

The proposed revisions to Model #22 make a few clarifying changes to this section for consistency with the revisions made to other sections concerning the information concerning formularies and PBMPs a health carrier must disclose in a policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

Section 12. Regulations

The proposed revisions to Model #22 make no changes to this section.

Section 13. Penalties

The proposed revisions to Model #22 make no changes to this section.

Section 14. Separability

The proposed revisions to Model #22 make no changes to this section.

Section 15. Effective Date

The proposed revisions to Model #22 add optional language related to the effective date of model revisions.

PROJECT HISTORY - 2003

HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT (#22)

1. Description of the project, issues addressed, etc.

This model law was drafted to address an issue of increasing concern to consumers—the use by health carriers of formularies and other pharmaceutical benefit management procedures to manage prescription drug utilization. The model sets out standards for the establishment, maintenance and management of prescription drug formularies and other pharmaceutical benefit management procedures to assure that covered persons have appropriate access to medically necessary prescription drugs. The model law also establishes a medical exceptions process that would permit consumers to request a nonformulary prescription drug or to request an exception to a dose restriction or step therapy requirement.

2. Name of group responsible for draft the model:

Pharmaceutical Issues Working Group of the Regulatory Framework (B) Task Force.

States Participating:

North Carolina, Chair
Colorado
Delaware
District of Columbia
Illinois
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
New Hampshire
Ohio
Texas
Vermont
Washington
Wisconsin

3. Project authorized by what charge and date first given to the group:

The following charge given in February 2000: Study the issue of formulary regulation and pharmacy benefit managers, and how they are currently handled at the state level; determine if a more formal regulatory framework is warranted. Report by Winter 2000 Meeting.

After the working group held public hearings in June 2000, the following revised charge was given in February 2001:

Study the issue of formulary regulation and pharmacy benefit managers, and how they are currently handled at the state level and develop a new model or amend an existing model or models, as appropriate. Report by Winter 2001 Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the working group. Numerous interested parties participated, including industry representatives, such as the American Association of Health Plans (AAHP), the Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association (BCBSA), the National Association of Health Underwriters (NAHU), the Academy of Managed Care Pharmacy (AMCP), the Pharmaceutical Care Management Association (PCMA), AdvancePCS, Express Scripts, Inc., Kaiser Permanente, and the American Republic Insurance Company; prescription drug manufacturer representatives, such as Pfizer Pharmaceuticals, Inc., the Pharmaceutical Research and Manufacturers of America (PhRMA), GlaxoSmithKline and Schering-Plough Corporation; provider representatives, such as the American Medical Association (AMA), the American Psychiatric Association (APA), the American Society of Health-System Pharmacists (ASHP), and the National Association of Chain Drug Stores (NACDS); consumer representatives, such as AARP, the National Mental Health Association (NMHA), Leukemia & Lymphoma Society (LLS), Epilepsy Foundation of Colorado, National Partnership for Women and Families; and other interested parties, such as the National Pharmaceutical Council (NPC), the National Health Council and the National Committee for Quality Assurance (NCQA).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There have been five drafts of the proposed new model. Each draft was circulated for comment to interested parties prior to discuss at NAIC quarterly meetings. In addition, all drafts of the proposed model were posted on the NAIC web site. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the working group.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

The most significant issue that arose during the drafting of this proposed model concerned its scope. Industry wanted to limit the scope of the model such that it applied only to prescription drug formulary development and maintenance. The working group, however, determined that because health carriers use other pharmaceutical benefit management procedures in addition to formularies to manage prescription drug utilization, these other procedures, such as prior authorization requirements, dose restrictions and step therapy protocols, should be included in the model and should be subject to the same requirements as prescription drug formularies.

Another significant issue of controversy that arose during the drafting of the proposed model concerned whether covered persons should be able to use the medical exceptions process to request a medical exception to having to pay a higher co-payment for a higher tier prescription drug when the lower tier drug (with a lower co-payment amount) was determined not to be effective or appropriate for treating the covered person's medical condition. The working group decided not to permit such requests under the medical exceptions process because they believed that this was a plan design issue and, in addition, this was an issue that could not be easily addressed in a model law due to a myriad of other issues, including cost and the ability for one covered person versus another covered person to pay that cost.

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Individual Market Health Insurance Coverage Model Act ("Act"). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

Section 2. Definitions

As used in this Regulation:

A. "Actuarial Value" or "AV" means the percentage paid by a health benefit plan of the total allowed costs of benefits.

B. "Annual open enrollment period" means the period each year during which an individual may enroll or change coverage in a health benefit plan.

C. "Benefit year" means a calendar year for which a health benefit plan provides coverage for health benefits.

D. "CMS" means the federal Centers for Medicare and Medicaid Services.

E. (1) "Cost-sharing" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits.

(2) "Cost-sharing" includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

F. "EHB-benchmark plan" means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.

G. "HHS" means the U.S. Department of Health and Human Services.

H. (1) "Health factor" means, in relation to any individual, any of the following health status-related factors:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care services;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including:

(i) Conditions arising out of acts of domestic violence; or

(ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or

(h) Disability.

(2) For purposes of this subsection, "health factor" does not include the decision whether to elect individual market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.

I. "Minimum essential coverage" has the meaning stated in Section 5000A(f) of the Internal Revenue Code (Code).

J. "Percentage of the total allowed costs of benefits" means the anticipated covered medical spending for EHB coverage, as defined in Section 3K of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

K. "Plan" means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in Section 1302(d) and (e) of the Federal Act, and service area. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.

L. "Policy year" means, with respect to:

(1) Grandfathered health plan coverage providing individual market health insurance coverage and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year; or

(2) Non-grandfathered health plan coverage providing individual market health insurance coverage, or a market in which the State has merged has merged the individual and small group market risk pools for coverage issued or renewed beginning Jan. 1, 2014, a calendar year for which health insurance coverage provides coverage for health benefits.

M. "Product" means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type (e.g., HMO, PPO, EPO, POS or indemnity) within a geographic service area.

N. "Special enrollment period" means a period during which an individual or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the initial and annual open enrollment periods.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing individual market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

A. The premium rate charged by a health carrier offering a health benefit plan providing individual market health insurance coverage may vary only, with respect to the particular coverage involved, on the basis of the following:

(1) Whether the plan covers an individual or family:

(a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), the total family premium shall include only the premiums for all covered family members over the age of twenty-one (21) and the three (3) oldest children under the age of twenty-one (21); and

(b) For family coverage, any rating variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(2), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Paragraph (1), but only if the state does not permit any rating variation for age and tobacco use as described in Paragraphs (3) and (4). If the state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Paragraph (1) will apply in that state.

(2) (a) (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Item (ii) of this subparagraph; and

(ii) The commissioner may adopt regulations establishing uniform geographic rating areas subject to the provisions of 45 CFR §147.102(b); and

Drafting Note: States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this subparagraph, such as Item (iii).

Drafting Note: States should be aware that 45 CFR §147.102(b) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state's geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

(b) For purposes of this paragraph, geographic rating area is to be determined in the individual market using the primary policyholder's address;

(3) Age:

(a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);

(b) The rate for each enrollee must be based on the enrollee's age as of the date of policy issuance, renewal or addition to the policy;

(c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and

(d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:

(i) A single age band for individuals age 0 through 20;

(ii) One-year age bands for individuals age 21 through 63; and

(iii) A single age band for individuals age 64 and older; and

Drafting Note: States should be aware that 45 CFR §147.102(e) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(4) Tobacco use:

(a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;

(b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;

(c) A rating surcharge for "tobacco use" may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and

(d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider "tobacco use" in terms of when a tobacco product was last used.

Drafting Note: States may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this Regulation as provided in Paragraph (4) above.

B. A premium rate may not vary with respect to a particular coverage by any other factor not described in Subsection A.

C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 5. Single Risk Pool

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must consider the claims experience of all enrollees in all health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the individual market in a state, including enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool.

Drafting Note: As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

B. (1) (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the individual market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.

(b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).

(c) The premium rate for all of the health carrier's plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).

(2) For policy years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(a) The actuarial value and cost-sharing design of the plan;

(b) The plan's provider network, delivery system characteristics and utilization management practices;

(c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits;

(d) Administrative costs, excluding exchange user fees; and

(e) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(3) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually.

C. This section does not apply to grandfathered health plan coverage in accordance with the provisions of Section 1312(c)(4) of the Federal Act.

Section 6. Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods

A. Subject to Section 6 of the Act and Subsections B through D, a health carrier offering a health benefit plan providing individual market health insurance coverage must offer to any individual in the state all products that are approved for sale in the individual market and must accept any individual that applies for coverage under any of those products.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for network plans, limited financial capacity, etc.) to guaranteed availability of coverage can be found in Section 6 of the *Individual Market Health Insurance Coverage Model Act* (#36). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

C. (1) A health carrier must allow an individual to purchase health insurance coverage during an annual open enrollment period established by HHS unless the commissioner establishes a broader open enrollment period than the open enrollment period established by HHS. Coverage must become effective consistent with the dates described in Paragraph (2).

(2) The health carrier must ensure coverage is effective for an individual who has applied for coverage under the health benefit plan in accordance with requirements established by the commissioner if the commissioner establishes a broader open enrollment period or as established by HHS.

D. For individuals enrolled in non-calendar year health benefit plans, a health carrier must provide a limited open enrollment period that begins on the date that is thirty (30) calendar days prior to the date the policy year ends in 2014. The effective date of coverage under this subsection must be consistent with the dates described in Subsection E(2)(b).

Drafting Note: States that permitted health carriers to renew non-ACA compliant policies pursuant to the November 2013 "Transitional Policy," and any extensions of that transitional policy, may need to alert carriers that they must provide a special enrollment period for those covered persons at least 30 calendar days prior to the date the policy ends.

E. (1) (a) In addition to the special enrollment periods provided in Section 9B of the Act and qualifying events, as defined under Section 603 of ERISA, a health carrier must provide special enrollment periods for the following triggering events:

(i) An individual or dependent loses minimum essential coverage;

(ii) An individual gains a dependent through marriage, birth, adoption or placement for adoption or placement in foster care;

(iii) An individual's enrollment or non-enrollment in a health benefit plan is unintentional, inadvertent or erroneous and as a result of the error, misrepresentation or inaction of an officer, employee or agent of the health carrier or HHS or its instrumentalities as evaluated and determined by the health carrier. In such cases, the health carrier may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;

(iv) A covered person adequately demonstrates to the health carrier that the health benefit plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the covered person;

(v) A covered person is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions. A health carrier must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable, as defined by federal law or regulation, or no longer provide minimum value, as defined by federal law or regulation, for his or her employer's upcoming plan year, to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; and

(vi) An individual or covered person gains access to new health benefit plans as a result of a permanent move.

(b) These special enrollment periods are in addition to any other special enrollment periods required under state or federal law.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow individuals to purchase coverage more frequently than the federal minimum requirements.

(2) (a) With respect to an election made under Subsection D or Paragraph (1) of this subsection, coverage must become effective consistent with the dates described in Subparagraph (b) of this paragraph.

(b) Except as provided in Subparagraph (c) of this paragraph, for a health benefit plan selection received by the health carrier from an individual:

(i) Between the first and fifteenth day of any month, the health carrier must ensure a coverage effective date of the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the health carrier must ensure a coverage effective date of the first day of the second following month.

(c) (i) In the case of birth, adoption or placement for adoption, the health carrier must ensure that coverage is effective regardless of enrollment date in accordance with the provisions of Section 9B of the Act on the date of birth, adoption or placement for adoption.

(ii) In the case of marriage, or in the case where an individual loses minimum essential coverage, as described in Paragraph (1)(a)(i), the health carrier must ensure coverage is effective on the first day of the following month.

F. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 7. Guaranteed Renewability of Individual Market Health Insurance Coverage

A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must renew or continue in force the coverage at the option of the individual.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for product discontinuation and market exit, etc.) to guaranteed renewability of coverage can be found in Section 7 of the *Individual Market Health Insurance Coverage Model Act* (#36). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:

(1) The individual has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

(3) The carrier is ceasing to offer coverage in the market in accordance with Section 7C (discontinuing a particular product) or Section 7D (discontinuing all coverage) of the Act and applicable state law;

(4) For network plans, there is no longer any covered person who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business); or

(5) For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered persons.

C. (1) At the time of coverage renewal only, a health carrier may modify the health insurance coverage for a product offered in the individual market if the modification is consistent with federal or state law and is effective uniformly among all policyholders with that product.

(2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state requirements is considered a uniform modification of coverage if:

(a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

(b) The modification is directly related to the imposition or modification of the federal or state requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the individual market health insurance coverage for the product meets all of the following criteria:

(a) The product is offered by the same health carrier, as that term is defined in Section 3B of the Act;

(b) The product is offered as the same product network type;

(c) The product continues to cover at least a majority of the same service area;

(d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in Section 1302(d) and (e) of the Federal Act; and

(e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in Section 5B of this regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(e)(4) permits a state to broaden the standards described in Paragraph (3)(c) and (d) above.

D. If a health carrier is renewing non-grandfathered individual market health insurance coverage as described in Subsection A, or uniformly modifying non-grandfathered individual market health insurance coverage as described in Subsection C, the health carrier must provide to each individual written notice of the renewal before the date of the first day of the next open enrollment period in a form and manner specified by the Secretary.

E. (1) Nothing in this section should be construed to require a health carrier to renew or continue in force individual market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.

(2) Medicare eligibility or entitlement to such benefits is not a basis for non-renewal or termination of an individual's health insurance coverage in the individual market.

F. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under Section 2742 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition of Preexisting Condition Exclusions

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.

B. As described in Section 4 of the Act, grandfathered health plan coverage that is individual health insurance coverage is not required to comply with this section.

Section 9. Prohibition on Discrimination Based on Health Factors

Drafting Note: For purposes of this *Individual Market Health Insurance Coverage Model Regulation* (#TBD), states should be aware that Section 2705 of the PHSA extends the HIPAA nondiscrimination prohibitions to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market. In addition, states should be aware that in the Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Final Rule (78 Fed. Reg. 33158) published in the *Federal Register* June 3, 2013, the preamble of that final rule (78 Fed. Reg. 33167) states that "[c]ommenters requested that the wellness provisions be extended to the individual market or that states be allowed to authorize participatory programs in the individual market. Although the proposed rule addressing the individual market is being finalized without change, it is HHS's belief that participatory wellness programs in the individual market do not violate the nondiscrimination provisions provided that such programs are consistent with State law and available to all similarly situated individuals enrolled in the individual health insurance coverage. This is because participatory wellness programs do not base rewards on achieving a standard related to a health factor, and thus do not discriminate based upon health status."

A. (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.

(2) For purposes of this section, a rule of eligibility includes a rule relating to:

(a) Enrollment;

(b) The effective date of coverage;

(c) Waiting or affiliation periods;

(d) Late and special enrollment;

(e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;

(f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);

(g) Continued eligibility; and

(h) Terminating coverage, including disenrollment, of an individual under the plan.

(3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.

B. (1) Subject to federal or state law or regulations and Paragraph (2), Subsection A does not require a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act to provide coverage for any particular benefit to similarly situated individuals.

(2) (a) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all individuals.

(b) For any restriction on a benefit or benefits provided under a plan, the health carrier:

(i) Shall apply the restriction uniformly; and

(ii) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at any individual or dependents of an individual based on any health factor of the individual or a dependent of the individual.

(c) The health carrier may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:

(i) Applies uniformly;

(ii) Is not directed at any individual or dependents of an individual based on any health factor of the individual or dependent of an individual; and

(iii) Does not apply to preventive benefits specified in Section 2713 of the Public Health Service Act (PHSA).

(d) For purposes of this paragraph, a plan amendment applicable to all individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual or dependent of an individual.

(3) If the health carrier generally provides benefits for a type of injury, the health carrier may not deny any individual or dependent of an individual benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury.

C. In accordance with Subsection A, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual policyholder's premium or contribution rate based on:

(1) Whether the policyholder is confined in a hospital or other health care institution; or

(2) The policyholder's ability to engage in normal life activities.

Section 10. Essential Health Benefits Package

A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:

(1) Are substantially equal to the EHB-benchmark plan including:

(a) Covered benefits;

(b) Limitations on coverage including coverage of benefit amount, duration and scope; and

(c) Prescription drug benefits that meet the requirements of Section 12 of this Regulation;

(2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;

(4) Include preventive health services, as provided in Section 14 of the Act;

(5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:

(a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;

(b) Is determined by the health carrier and reported to HHS; or

(c) As determined by the state as provided in 45 CFR §156.110(f).

B. A health carrier offering a health benefit plan in the individual market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.

(1) Substitutes a benefit that:

(a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);

(b) Is made only within the same essential health benefit category; and

(c) Is not a prescription drug benefit; and

(2) Submits evidence of actuarial equivalence that is:

(a) Certified by a member of the American Academy of Actuaries;

(b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(c) Based on a standardized plan population; and

(d) Determined regardless of cost-sharing.

C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

D. A health carrier offering a health benefit plan in the individual market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.

Drafting Note: States should be aware that in the preamble of the final regulations published in the *Federal Register* Feb. 25, 2013 (78 FR 12866), there is commentary related to a provision in the ACA and implementing regulations that provides that if an exchange offers a standalone dental plan offering a pediatric dental EHB benefit, medical insurance plans are not required to offer a pediatric dental plan on that exchange. HHS was encouraged by commenters on the proposed regulation to extend into the non-exchange market (outside market) the ability of a medical insurance plan to not offer the pediatric dental EHB in cases where a standalone dental plan that meets the standards to cover the pediatric dental EHB is offered. In its response to the comments, HHS notes that the ACA does not provide for the same exclusion of a pediatric dental EHB outside of the exchange as it does in Section 1304(b)(4) of the ACA for exchanges. Therefore, individuals enrolling in health insurance coverage in the outside market must be offered the full ten EHB categories, including the pediatric dental benefit. HHS notes, however, that in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an exchange-certified stand-alone dental plan off the exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. As such, when an issuer is reasonably assured that an individual has obtained such coverage through an exchange-certified stand-alone dental plan offered outside an exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the exchange-certified stand-alone dental plan, ensures full coverage of EHB. HHS also notes that this alternative method of compliance is at the option of the medical insurance plan issuer, and would only apply with respect to individuals for whom the medical insurance plan issuer is reasonably assured have obtained pediatric dental coverage through an exchange-certified stand-alone dental plan. In addition, this option is only available for pediatric dental EHB, and not for any other EHB. States should be aware that because this alternative option is included in the final regulation's preamble, but not in the text of the final regulation, states may be taking a different approach to address this issue.

E. A health carrier offering health benefit plan in the individual market providing essential health benefits may not impose annual and lifetime dollar limits on essential health benefits in accordance with 45 CFR §147.126.

Section 11. Parity in Mental Health and Substance Use Disorder Benefits

A. (1) The provisions of 45 CFR §146.136 apply to a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act in the same manner and to the same extent as such provisions apply to health insurance coverage offered in connection with a group health insurance plan in the large group market.

(2) For purposes of this subsection, "large group market" has the meaning stated in 45 CFR §144.103.

B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 12. Prescription Drug Benefits

A. A health benefit plan does not provide essential health benefits unless it:

(1) Except as provided in Subsection B, covers at least the greater of:

(a) One drug in every United States Pharmacopeia (USP) category and class; or

(b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the state.

B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

C. (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.

(2) (a) The procedures must include a process for an enrollee, the enrollee's designee or the enrollee's prescribing physician or other prescriber to request an expedited review based on exigent circumstances.

(b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.

(d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Section 13. Prohibition on Discrimination in Providing Essential Health Benefits

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.

B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 14. Cost-Sharing Requirements

A. (1) For a policy year beginning in calendar year 2014, cost-sharing may not exceed the following:

(a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or

(b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.

(2) For a policy year beginning in a calendar year after 2014, cost-sharing may not exceed the following:

(a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or

(b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.

B. In the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in Subsection A does not apply to benefits provided out-of-network, other than benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably accessible within the network.

Drafting Note: Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. Federal law does not prevent a state from establishing lower cost-sharing limits, or establishing limits that apply to out-of-network benefits.

C. For a policy year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsection A that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.

D. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

E. Nothing in this section is in derogation of the requirements of Section 14 of the Act.

F. Emergency department services must be provided as follows:

(1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act*].

Section 15. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.

B. If a health benefit plan's design is not compatible with the AV Calculator, the health carrier must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:

(a) Calculate the plan's AV by:

(i) Estimating the fit of its plan design into the parameters of the AV calculator; and

(ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and

(2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.

C. (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.

(2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.

(3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.

D. (1) The AV, calculated as described in Subsections A through C, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.

(2) The levels of coverage are:

(a) A bronze plan is a health benefit plan that has an AV of 60%.

(b) A silver plan is a health benefit plan that has an AV of 70%.

(c) A gold plan is a health benefit plan that has an AV of 80%.

(d) A platinum plan is a health benefit plan that has an AV of 90%.

(3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.

Section 16. Enrollment in Catastrophic Plans

A. A health benefit plan is a catastrophic plan if it meets the following conditions:

(1) Meets all of the applicable requirements for individual market health insurance coverage and is offered only in the individual market;

(2) Does not provide a bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act;

(3) Provides coverage of essential health benefits under Section 1302(b) of the Federal Act once the annual limitation on cost-sharing in Section 1302(c)(1) of the Federal Act is reached and, except as provided in Paragraph (4) and Subsection B, provides no benefits for any policy year until such limitation on cost-sharing is reached;

(4) Provides coverage for at least three (3) primary care visits per year before reaching the deductible; and

(5) Covers only individuals who meet either of the following conditions:

(a) Have not attained the age of thirty (30) years prior to the first day of the policy year; or

(b) Have received a certificate of exemption for reasons identified in Section 1302(e)(2)(B)(i) or (ii) of the Federal Act.

B. A catastrophic plan may not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, for preventive services, in accordance with Section 2713 of the Public Health Service Act (PHSA).

C. For other than self-only coverage, each individual enrolled must meet the requirements of Subsection A(5).

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, have issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs) and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. The drafting note below details this sub-regulatory guidance and issuer enforcement safe harbors.

Drafting Note: The Departments have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The Departments confirmed their intent in the Affordable Care Act Implementation FAQs Part XIX, Q8 issued May 2, 2014,"in recognition of and to ensure a smooth transition to new market changes in 2014," to extend the following previously-issued enforcement and transition relief guidance until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies' basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer's obligation to provide an SBC with respect to benefits it does not insure);
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);
- Affordable Care Act Implementation FAQs Part XIV, Q2 (regarding providing information about MEC (minimum essential coverage) and MV (minimum value) without changing the SBC template;
- Affordable Care Act Implementation FAQs Part XIV, Q3 (removal of the row on the SBC template related to annual limits information);
- Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding carve-out arrangements);
- Affordable Care Act Implementation FAQs Part XIV, Q7 (regarding anti-duplication rule for student health insurance coverage);
- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage); and
- Affordable Care Act Implementation FAQs Part XIV, Q6 (an enforcement safe harbor related to closed blocks of business).

The May 2, 2014 guidance also noted that "[t]his guidance supersedes any previous sub-regulatory guidance, including FAQs, stating that certain enforcement relief for the SBC and uniform glossary requirements is limited to the first or second year of applicability."

A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to the individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

B. (1) A health carrier must provide an SBC to an individual covered under the health benefit plan, including every dependent, upon receiving an application for any plan, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.

(2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.

(3) (a) A health carrier must provide the SBC to policyholders annually at renewal in accordance with Subparagraph (b) of this paragraph. The SBC must reflect any modified plan terms that would be effective on the first day of the new policy year.

(b) The SBC must be provided as follows:

(i) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(ii) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new policy year; however, if the policy, certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new policy, certificate or contract of insurance or the receipt of the written confirmation of intent to renew, whichever is earlier.

(4) (a) A health carrier must provide an SBC to any individual or dependent anytime the individual or dependent requests an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

(b) For purposes of this subsection, a request for an SBC or summary information about a health insurance product includes a request made both before and after an individual submits an application for coverage.

(5) If a health carrier provides a single SBC to an individual and any dependents at the individual's last known address, then the carrier's requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, the carrier must provide a separate SBC to the dependent at the dependent's last known address.

C. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:

(a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;

(b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;

(c) The exceptions, reductions and limitations of coverage;

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

(e) The renewability and continuation of coverage provisions;

(f) Coverage examples in accordance with Paragraph (2);

(g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage's share of the total allowed costs of benefits provided under the coverage meets applicable requirements;

(h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;

(j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;

(k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and

(l) An Internet address for obtaining the uniform glossary, as described in Subsection H, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(2) (a) The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.

(b) For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary of will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(c) (i) For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.

(ii) The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.

(3) (a) In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the Unites States.

Drafting Note: In Frequently Asked Questions (FAQ s), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

(b) In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.

D. (1) A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: "To the extent a plan's terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."

(2) The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.

(3) The carrier must provide the SBC as a stand-alone document.

E. (1) A carrier must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

(2) A carrier satisfies the requirements of this subsection if the carrier:

(a) Hand-delivers a printed copy of the SBC to the individual or dependent;

(b) Mails a printed copy of the SBC to the mailing address provided to the carrier by the individual or dependent;

(c) Provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email;

(d) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with Subparagraphs (a) through (c) of this paragraph, that the SBC is available on the Internet and includes the applicable Internet address; or

(e) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

(3) An SBC may not be provided electronically unless:

(a) The format is reasonably accessible;

(b) The SBC is placed in a location that is prominent and readily accessible;

(c) The SBC is provided in an electronic form which can be electronically retained and printed;

(d) The SBC is consistent with the appearance, content and language requirements of this section; and

(e) The carrier notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

(4) A carrier that provides the content required under Subsection C, as specified in guidance published by the Secretary, to the federal health reform Web portal described in 45 CFR 159.120 will be deemed to satisfy the requirements of Subsection B(4) with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting the carrier's obligations under this section.

F. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.

G. (1) If a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act makes any material modification, as defined under Section 102 of ERISA, in any terms of the coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with renewal or reissuance of coverage, the health carrier must provide notice of the modification to an individual covered under a health benefit plan not later than sixty (60) days prior to the date on which the modification will become effective.

(2) The health carrier must provide the notice of modification in a form that is consistent with Subsection E.

H. (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must make available to applicants, policyholders and covered dependents, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).

(2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:

(a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;

(b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.

(3) A carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.

(4) A carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

Drafting Note: States should be aware that consumers may review and obtain the uniform glossary at several websites, including www.healthcare.gov (Centers for Medicare and Medicaid Services (CMS)), www.cciio.cms.gov (Center for Consumer Information and Insurance Oversight (CCIIO)), and www.dol.gov/ebsa/healthreform (U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA)).

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 30341) in the *Federal Register* May 27, 2014, amending 45 CFR §148.124 to eliminate the requirement in the individual market to provide certificates of credible coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §148.124 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.

B. The provisions of this section apply beginning December 31, 2014.

Section 19. Rules Related to Fair Marketing

A. A health carrier offering health benefit plans providing individual market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for health benefit plans providing individual market health insurance coverage not subject to Section 6 of the Act, a health carrier must offer coverage upon request and is not required to actively market such coverage.

Drafting Note: This regulation requires the active marketing of all individual market health benefit plans offered by a carrier. This requirement is present to prevent targeted marketing by a carrier or producer. Marketing materials should make clear, however, that not all individuals may be eligible for all individual market health benefit plans issued by the carrier. Those materials should also make clear that some individual market health benefit plans may only be available in certain geographic areas and based on certain eligibility criteria (e.g. catastrophic plans).

B. The health carrier shall maintain a toll-free telephone service that answers its telephone calls in a timely manner to provide information to individuals regarding the availability of individual market health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and telephone numbers of producers located geographically proximate to the caller or other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of individual market health benefit plans in their state. For those states that determine this provision is necessary, it is imperative that the toll-free number be accessible.

C. The health carrier may not require an individual to join or contribute to an association or group as a condition of being accepted for coverage by the carrier.

D. The health carrier may not require, as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

E. (1) A health carrier must file annually the following information with the commissioner related to individual market health benefit plans issued by the carrier to individuals in this state:

(a) The number of individuals that were issued, or received renewals of, individual market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of individual market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic divisions.

(c) The number of individual market health benefit plans that were voluntarily not renewed by individuals in the previous calendar year; and

(d) The number of individual market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

F. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its individual market health benefit plans. The commissioner shall have authority to review a carrier's commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its individual market health benefit plans are created by the structure.

G. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection G above and, if necessary, revise the language in Subsection G.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.

Section 21. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 22. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2014 Proc. 3rd Quarter Vol. I 122-125, 137, 256, 266 (adopted).

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

What are the state pages?

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INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

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Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2014

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION (#26)

1. Description of the Project, Issues Addressed, etc.

At the 2013 Spring National Meeting, the Regulatory Framework (B) Task Force began its review of an initial outline for developing the Individual Market Health Insurance Coverage Model Regulation as a companion regulation to the *Individual Market Health Insurance Coverage Model Act* (#36). The Task Force began discussing an initial draft of the model regulation at the 2013 Summer National Meeting. The draft model regulation incorporates the provisions of various federal regulations implementing the 2014 market reform provisions and other relevant provisions of the federal Affordable Care Act (ACA). The Task Force adopted the Individual Market Health Insurance Coverage Model Regulation Nov. 16 at the 2014 Fall National Meeting and presented it to the Health Insurance and Managed Care (B) Committee for its consideration. As part of the Task Force's report, the Committee adopted the Individual Market Health Insurance Coverage Model Regulation Nov. 17.

Major provisions in the model regulation include:

- Restrictions Relating to Premium Rates (Section 4)
- Single Risk Pool (Section 5)
- Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods (Section 6)
- Guaranteed Renewability of Individual Market Health Insurance Coverage (Section 7)
- Prohibition on Preexisting Condition Exclusions (Section 8)
- Essential Health Benefits Package (Section 10)
- Prescription Drug Benefits (Section 12)
- Cost-Sharing Requirements (Section 14)
- Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage (Section 15)
- Enrollment in Catastrophic Plans (Section 16)
- Provision of Summary of Benefits and Coverage (Section 17)
- Certification and Disclosure of Prior Creditable Coverage (Section 18)

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force drafted the model regulation. The members of the Task Force at the time of adoption were: Wisconsin, Chair; Utah, Vice Chair; Arizona; California; Colorado; Connecticut; Delaware; Florida; Idaho; Illinois; Indiana; Kansas; Kentucky; Maine; Minnesota; Missouri; Montana; Nebraska; Nevada; New Jersey; N. Marina Islands; Ohio; Oklahoma; Oregon; Pennsylvania; Puerto Rico; South Dakota; Tennessee; Virginia; and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. The Task Force also has a specific charge to consider the development of new NAIC model laws and regulations, as well as the revision of existing NAIC model laws and regulations affected by federal legislation and final federal regulations promulgated pursuant to such legislation.

After the enactment of the ACA in March 2010, consistent with its charges, the Health Insurance and Managed Care (B) Committee directed the Task Force to review and revise existing NAIC models affected by the ACA or, as necessary, develop new NAIC models to assist the states in implementing the ACA. This proposed new NAIC model regulation is consistent with that directive.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The model regulation was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2013 and 2014 National Meetings and several open conference calls, during which the drafts and comments received on the drafts were discussed. All drafts and comments were posted on the Task Force's page on the NAIC website. During these in-person meetings and open conference calls, representatives from various stakeholder groups participated,

including consumer representatives, such as the Georgetown University Health Policy Institute, the Center on Budget and Policy Priorities (CBPP), the Consumers Union and Families USA, and the Alzheimer's Foundation of America; industry representatives, such as the America's Health Insurance Plans (AHIP), the BlueCross and BlueShield Association (BCBSA), and the Pharmaceutical Research and Manufacturers of America (PhRMA); and individual consumers.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The model regulation was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2013 and 2014 National Meetings and several open conference calls, during which the drafts and comments received on the drafts were discussed. All drafts and comments were posted on the Task Force's page on the NAIC website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was only one significant issue discussed at the end of the drafting process. During the last public comment period, more than 40 comment letters were received concerning an issue related to network plans found in Section 14B. The issue related to a provision in the final federal regulations concerning the application of non-network cost-sharing to the annual limitation on cost-sharing. As provided in 45 CFR §156.130, in the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in 45 CFR §156.130(a), does not apply to benefits provided out-of-network. Section 14B of the model regulation reflected the federal provision, but included a drafting note alerting state insurance regulators that subject to state or federal law or regulations, nothing prohibits a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in the federal regulations or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. A majority of the comment letters received on this issue urged the Regulatory Framework (B) Task Force to consider revising the model regulation, at a minimum, to provide that the out-of-network cost-sharing that results from an exceptions or appeal process permitting a covered person to obtain covered benefits from an out-of-network provider should apply to the annual cost-sharing limitation.

During its meeting at the 2014 Fall National Meeting, the Task Force discussed the comment letters received on this issue and the suggested revisions to address it. The Task Force voted unanimously to revise Section 14B to permit benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably available within the network to be applied to the annual cost-sharing limitation. The Task Force also voted unanimously to add a sentence to the drafting note specifically alerting the states that federal law does not prevent a state from establishing lower cost-sharing limits or establishing limits that apply to out-of-network benefits.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

Table of Contents

Drafting Note: This regulation is for use by states that have current statutory authority to prescribe a standard claim form for the filing of health care claims. It assumes the authority is broad enough to require compliance by the health care practitioner community. States that do not have this broad authority should delete the requirements that apply to providers.

Section 1. Short Title

This regulation shall be known and may be cited as the Standardized Health Claim Form Regulation.

Section 2. Purpose

The purpose and intent of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized, increase efficiency in the reimbursement of health care through standardization and encourage the use of and prescribe a timetable for implementation of electronic data interchange of health care expenses and reimbursement.

Section 3. Definitions

As used in this regulation:

A. "ASC X12N standard format" means the standards for electronic data interchange within the health care industry developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute.

B. "CDT-1 Codes" means the current dental terminology prescribed by the American Dental Association.

C. "CPT-4 Codes" means the physicians current procedural terminology, fourth edition published by the American Medical Association.

D. "HCFA" means the Health Care Financing Administration of the U.S. Department of Health and Human Services.

E. "HCFA Form 1450" means the health insurance claim form maintained by HCFA for use by institutional care practitioners.

F. "HCFA Form 1500" means the health insurance claim form maintained by HCFA for use by health care practitioners.

G. "HCPCS" means HCFA's Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician Current Procedural Terminology, Fourth Edition (CPT-4) codes, alphanumeric codes, and related modifiers. This includes:

(1) "HCPCS Level 1 Codes" which are the AMA's CPT-4 codes and modifiers for professional services and procedures.

(2) "HCPCS Level 2 Codes" which are national alpha-numeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(3) "HCPCS Level 3 Codes" which are local alpha-numeric codes and modifiers for items and services not included in HCPCS Level 1 or HCPCS Level 2.

H. "Health care practitioner" means:

(1) An acupuncturist licensed under [insert state statute defining an acupuncturist].

(2) A chiropractor licensed under [insert state statute defining a chiropractor].

(3) A corporation or partnership of health care practitioners defined in this section.

(4) A dentist licensed under [insert state statute defining a dentist].

(5) A nurse licensed under [insert state statute defining each level of nursing (i.e. registered nurse, licensed practical nurse)].

(6) An ophthalmologist licensed under [insert state statute defining an ophthalmologist].

(7) An optometrist licensed under [insert state statute defining an optometrist].

(8) A physician licensed under [insert state statute defining a physician].

(9) A podiatrist licensed under [insert state statute defining a podiatrist].

(10) A psychologist licensed under [insert state statute defining a psychologist].

(11) A speech, physical, respiratory or occupational therapist licensed under [insert state statutes defining speech, physical, respiratory and occupational therapists].

(12) A home health care provider [insert state statute defining home health care providers].

Drafting Note: States are encouraged to consult with the state agency responsible for licensing health care practitioners to be certain all practitioners of health care licensed by the state are included in this section.

I. "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth revision, clinical modifications published by the U.S. Department of Health and Human Services.

J. "Institutional Care Practitioner" means:

(1) A hospice licensed under [insert state statute defining a hospice];

(2) A hospital licensed under [insert state statute defining a hospital]; and

(3) Skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, and personal care facility licensed under [insert state statute defining long-term care related facilities].

Drafting Note: States are encouraged to consult with the state agency responsible for licensing institutional care practitioners to be certain all institutional providers of health care licensed by the state are included in this section.

K. "Issuer" means an insurance company, fraternal benefit society, health care service plan, health maintenance organization, and third party administrator, and any other entity reimbursing the costs of health care expenses.

Drafting Note: States that do not regulate third party administrators should delete the reference to them from this section.

L. "J512 Form" means the uniform dental claim form approved by the American Dental Association for use by dentists.

M. "Revenue Codes" means the codes established for use by institutional care practitioners by the National Uniform Billing Committee.

Drafting Note: The U.S. Government Printing Office, 710 North Capitol Street NW, Washington, DC 20401 can supply copies of the following: HCPCS Codes, ICD-9-CM Diagnosis Codes, Volumes 1 & 2, HCFA Form 1450 and instructions, HCFA Form 1500 and instructions. The American Dental Association, 211 East Chicago Ave., Chicago, IL 60611 can supply the CDT-1 Codes and users manual and the J512 Form. The American Medical Association Form Order Department can supply copies of the Physician's Current Procedural Terminology (CPT-4) book.

Section 4. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to issuers, health care practitioners, and institutional care practitioners.

B. Nothing in this regulation shall prevent an issuer from requesting additional information that is not contained on the forms required under this regulation to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

C. Nothing in this regulation shall prohibit an issuer, health care practitioner or institutional care practitioner from using alternative forms or procedures for filing claims as are specified in a written contract between the health care practitioner or institutional care practitioner and issuer.

Drafting Note: A contract under Subsection C cannot relieve a health care practitioner, institutional care practitioner or issuer from data reporting requirements under state or federal law or regulation.

Section 5. Requirements for Use of HCFA Form 1500

A. Health care practitioners, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when filing claims with issuers for professional services. Health care practitioners that bill patients directly shall provide a properly completed HCFA Form 1500 in addition to any other explanatory information used to bill the patient when requested by the patient.

B. Issuers may only require health care practitioners to use the following coding system for the initial filing of claims for health care services:

(1) HCPCS Codes; and

(2) ICD-9-CM Codes.

C. Issuers may only require health care practitioners to use other explanations with a code or to furnish additional information with the initial submission of a HCFA Form 1500 under the following circumstances:

(1) When the procedure code used describes a treatment or service that is not otherwise classified; or

(2) When the procedure code is followed by the CPT-4 modifier 22, 52 or 99. Health care practitioners may use item 19 of the HCFA Form 1500 to explain multiple modifiers, unless item 19 is used for other purposes in accordance with the instructions for this form.

D. Health care practitioners may use Box 19 of the HCFA Form 1500 to indicate the form is an amended version of a form previously submitted to the issuer by inserting the word "amended" in the space provided.

E. Health care practitioners billing for services based on the amount of time involved shall define on line 19 the time interval in item 24 G of the HCFA Form 1500, if the time interval is not already defined the HCPCS code. If not defined by either HCPCS or in line 19, units will be assumed to be days of treatment.

F. Health care practitioners shall provide the unique physician identification number, as assigned by HCFA, in box 17a and the federal tax identification number or social security number to complete Item 25 of the HCFA Form 1500, as required by the HCFA instructions.

Section 6. Requirements for Use of HCFA Form 1450

A. Institutional care practitioners shall use the HCFA Form 1450 and instructions provided by HCFA for use of the HCFA Form 1450 when filing claims with issuers for health care services. Institutional care providers that bill patients directly shall provide a properly completed HCFA Form 1450 in addition to any other explanation information used to bill the patient when requested by the patient.

B. Issuers may only require institutional care practitioners to use the following coding system for the initial filing of claims for health care services:

(1) ICD-9-CM Codes;

(2) Revenue Codes;

(3) HCPCS Codes; and

(4) The information outlined in Section 5 of this regulation, if the charges include direct service furnished by a health care practitioner, and the direct service are not covered by the instructions for the HCFA form 1450.

C. Hospitals may use the HCFA Form 1500 to supplement a HCFA Form 1450 if necessary in billing patients or their representatives or filing claims with issuers for outpatient services.

Section 7. Requirements for Use of J512 Form

A. Dentists shall use the J512 Form and instructions provided by the American Dental Association CDT-1 for use of the J512 Form for filing claims with issuers for professional services. Dentists that bill patients directly shall provide a properly completed J512 Form in addition to any other form used to bill the patient when requested by the patient.

B. Issuers may not require a dentist to use any code other than the CDT-1 codes for the initial filing of claims for dental care services, unless the use of supplemental codes are defined and permitted in a written contract between the issuer and dentist.

Section 8. General Provisions

A. Health care practitioners and institutional care practitioners shall file claims in a manner consistent with the requirements of this regulation. Claims filed in paper form shall be printed on 8.5 x 11 inch paper.

B. Issuers shall accept forms submitted in compliance with this regulation for the processing of claims.

C. Health care practitioners, institutional care practitioners and issuers shall:

(1) Use and accept the most current editions of the HCFA Form 1500, HCFA Form 1450, or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers.

(2) Modify their billing and claim reimbursement practices to encompass the coding changes for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes and procedures required under this regulation.

Section 9. Mandatory Electronic Format

Issuers that receive claims or send payments by electronic means shall, by [insert date] or the date on which the Health Care Financing Administration requires it of Medicare intermediaries and carriers, whichever is later, accept the ASC X12N standard format for the health care claims submission transaction set (837) and send the ASC X12N health care claim payment transaction set (835).

Section 10. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1993 Proc. 4th Quarter 16, 18, 660, 664-668 (adopted).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE § 27-1-16 (1981/1993).
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 28.700 to 28.725 (1995/1997).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. § 23-85-136 (1987/2001); § 23-86-117 (1987/2001).
California			CAL. HEALTH & SAFETY CODE §§ 127575 to 127600 (1995/2006).
Colorado			COLO. REV. STAT. § 10-1-131 (1993); § 10-16-106.3 (2002/2007).
Connecticut			CONN. GEN. STAT. § 38a-477 (1993/2012).
Delaware			DEL. CODE ANN. tit. 18, § 3310 (1968/1992).
District of Columbia			D.C. CODE ANN. § 31-3201 (1995).

STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 627.647 (1988/2003); § 408.7071 (1993/2000); FLA. ADMIN. CODE ANN. r. 69O-161.001 to 69O-161.011 (1994/2017).
Georgia			GA. CODE ANN. § 33-24-10.1 (1992/2019); GA. COMP. R. REGS. 120-2-59 (1994/1999).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO ADMIN. CODE 18.01.71 (1995).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2017.10 to 2017.70 (1994/1996).		
Indiana			IND. CODE § 27-8-5.5-2 (1977/1989); 760 IND. ADMIN. CODE 1-23-1 to 1-23-5 (1977).
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. § 40-2253 (1991/1992); KAN. ADMIN. REGS. § 40-4-40 (1993).
Kentucky			KY. REV. STAT. ANN. § 304.14-135 (1980/2010); 806 KY. ADMIN. REGS 17:370 (2003/2008).
Louisiana	LA. ADMIN. CODE tit. 37, Pt. XIII, §§ 2301 to 2313 (Regulation 48) (1994) (portions of model).		LA. REV. STAT. ANN. § 22:982 (1993/2008).
Maine			ME. REV. STAT. ANN. tit. 24, § 2332-E (1993/2003); § 2985 (1993/2003); § 1912 (1993/2005); § 2680 (1993/2003); § 2753 (1993/2005); § 2823-B (1993/2005); § 4235 (1993/2005).

STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland	MD. CODE REGS. §§ 31.10.11.01 to 31.10.11.14 (1993/2015) (portions of model).		MD. CODE ANN. INS. §§ 15-1002 to 15-1004 (1997/2017).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 62J.50 to 62J.581 (1994/2014).
Mississippi			MISS. CODE ANN. § 83-9-13 (1985/1993).
Missouri			MO. REV. STAT. § 374.184 (1992).
Montana	MONT. ADMIN. R. 6.6.5501 to 6.6.5515 (1995).		
Nebraska			NEB. REV. STAT. §§ 44-524 to 44-530 (1994/2007).
Nevada			NEV. REV. STAT. § 679B.138 (1999/2001) (authority to adopt regulations); § 689A.105 (1975); § 689B.250 (1975/2001); NEV. ADMIN. CODE §§ 689A.310 to 689A.360 (1976/1992).
New Hampshire			N.H. REV. STAT. ANN. § 400-A:15-a (1993/2003); N.H. CODE R. INS. 4001.01 to 4007.01 (2005/2016).
New Jersey			N.J. ADMIN. CODE §§ 11:22-3.1 to 11:22-3.9 (2001/2011); BULLETIN 2009-5 (2009).
New Mexico	N.M. CODE R. § 13.10.12 (1994/2001).		N.M. STAT. ANN. § 59A-18-27.1 (1993).
New York			N.Y. INS. LAW § 3224 (1984); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 17.0 to 17.6 (1979/2013).

STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina			N.C. GEN. STAT. §§ 58-3-171 to 58-3-172 (1993/2007); 11 N.C. ADMIN. CODE §§ 12.1501 to 12.1509 (1994/1995).
North Dakota	N.D. ADMIN. CODE §§ 45-06-03.1-01 to 45-06-03.1-03 (1994).		N.D. CENT. CODE § 26.1-36-37.1 (1985/1993).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-8-03 (2012/2016) (portions of model).		OHIO REV. CODE ANN. §§ 3902.21 to 3902.23 (1992/2006).
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-1-30 to 365:10-1-36 (1994/2012) (portions of model).		OKLA. STAT. tit. 36, § 6581 (1993/1995).
Oregon			OR. ADMIN. R. 836-050-0110 (1977/1995).
Pennsylvania			40 PA. STAT. ANN. §§ 991.1201 to 991.1205(1992).
Puerto Rico			P.R. REGS. OCS § 6559 (2003).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-71-230 (1992/2008).
South Dakota	S.D. ADMIN. R. 20:06:27 (1995/2015).		S.D. CODIFIED LAWS §§ 58-12-12 to 58-12-14 (1994).
Tennessee			TENN. CODE ANN. § 56-7-1008 (1980); § 56-1-104 (1993/2008); TENN. COMP. R. & REGS. 0780-01-73-.01 to 0780-01-.06 (2002).
Texas			28 TEX. ADMIN. CODE §§ 21.2801 to 21.2826 (2000/2014).

STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah			UTAH CODE ANN. § 31A-22-614.5 (1993/2017); § 31A-22-614.7 (2013/2017).
Vermont	VT. ADMIN. CODE §§ 4-3-23:1 to 4-3-23:11 (1993).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-322 (1993/1997).
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 3.65 (1993/2017).		WIS. STAT. § 601.41 (2002/2013); § 610.65 (1977/2013); WIS. ADMIN. CODE INS. § 3.60 (1992/1993); § 3.651 (1993/1994).
Wyoming	WYO. ADMIN. CODE 044.0002.51 §§ 1 to 9 (1996/2017).		

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Carrier Claim Audit Guidelines Model Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the reasonable standardization of statewide claim audit guidelines of health care bills for health care services and their reimbursement by health carriers, preferred provider organizations, third party administrators, or any other health benefit plan to determine whether data in a health care record of an institutional provider is supported by services listed on the claim for payment of an insured or an institutional provider. It is further the purpose of this Act to alleviate the potential conflict of the audit with medical uses of the health record and to reduce the cost of conducting a necessary audit.

Drafting Note: States should consider coordinating with other state agencies and amending other state laws to provide for sanctions against institutional providers that violate provisions of state insurance law.

Section 3. Definitions

For purposes of this Act:

A. "Ambulatory surgical center" means an establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services available whenever a patient is in the center, that does not provide services or other accommodations for patients to stay overnight, and that offers the following services whenever a patient is in the center: drug services as needed for medical operations and procedures performed, provisions for physical and emotional well-being of patients, provision of emergency services, organized administrative structure and administrative, statistical and medical records.

B. "Claim audit" means a process to determine whether data in a claimant's medical record for health care documents health care services listed on a claim for payment submitted to a carrier. Claim audit does not mean a review of the medical necessity of the services provided, or the reasonableness of charges for the services.

C. "Claimant" means an insured or enrollee under a health benefit plan who receives surgical or inpatient care, the costs of which are submitted to a carrier for payment, either by the claimant or by another on the claimant's behalf.

D. "Final claim" means the final itemized bill from an institutional provider detailing all the charges for which the institutional provider is seeking payment.

E. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

F. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

G. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a provider-sponsored organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

H. "Institutional provider" means an institution providing health care services in a health care setting, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers.

I. "Medical record" means a compilation of charts, records, reports, documents, and other memoranda maintained by an institutional provider wherever located, to record or indicate the past or present condition, sickness or disease, and treatment rendered, physical or mental, of a patient.

J. "Qualified claim auditor" means a person employed by a corporation or firm that is recognized as competent to perform or coordinate claim audits and that has explicit policies and procedures protecting the confidentiality and disposal of all patient information in its possession.

K. "Underbilled charges" means the volume of services indicated on a claim is less than the volume identified in the institutional provider's medical documentation; also known as undercharges.

L. "Unbilled charges" means charges or services provided for and not billed.

M. "Unsupported charges" or "undocumented charges" means the volume of services indicated on a claim exceeds the total volume identified in the institutional provider's medical documentation; also known as overcharges.

Section 4. Applicability and Scope

This Act shall apply to all health carriers. The institutional provider accepting assignment of benefits of an insured shall be responsible for the conduct and results of the claim audit whether conducted by an employee or by contract with another firm. The institutional provider and carrier shall:

A. Exercise proper supervision of the process to ensure that the audit is conducted in accordance with the requirements of this Act;

B. Be aware of the actions being undertaken by the auditor in connection with the claim audit and its related activities; and

C. Take prompt remedial action if inappropriate behavior by the auditor is discovered.

Section 5. Qualifications of Auditors and Institutional Provider Audit Coordinators

A. All persons performing claim audits as well as persons functioning as institutional provider audit coordinators shall have appropriate knowledge, experience, and expertise in health care including, but not limited to, the following areas:

(1) Format and content of the health record as well as other forms of medical and clinical documentation;

(2) Generally accepted auditing principles and practices as they apply to claim audits;

(3) Billing claims forms, including the UB92 and the HCFA 1500, and charging and billing procedures;

(4) All state and federal regulations concerning the use, disclosure and confidentiality of patient records;

(5) Specific critical care units, specialty area, and ancillary units involved in a particular audit; and

(6) Coding, including ICD-9, CPT, HCPCS and medical terminology.

B. Institutional providers or carriers that encounter audit personnel who do not meet these qualifications shall immediately contact the auditor's firm or sponsoring party.

C. Audit personnel shall conduct themselves in a professional manner and adhere to ethical standards and confidentiality requirements, and shall remain objective. They shall completely document their findings and problems.

D. All unsupported, unbilled or underbilled charges identified in the course of an audit shall be documented in the audit report by the auditor.

E. Individual audit personnel shall not be placed in a situation through their remuneration, benefits, contingency fees or other instructions that would call their findings into question. Compensation of audit personnel shall be structured so that it does not create incentives to produce questionable audit findings. Institutional providers or carriers that encounter an individual who appears to have a conflict of interest shall contact the appropriate management of the sponsoring organization.

Section 6. Notification of Audit

A. Carriers and institutional providers shall make every effort to resolve claim inquiries directly. The name, contact telephone number and facsimile number of each carrier or institutional provider representative shall be exchanged no later than at the time of billing for an institutional provider and the point of first inquiry by a carrier.

Drafting Note: Subsection A states that resolution of questionable charges may be resolved telephonically. It often happens that an auditor representing a carrier must travel many miles and incur hotel, plane, and other expenses in order to perform an on-site audit. If the institutional provider is unable to resolve charges at the time of audit, resolution by telephone or fax saves time and money for the carrier and removes the incentive to postpone audit completion for the institutional provider.

B. If a satisfactory resolution of the questions surrounding the bill is not achieved by carrier and institutional provider representatives, then a full audit process may be initiated by the carrier.

C. Claim audits require documentation from or review of a patient's health record and other similar medical or clinical documentation. Health records exist primarily to ensure continuity of care for a patient; therefore, the use of a patient's record for an audit must be secondary to its use in patient care.

D. All carrier claim audits shall begin with a notification to the institutional provider of an intent to audit. Notification to the institutional provider by the qualified claim auditor shall occur within six (6) months following receipt of the final claim for payment by the carrier. Once notified, the institutional provider shall respond to the qualified claim auditor within one month with a schedule for the conduct of the audit. The qualified auditor shall complete the audit within twelve (12) months of receipt of the final claim by the carrier. When there is a substantial and continuing relationship between a carrier and an institutional provider, this relationship may warrant a notification, response and audit schedule other than that outlined in this Act. Each party shall make reasonable provisions to accommodate circumstances in which the schedule specified cannot be met by the other party. The carrier will not request nor accept audits after twelve (12) months from the date of receipt of the final claim.

E. All claim audits shall be conducted on the premises of the institutional provider ("on-site") except in instances where an institutional provider chooses to allow individual, reasonable requests for off-site audits.

F. All requests for claim audits, whether telephonically, electronically or written, shall include the following information:

(1) The basis of the carrier's intent to conduct an audit on a particular bill or group of bills. When the intent is to audit only specific charges or portions of the bills, this information should be included in the notification request;

(2) Name of the patient;

(3) Admit and discharge dates;

(4) Name of the auditor and the name of the audit firm;

(5) Medical record number and institutional provider's patient account number; and

(6) Whom to contact to discuss the request and scheduled audit.

G. Institutional providers that cannot accommodate an audit request that conforms to these guidelines shall explain why the request cannot be met in a reasonable period of time and shall be provided with a reasonable period to reschedule the audit. Auditors shall group audits to increase efficiency whenever possible.

H. It shall be the responsibility of the institutional provider seeking payment of a claim or reimbursement under a managed care contract to notify the auditor prior to the scheduled date of audit, if the auditor will have problems accessing records. As a condition for payment, the institutional provider shall be responsible for supplying the auditor with any information that could affect the efficiency of the audit once the auditor is on-site.

Section 7. Institutional Provider Audit Coordinators

A. Institutional providers shall designate an individual to coordinate all claim audit activities. An audit coordinator shall have the same qualifications as required for an auditor pursuant to Section 5 of this Act. The duties of an audit coordinator include, but are not limited to, the coordination of the following areas:

(1) Scheduling an audit;

(2) Advising other institutional provider personnel and departments of a pending audit;

(3) Ensuring that the condition of admission statement is part of the medical record;

(4) Verifying that the auditor is an authorized representative of the carrier;

(5) Gathering the necessary documents for the audit;

(6) Coordinating auditor requests for information, space in which to conduct an audit, and access to records and institutional provider personnel;

(7) Orienting auditors to hospital/surgery center audit procedures, record documentation conventions, and billing practices;

(8) Acting as a liaison between the auditor and other institutional provider personnel;

(9) Conducting an exit interview with the auditor to answer questions and review audit findings;

(10) Reviewing the auditor's final written report and following up on any charges still in dispute;

(11) Arranging for payment as applicable; and

(12) Arranging for any required adjustment to bills or refunds.

Section 8. Conditions and Scheduling of Audits

A. In order to have a fair, efficient, and effective audit process, institutional providers and carrier auditors shall adhere to the following requirements:

(1) Whatever the original intended purpose of the claim audit, all parties shall agree to recognize, record or present any identified unsupported, unbilled or underbilled charges discovered by the audit parties;

(2) The scheduling of an audit shall not preclude late billing;

(3) The parties involved in the audit shall mutually agree to set and adhere to a predetermined time frame for the resolution of any discrepancies, questions or errors that surface in the audit;

(4) An exit conference and a written report shall be part of each audit; if the institutional provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;

(5) The institutional provider shall be afforded sixty (60) days to contest all findings, after which the audit shall be considered final;

(6) Once both parties agree to the audit findings, audit results are final;

(7) All personnel involved shall maintain a professional, courteous manner and resolve all misunderstandings amicably; and

(8) At times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process, the management of the institutional provider and carrier shall be contacted to apprise them of the situation. The institutional providers and carriers shall take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

Section 9. Confidentiality and Authorizations

A. All parties to a claim audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patient information.

B. The release of medical records requires authorization from the patient. An authorization shall be provided for in the condition of admission or equivalent statement procured by the institutional provider upon admission of the patient. If no such statement is obtained, an authorization for a claim audit is required. The authorization need not be specific to the insurer or auditor conducting the audit.

C. The authorization shall be obtained by the claim audit firm or institutional provider and shall include at least the following information:

(1) The name of the carrier and, if applicable, the name of the audit firm that is to receive the information;

(2) The name of the institution that is to release the information;

(3) The full name, birth date, and address of the patient whose records are to be released;

(4) The extent or nature of the information to be released, with inclusive dates of treatment;

(5) The institutional provider's patient account number if included on the bill; and

(6) The signature of the patient or his legal representative and the date the consent is signed.

D. A patient's assignment of benefits shall include a presumption of authorization to review records.

E. The audit coordinator or medical records representative shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.

F. The institutional provider will inform the requestor, on a timely basis, if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedures affecting the review. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

Section 10. Documentation

A. Verification of charges shall include the investigation of whether or not:

(1) Charges are reported on the bill accurately;

(2) Services are documented in medical or other appropriate records as having been rendered to the patient; and

(3) Services were delivered by the institution in compliance with the physician's plan of treatment. In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All those policies shall be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Healthcare Organizations or other accreditation agencies. Policies shall be available for review by the auditor.

B. The medical record documents clinical data on diagnoses, treatments and outcomes. It is not designed to be a billing document. A patient medical record generally documents pertinent information related to care. The medical record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the institutional provider's ancillary departments in the form of department treatment logs, daily records, individual service or order tickets, and other documents.

C. Auditors may have to review a number of other documents to determine valid charges. Auditors must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Institutional providers must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and logs. These procedures document that services have been properly ordered for and delivered to patients. When sources other than the health record are providing documentation, the institutional provider shall notify the auditor and make those sources available to the auditor.

Section 11. Fees and Payments

A. A health carrier shall make prompt payment of a bill and shall not delay payment for an audit process. Payment on a submitted bill from a third-party carrier shall be based on amounts billed and covered by the patient's health benefit plan.

B. (1) A payment of ninety-five percent (95%) of the insurance liability shall be an acceptable amount of payment under Subsection A prior to the scheduling of an audit. Based on ninety-five percent (95%) of payment of the insurance liability by the payer, all hospital audit fees shall be waived.

(2) A payment of less than ninety-five percent (95%) of the insurance liability is appropriate when state regulations, federal regulations or contractual agreements apply.

(3) In no case shall an audit fee exceed $100.

C. Audit fees, if required, are to be paid upon commencement of the on-site claim audit. A payment identified in the audit results that is owed to either party by the other, shall be settled by the audit parties within a reasonable period of time not to exceed thirty (30) days after completion of the audit unless the parties agree otherwise.

D. Photocopying and duplication charges shall not exceed [fifty-cents] per page.

Drafting Note: Parties are entitled to reimbursement of costs for duplication charges. Insert the appropriate monetary amount reflecting the average duplication charges in your state.

Drafting Note: Many carriers have ongoing relationships with institutional providers. If a negative balance exists between the carrier and the institutional provider, that balance may be settled as future claims arise.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 1st Quarter 8, 9, 537, 544, 596-601 (adopted).

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. ADMIN. CODE 37:XIII.2501 to 37:XIII.2519 (Regulation 49) (1994).		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. STAT. ANN. §§ 17B:30-30 to 17B:30-31 (1999).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		

HEALTH CARRIER CLAIM AUDIT GUIDELINES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 21.2801 to 21.2826 (2000/2014).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

Editor's Note: Provided for your convenience are references to the corresponding sections of the federal Public Health Service Act (PHSA). A key to the PHSA section titles appears at the end of the model. Any references to PHSA sections, including the key, are not intended to be adopted in legislation.

Section 1. Short Title

This Act shall be known and may be cited as the [Individual Market Health Insurance Coverage Model Act].

Section 2. Purpose and Intent

The purpose and intent of this Act is to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

Drafting Note: The provisions of this Act are consistent with the provisions of the federal Patient Protection and Affordable Care Act (ACA) Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (and with Title XXVII of the PHSA as amended by those statutes) and, as applicable, the regulations issued related to provisions of the ACA. However, states should be aware that the federal preemption standards permit states to impose more stringent, consumer protection requirements.

Section 3. Definitions

For purposes of this Act:

A. "Bona fide association" means an association that meets all of the following criteria:

(1) Serves a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession;

(2) Has been actively in existence for five (5) years;

(3) Has a constitution and by-laws or other analogous governing documents;

(4) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(5) Is not owned or controlled by a carrier or affiliated with a carrier;

(6) Does not condition membership in the association on any health status-related factor;

(7) Has at least 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association;

(8) All members and dependents of members are eligible for coverage regardless of any health status-related factor;

(9) Does not make a health benefit plan offered through the association available other than in connection with a member of the association;

(10) Is governed by a board of directors and sponsors annual meetings of its members; and

(11) Producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the association.

Drafting Note: This definition of "bona fide association" is narrower than the definition of "bona fide association" contained in Section 2791(d)(3) of the (PHSA) because of the requirement of Paragraph (1) above that the professional association serve a single profession. Specifically, Section 2791(d)(3) of the PHSA defines "bona fide association," as an association, which: (1) has been actively in existence for at least 5 years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); (4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); (5) does not make health insurance offered through the association available other than in connection with a member of the association; and (6) meets such additional requirements as may be imposed under state law. Because the definition of "bona fide association" contained in Section 2791(d)(3) explicitly permits the states to impose additional requirements, the narrower definition of "bona fide association" used in this Act does not conflict with or prevent the application of the federal law. Therefore, the states can elect to adopt either version of this definition.

Drafting Note: States should be aware that the term "bona fide association" is used in this Act in connection with providing an exception to the guaranteed renewability requirements in Section 7B(6) of this Act. Section 7B(6) of this Act only permits a health carrier to non-renew health coverage for an individual whose association membership ceases if the association is a "bona fide association" the individual's membership was the basis of which the coverage is provided, and the coverage is terminated uniformly for all individuals leaving the association without regard to any health status-related factor relating to any covered person. Associations that are not "bona fide associations" are not eligible for this exception. The definition of "bona fide association" does not impact how states have chosen to define "associations" for other purposes.

B. "Carrier" or "health carrier" means any entity licensed, or required to be licensed, by the Department of Insurance that offers health benefit plans covering eligible individuals pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

C. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "Commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

D. "Converted policy" means a health benefit plan issued pursuant to [insert reference in **s**tate law comparable to the Group Health Insurance Mandatory Conversion Privilege Model Act].

E. "Covered benefits" or "benefits" mean those health care services to which an individual is entitled under the terms of a health benefit plan.

F. "Covered person" means a policyholder or enrollee participating in a health benefit plan.

G. "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;

(2) A health benefit plan;

(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

(5) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or

(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

H. Except as otherwise may be defined for purposes of Section 8 of this Act, "dependent" shall be defined in the same manner as in [insert reference in state law defining dependent].

I. "Employee" has the meaning given such term under Section 3(6) of ERISA.

J. "Enrollee" means an individual who is covered by a health benefit plan providing individual health insurance coverage.

K. (1) "Essential health benefits" has the meaning under Section 1302(b) of the Federal Act and applicable regulations.

(2) "Essential health benefits" include:

(a) Ambulatory patient services,

(b) Emergency services;

(c) Hospitalization;

(d) Laboratory services;

(e) Maternity and newborn care;

(f) Mental health and substance abuse disorder services, including behavioral health treatment;

(g) Pediatric services, including oral and vision care;

(h) Prescription drugs;

(i) Preventive and wellness services and chronic disease management; and

(j) Rehabilitative and habilitative services and devices.

L. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

M. "Family member" means with respect to an individual:

(1) A dependent of the individual; and

(2) Any other individual who is a first-degree, second-degree, third-degree or fourth-degree relative of the individual or an individual described in Paragraph (1).

N. (1) "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (ACA), and any amendments thereto, or regulations or guidance issued under, those Acts.

(2) "Federal Act" includes Title XXVII of the Public Health Service Act (PHSA), as amended by the ACA.

O. (1) "Genetic information" means, with respect to any individual, information about:

(a) The individual's genetic tests;

(b) The genetic tests of the individual's family members; and

(c) The manifestation of a disease or disorder in family members of the individual.

(2) "Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by the individual or any family member of the individual.

(3) "Genetic information" does not include information about the sex or age of any individual.

P. "Genetic services" means:

(1) A genetic test;

(2) Genetic counseling, including obtaining, interpreting or assessing genetic information; or

(3) Genetic education.

Q. (1) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes.

(2) "Genetic test" does not mean:

(a) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; or

(b) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

R. "Geographic rating area" is an area established in accordance with Section 2701(a)(2) of the PHSA, or any federal regulation adopted thereunder, for purposes of adjusting the rates for a health benefit plan.

S. "Grandfathered health plan coverage" means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations, and includes any extension of coverage to individuals who become dependents of grandfathered enrollees after March 23, 2010.

T. "Group health insurance plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to an employer or group of employers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

U. "Group health plan" has the meaning given such term under Section 2791(a) of the PHSA.

V. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XXVII of the PHSA, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health insurance plan.

W. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not "corporate persons."

X. "Health care provider" or "provider" means a health care professional or facility.

Y. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.

Z. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

AA. "Health status-related factor" means any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care services;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities;

(8) Disability; or

(9) Any other health status-related factor determined appropriate by the Secretary.

BB. (1) "Individual market health insurance coverage" means health insurance coverage, other than a converted policy, offered to individuals in the individual market, but does not include short-term limited duration insurance.

(2) For purposes of this Act, "student health insurance coverage," as defined in Subsection MM of this Act, shall be considered a type of individual health insurance coverage.

CC. "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

DD. "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

EE. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

FF. (1) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date of the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(2) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

GG. "Policyholder" means an individual who has paid premium for himself or herself and his or her dependents, if any, who are also covered under a health benefit plan providing individual health insurance coverage, and is responsible for continued premium payments under the terms of the health benefit plan.

HH. "Premium" means all moneys paid by a policyholder as a condition of receiving individual health insurance coverage from a health carrier, including any fees or other contributions associated with the health benefit plan and includes any portion of premium paid on behalf of a policyholder.

II. "Producer" means [incorporate reference to definition in state law for licensing producers].

Drafting Note: States that have not adopted the NAIC Producer Licensing Model should substitute the term "agent" or "broker" for the term "producer," as appropriate.

JJ. (1) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(2) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

KK. "Secretary" means the Secretary of the federal Department of Health and Human Services.

LL. "Student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

MM. "Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health carrier and provided to students enrolled in that institution of higher education and their dependents, that meets the following:

(1) Does not make health insurance coverage available other than in connection with enrollment as student (or as a dependent of a student) in the institution of higher education;

(2) Does not condition eligibility for health insurance coverage on any health status-related factor related to a student (or a dependent of a student); and

(3) Meets any additional requirement that may be imposed under state law.

Drafting Note: On March 21, 2012, the U.S. Department of Health and Human Services (HHS) published in the *Federal Register* the final rule on the requirements for student health insurance coverage under the PHSA and the ACA. The final rule applied many, but not all, of the provisions of the PHSA and the ACA to student health insurance coverage. Therefore, it is important that states are aware of which provisions do and do not apply to these plans. Although HHS declined to regulate self-funded student health plans in the final regulation, HHS recognized that states may regulate these plans.

NN. "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the health benefit plan;

(2) The computation of premium or contribution amounts under the health benefit plan; and

(3) Other activities related to the creation, renewal or replacement of a contract of individual health insurance coverage.

OO. "Waiting period" means the period of time that must pass before coverage for a covered person who is otherwise eligible to enroll under the terms of a health benefit plan can become effective.

Section 4. Applicability and Scope

A. Subject to Subsection B, this Act shall apply to health carriers offering health benefit plans providing individual health insurance coverage in this state.

B. Except for Sections 7, 8, 10C, 11A(1), 12, 17, 18 and 19 of this Act and to the extent provisions of other sections in this Act were in effect pursuant to Pub. L. No. 104-191 (HIPAA) and Pub. L. No. 110-233 (GINA) prior to the effective date of the Federal Act, this Act does not apply to any grandfathered health plan coverage.

Drafting Note: Generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as "grandfathered health plan coverage." However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHSA, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the interim final regulations on grandfathered plans (26 CFR 54.9815-1251T, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* June 17, 2010. In particular, HIPAA portability and nondiscrimination requirements and GINA requirements applicable prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. The following table lists the new health coverage reforms in part A of title XXVII of the PHSA, as amended by the ACA, which apply to grandfathered health plan coverage:

List of New Health Coverage Reform ACA Provisions That Apply to Grandfathered Health Plan Coverage

PHSA Statutory Provisions	Application to Grandfathered Health Plan Coverage
§ 2704 of the PHSA—Prohibition of preexisting condition exclusion or other discrimination based on health status.	Applicable to grandfathered group health plans and group health insurance coverage. Not applicable to grandfathered individual health insurance coverage.
§ 2708 of the PHSA—Excessive waiting periods.	Applicable to grandfathered group health plan coverage.
§ 2711 of the PHSA—No lifetime or annual limits.	Lifetime limits applicable to grandfathered health plan coverage. Annual limits applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage.
§ 2712 of the PHSA—Prohibition on rescissions.	Applicable to grandfathered health plan coverage.
§ 2714 of the PHSA—Extension of dependent coverage until age 26.	Applicable to grandfathered health plan coverage. For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before Jan. 1, 2014, §2714 of the PHSA is applicable in the case of an adult child only if the adult child is not eligible for other employer-based health plan coverage.
§ 2715 of the PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions.	Applicable to grandfathered health plan coverage.
§ 2718 of the PHSA—Bringing down the cost of health care coverage (for insured coverage).	Applicable to insured grandfathered health plan coverage.

Drafting Note: As noted in the drafting note above, some requirements of the PHSA, ERISA and IRC that were applicable prior to the enactment of the ACA continue to apply to grandfathered health plan coverage. As such, HIPAA portability and nondiscrimination requirements applicable to the individual market and GINA requirements applicable to the individual market prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. States should be aware that this Act does not include many of these provisions, such as provisions related to crediting previous coverage for purposes of applying a preexisting condition exclusion period with respect to the small group market or provisions related to determining whether an individual can be treated as an "eligible individual" (or HIPAA-eligible) for purposes of qualifying for guaranteed issued coverage without the imposition of any preexisting condition exclusions with respect to the individual market. States will have to consider how they want to address this situation in retaining some provisions that continue to apply to grandfathered health plan coverage and enacting new provisions consistent with the requirements of the ACA that are applicable to health benefit plans beginning Jan. 1, 2014, in the individual and small group markets.

Section 5. Restrictions Relating to Premium Rates

A. (1) With respect to the premium rates charged by a health carrier offering a health benefit plan providing individual market health insurance coverage subject to this Act, the carrier shall develop its premium rates based on the following and vary the premium rates with respect to the particular plan or coverage only by:

(a) Whether the plan or coverage covers an individual or family;

(b) Geographic rating area, established in accordance with Section 2701(a)(2) of the PHSA;

(c) Age, except that the rate shall not vary by more than 3 to 1 for adults; and

(d) Tobacco use, except that the rate shall not vary by more than 1.5 to 1.

(2) A premium rate shall not vary with respect to any particular health benefit plan or individual market health insurance coverage by any other factor not described in Paragraph (1).

(3) With respect to family coverage under a health benefit plan providing individual market health insurance coverage, the rating variations permitted under Paragraph (1)(c) and (d) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

B. The premium charged with respect to any particular health benefit plan or individual market health insurance coverage shall not be adjusted more frequently than annually except that the premium rates may be changed to reflect:

(1) Changes to the family composition of the policyholder;

(2) Changes in geographic rating area of the policyholder, as provided in Subsection A(1)(b);

(3) Changes in tobacco use, as provided in Subsection (A)(1)(d);

(4) Changes to the health benefit plan requested by the policyholder; or

(5) Other changes required by federal law or regulations or otherwise expressly permitted by state law.

C. A health carrier shall consider all enrollees in all health benefit plans (other than grandfathered health plan coverage) offered by the carrier in the individual market, including those enrollees who do not enroll in such plans through an exchange, as established under Section 1311 of the Federal Act, to be members of a single risk pool.

Drafting Note: States should be aware that Section 1312(c)(3) of the Federal Act permits a state to merge its individual and small group health insurance markets. States should also be aware that Section 1312(c)(4) of the Federal Act prohibits states from requiring grandfathered health plan coverage to be included in the single risk pool for non-grandfathered health plan coverage.

Drafting Note: If the final ACA Health Insurance Market Reforms and Rate Review regulations determine to exempt student health insurance coverage from certain provisions of the federal regulations, States may wish to modify their requirements accordingly.

D. The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by health carriers are consistent with the purposes of this Act.

E. In connection with the offering for sale of individual market health insurance coverage under this Act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the coverage concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

Drafting Note: States should be aware that the requirement that health carriers disclose the information described in Paragraph (1) above is required under Section 2709 of the PHSA. However, States may not require that this information be provided in the summary of benefits and coverage (SBC) required under Section 2715 of the PHSA and the federal regulations implementing that section.

(2) A listing of and descriptive information, including benefits and premiums, about all health benefit plans offered by the carrier that provide individual market health insurance coverage and the availability of the plans for which the individual is qualified.

F. (1) Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each health carrier shall file with the Commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.

(3) (a) A health carrier shall make the information and documentation described in Paragraph (1) available to the Commissioner upon request.

(b) Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department of Insurance except as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

Drafting Note: States should be aware that, with respect to the information and documentation described in Paragraph (1), certain provisions of the Federal Act or federal regulations or other federal law or state law or regulations may require the Department of Insurance to make public or share with other entities, such as health insurance exchanges or federal agencies.

Section 6. Guaranteed Availability of Individual Market Health Insurance Coverage

A. Subject to Subsections B-E, each health carrier that offers a health benefit plan providing individual market health insurance coverage in this state shall issue any applicable health benefit plan to any eligible individual who applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

B. (1) A health carrier described under Subsection A may restrict enrollment in coverage described in Subsection A to open or special enrollment periods.

(2) A health carrier described under Subsection A shall, in accordance with regulations established by the Secretary, establish special enrollment periods for qualifying events and as provided in Section 9B of this Act.

C. (1) Subject to Paragraph (3), a health carrier with respect to coverage offered through a network plan shall not be required to offer coverage under that plan or accept applications for that plan pursuant to Subsection A in the case of the following:

(a) To an individual, when the individual does not live or reside within the carrier's established geographic service area for such network plan; or

Drafting Note: States should be aware that Section 2702 of the PHSA does not expressly provide, for network plans, an exception for guaranteed issue in the individual market for individuals who do not live or reside within the carrier's established geographic service area.

(b) Within the geographic service area for such network plan where the carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

(2) A health carrier that cannot offer coverage pursuant to Paragraph (1)(b) may not offer coverage in the individual market in the applicable geographic service area to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services.

(3) A health carrier shall apply the provisions of this subsection uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

D. (1) A health carrier described under Subsection A shall not be required to provide coverage if:

(a) For any period of time the carrier demonstrates, and the Commissioner determines, the carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The carrier is applying this subsection uniformly to all individuals in the individual market in this state consistent with applicable state law and without regard to the claims experience of an individual and their dependents or any health status-related factor relating to such individual and their dependents.

(2) A health carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the individual market in this state for the later of:

(a) A period of 180 days after the date the coverage is denied; or

(b) Until the carrier has demonstrated to the Commissioner that it has sufficient financial reserves to underwrite additional coverage.

Drafting Note: States may apply the provisions of Paragraph (2) on a service-area-specific basis.

E. (1) This section shall not be construed to require a health carrier offering health benefit plans only in connection with group health plans to offer coverage in the individual market.

(2) This section shall not be construed to require that a health carrier offering health benefits plans only through one or more bona fide associations offer coverage in the individual market. However, if the health carrier offers health benefit plan bona fide association coverage in the individual market, the health carrier shall offer such coverage to eligible individuals in the individual market as required under Subsection A and consistent with the provisions of Section 3A of this Act.

Drafting Note: With respect to Paragraph (2), states should be aware that Section 2742(e)(1) of the PHSA, as enacted by HIPAA, provided an exception to guaranteed issue in the individual market for bona fide associations with respect to "eligible individuals" (as that term is defined in Section 2741(b) of the PHSA). With the enactment of the Federal Act and its guaranteed issue requirements under Section 2702 of the PHSA for the individual market, this exception for bona fide associations in Section 2742(e)(1) of the PHSA was effectively eliminated such that, beginning Jan. 1, 2014, bona fide associations that choose to participate in the individual market are subject to the guaranteed issue requirements of Section 2702 of the PHSA.

Drafting Note: States should be aware that, the proposed regulations issued by the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register*, Nov. 26, 2012, and as further described below in the drafting note, state that Section 2702 of the PHSA, as enacted by the ACA, does not include an explicit guaranteed availability exception allowing health carriers to limit the offering of certain plans to members of bona fide associations. As such, it appears, that, under the proposed rules, health carriers must offer plans to all individuals regardless of membership in the bona fide association. Therefore, given this provision in the proposed regulations, states may want to consider not addressing this issue in statute and consider, instead, addressing it by regulation after final regulations are issued on the subject. In addition, those states that may have existing laws on this issue related to bona fide associations may wish to review that language and consider repealing it until final regulations are issued.

F. This section shall not be construed to require that a health carrier offering only student health insurance coverage to otherwise offer coverage in the individual market so long as the carrier is offering student health insurance coverage consistent with the provisions of Section 3MM of this Act.

G. At the time of renewal, a health carrier may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with state law and effective on a uniform basis among all individuals with the health benefit plan.

Section 7. Guaranteed Renewability of Individual Market Health Insurance Coverage

A. Except as provided in this section, a health carrier offering health benefit plans providing individual market health insurance coverage in this state subject to this Act shall renew or continue in force the coverage, at the option of the policyholder.

B. A health carrier may not renew or discontinue coverage under a health benefit plan subject to this Act if:

(1) The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

(2) The policyholder or the policyholder's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

(3) The carrier elects to cease offering individual market health insurance coverage in this state in accordance with Subsection D and other applicable state law;

(4) In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 6C(1)(b) of this Act;

(5) The Commissioner:

(a) Finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the carrier's ability to meet its contractual obligations; and

(b) Assists affected covered persons in finding replacement coverage;

(6) In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered person;

(7) In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage is terminated under this paragraph uniformly without regard to any health status-related factor related to any covered person; or

(8) The Commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in this state's individual market if the carrier:

(a) Provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed;

(b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All affected policyholders; and

(ii) The Commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders;

(c) Provides notice to each enrollee issued that particular type of health benefit plan (obsolete product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the carrier in the individual market in this state; and

(d) In exercising this option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to subparagraph (c) of this paragraph acts uniformly without regard to the claims experience of those covered persons or any other health status-related factor relating to any covered person who may become eligible for coverage.

C. In any case in which a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier may discontinue coverage in accordance with applicable state law only if the carrier:

(1) Provides advance notice of its decision under this subsection to the Commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:

(a) All affected policyholders; and

(b) The Commissioner in each state in which an affected policyholder is known to reside, provided the notice to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders;

(3) Provides notice to each enrollee issued that particular type of health benefit plan that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the carrier in this state; and

(4) In exercising this option to discontinue that particular type of health benefit plan and in offering the option of coverage pursuant to Paragraph (3) acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.

D. (1) In any case in which a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in this state, the carrier may discontinue such coverage only in accordance with applicable state law and if:

(a) The carrier provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed; and

(b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All affected policyholders; and

(ii) The Commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders.

(2) In the case of a discontinuance under Paragraph (1), the health carrier shall be prohibited from writing new business in the market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

(3) In the case of a discontinuance under Paragraph (1), the health carrier, as determined by the Commissioner, may renew its existing business in the market in this state or may be required to nonrenew all of its existing business in the market in this state.

E. In the case of a health carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in that service area.

Section 8. Extension of Dependent Coverage

A. A health carrier offering a health benefit plan providing individual market health insurance coverage that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six (26) years of age.

B. (1) With respect to a child who has not attained twenty-six (26) years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the policyholder.

(2) (a) A health carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on a factor, such as the presence or absence of the child's financial dependency upon the policyholder or any other person, residency with the policyholder or with any other person, marital status, student status, employment or any combination of those factors.

(b) In addition to Subparagraph (a) of this paragraph, a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.

C. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

D. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

Drafting Note: For purposes of this section, there is no definition of "dependent". Section 152(f)(1) of the Internal Revenue Code defines "child" as including only sons, daughters, stepchildren, adopted children, including children placed for adoption and foster children. Some states have defined "dependent" similarly, while others have not. In defining "dependent," states should keep in mind that the intent of the ACA is to require the availability of dependent coverage of children until the child reaches age 26 and that coverage cannot be conditioned based on certain dependency factors, such support, residency, student status or marital status.

Section 9. Prohibition of Preexisting Condition Exclusions; Special Enrollment Periods

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall not impose any preexisting condition exclusion with respect to such coverage.

B. (1) A health carrier described in Subsection A that makes coverage available under a health benefit plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Paragraph (2) during which the dependent in the case of the birth or adoption (or placement for adoption) of a child or the spouse of the individual, if the spouse is otherwise eligible for coverage, may be enrolled as a dependent of the individual.

(2) The special enrollment period for individuals that meet the provisions of Paragraph (1) shall be a period of not less than thirty (30) days and begins on the later of:

(a) The date dependent coverage is made available; or

(b) The date of the marriage, birth or adoption or placement for adoption described in Paragraph (1).

(3) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Paragraph (2), the coverage of the dependent shall be effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; and

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Drafting Note: States should be aware that, in some cases, individuals having prior group health plan coverage may be eligible for special enrollment in a health benefit plan if the individual was under a COBRA continuation provision and the coverage under such provision was exhausted or the individual was not under a COBRA continuation provision, but the coverage was terminated as a result of a COBRA qualifying event resulting in the loss of eligibility of coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or employer contributions toward such coverage were terminated.

Section 10. Prohibition on Discrimination Based on Health Status; Genetic Testing

Drafting Note: This section is based, in part, on Section 2753 of the PHSA. Section 2753 of PHSA prohibits health discrimination on the basis of genetic information in the individual health insurance market, as provided in GINA. GINA was enacted prior to the ACA and the provisions of Section 2753 were not specifically supplanted by the ACA. GINA included certain provisions, however, that because of ACA provisions related to premium rating restrictions, as reflected in Section 5 of this Act and a prohibition on preexisting condition exclusion periods, as reflected in Section 9 of this Act, are no longer permitted beginning Jan. 1, 2014. Given this, those provisions permitting the use of health status as a rating factor and the imposition of preexisting condition exclusion periods, are not included in this section. In addition, the definition of "underwriting purposes" in Section 3LL of this Act is broad enough to include the application of any preexisting condition exclusion, when those exclusions are permitted. As noted in Section 4 of this Act, states should be aware that those provisions could continue to apply to grandfathered health plan coverage.

A. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for eligibility, including continuing eligibility, of any individual to enroll under the terms of coverage based on any health status-related factor in relation to the individual or dependent of the individual.

B. (1) A health carrier described in Subsection A shall not require any individual as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the bases of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in Paragraph (1) may be construed to restrict the amount that an individual may be charged for individual market health insurance coverage.

Drafting Note: Section 2705(1) of the PHSA authorizes the Secretary to establish a 10-state demonstration project under which participating states shall apply the provisions of Section 2705(j) of the PHSA to programs of health promotion offered by a health carrier that offers health insurance coverage in the individual market in such state. If a state chooses to participate in the demonstration project, then it should revise Paragraph (2) above as follows:

(2) Nothing in Paragraph (1) may be construed to:

(a) Restrict the amount that an individual may be charged for coverage under the plan; or

(b) Prevent the health carrier from establishing premium discounts or rebates or modifying otherwise applicable copayment amounts or deductibles in return for adherence to programs of health promotion and disease prevention, as provided in Section 2705(l) of the PHSA.

C. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for the eligibility, including continued eligibility, of any individual to enroll for coverage under an individual health benefit plan based on genetic information.

D. A health carrier offering health benefit plans providing individual market health insurance coverage shall not adjust premium or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual.

E. A health carrier offering health benefit plans providing individual market health insurance coverage shall not on the basis of genetic information impose any preexisting condition exclusion with respect to coverage under the plan.

F. (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request or require an individual or a family member of an individual to undergo a genetic test.

(2) Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

(3) (a) Nothing in Paragraph (1) shall be construed to preclude the health carrier from obtaining and using the results of a genetic test in making a determination regarding payment (as that term is defined for purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and Section 264 of HIPAA, as may be revised from time to time) consistent with Subsections C and E.

(b) For purposes of Subparagraph (a) of this paragraph, the health carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Notwithstanding Paragraph (1), the health carrier may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulations for the protection of human subjects in research;

(b) The carrier clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes;

(d) The carrier notifies the Secretary in writing that the carrier is conducting activities pursuant to the exception provided in this paragraph, including a description of the activities conducted; and

(e) The carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

G. (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information for underwriting purposes.

(2) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information with respect to any individual prior to the individual's enrollment under the plan in connection with such enrollment.

(3) If the health carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase shall not be considered a violation of Paragraph (2) if such request, requirement or purchase is not in violation of Paragraph (1).

H. Any reference in this section to genetic information concerning an individual or family member of an individual shall:

(1) With respect to the individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

(2) With respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

Section 11. Prohibition on Lifetime and Annual Limits

A. (1) Except as provided in Subsection B, health carriers offering health benefit plans providing individual market health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

(2) (a) Except as provided in Subparagraph (b) of this paragraph and Subsections B and C, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any individual.

(b) A health flexible spending arrangement (FSA), as defined in Section 106(c)(2) of the Internal Revenue Code, a medical savings account (MSA), as defined in Section 220 of the Internal Revenue Code, and a health savings account (HSA), as defined in Section 223 of the Internal Revenue Code are not subject to the requirements of Subparagraph (a) of this paragraph.

B. The provisions of Subsection A shall not prevent a health carrier from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

C. Nothing in this section prohibits a health carrier from excluding all benefits for a given condition, as otherwise permitted under federal or state law.

Section 12. Prohibition on Rescissions of Coverage

A. (1) A health carrier shall not rescind coverage under a health benefit plan with respect to an individual, including family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

(2) For purposes of Paragraph (1)(a), a person seeking coverage on behalf of an individual does not include a producer or employee or authorized representative of the health carrier.

B. A health carrier shall provide at least thirty (30) days advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A regardless of whether the rescission applies to the entire group in the case of family coverage or only to the policyholder.

Drafting Note: States should be aware that Sections 9 and 10 of the NAIC Utilization Review and Benefit Determination Model Act include language describing what should be included in an advance notice of a rescission that is considered an adverse determination.

C. The provisions of this section apply regardless of any applicable contestability period.

Section 13. Comprehensive Health Insurance Coverage Requirements

A. (1) Health carriers offering health benefit plans providing individual market health insurance coverage shall ensure that such coverage includes the essential health benefits package required under Section 1302(a) of the Federal Act, as described in Paragraph (2) of this subsection.

(2) For purposes of this subsection, "essential health benefits package" means coverage that:

(a) Provides for the essential health benefits, as defined in section 3K of this Act;

(b) Limits cost-sharing for such coverage in accordance with section 1302(c) of the Federal Act, as described in Subsection B; and

(c) Subject to Subsection C, provides bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act as follows:

(i) Bronze level. A health benefit plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan;

(ii) Silver level. A health benefit plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;

(iii) Gold level. A health benefit plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and

(iv) Platinum level. A health benefit plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

B. If a health carrier offers health insurance coverage in any level of coverage specified under Section 1302(d) of the Federal Act, as described in Subsection A(2)(c) above, the carrier shall also offer such coverage in that level as a health benefit plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.

C. A health benefit plan not providing a bronze, silver, gold or platinum level of coverage, as described in Subsection A(2)(c) above, shall be treated as meeting the requirements of Section 1302(d) of the Federal Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of Section 1302(e) of the Federal Act.

D. This section shall not apply to a dental plan described in Section 1311(d)(2)(B)(ii) of the Federal Act.

Section 14. Coverage of Preventive Health Services

A. (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(a) Except as otherwise provided in Subsection B, evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

Drafting Note: The items and services referenced in subparagraph (a) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. States should be aware that these items and services could change over time.

(b) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

Drafting Note: The recommended immunizations for children, adolescents and adults referenced in Subparagraph (b) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

(c) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

Drafting Note: The comprehensive guidelines referenced in Subparagraph (c) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

(d) With respect to women, to the extent not described in Paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Drafting Note: The comprehensive guidelines referenced in Subparagraph (d) above can be found at this link: http://www.hrsa.gov/womensguidelines.

(2) (a) (i) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in Paragraph (1) after the recommendation or guideline is no longer described in Paragraph (1).

(ii) Other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section 2715(d)(4) of the Public Health Service Act, which requires a health carrier to give sixty (60) days advance notice to an enrollee before any material modification will become effective.

(b) For purposes of Paragraph (1) and for purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

(c) A health carrier shall, for policy years that begin on or after the date that is one year after the recommendation or guideline is issued, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

Drafting Note: This website: *http://www.HealthCare.gov/center/regulations/prevention.html* is provided in the interim final regulations published in the *Federal Register* July 19, 2010, which health carriers can visit once a year to find information necessary to determine any additional items or services that must be covered without cost-sharing requirements or to determine any items or services that are no longer required to be covered.

B. (1) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

(3) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(4) Notwithstanding the requirements of this section, student administrative health fees are not considered cost-sharing requirements with respect to specified recommended preventive services.

C. (1) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described in Subsection A that are delivered by an out-of-network provider.

(2) Nothing in Subsection A precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described in Subsection A that are delivered by an out-of-network provider.

D. Nothing prevents a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in Subsection A to the extent not specified in the recommendation or guideline.

E. Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in Subsection A even if the treatment results from an item or service described in Subsection A.

Drafting Note: States should be aware that, under Section 2713(c) of the PHSA, the Secretary is given the discretionary authority to develop guidelines that would permit health carriers offering health benefit plans providing individual market health insurance coverage to utilize value-based insurance designs. If the Secretary develops such guidelines, the language in this section may have to be revised.

Section 15. Coverage for Participation in Approved Clinical Trials

A. As used in this section, the following definitions apply:

(1) "Approved clinical trial" means a phase I, a phase II, a phase III or a phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and the trial must be:

(a) Conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);

(b) Exempt from obtaining an investigational new drug application; or

(c) Approved or funded by:

(i) The National Institutes of Health, the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services or a cooperative group or center of any of the entities described in this item;

(ii) A cooperative group or center of the U.S. Department of Defense or the U.S. Department of Veterans Affairs;

(iii) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(iv) The U.S. Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the Secretary to:

(I) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

(2) "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(3) "Qualified individual" means an individual with individual market health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life threatening condition because:

(a) The referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or

(b) The individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.

(4) (a) "Routine patient costs" include all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

(b) "Routine patient costs" do not include:

(i) An investigational item, device or service that is part of the trial;

(ii) An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or services is not used in the direct clinical management of the patient;

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(iv) An item or service customarily provided and paid for by the sponsor of a trial.

B. A health carrier that offers a health benefit plan providing individual market health insurance coverage in this state may not:

(1) Deny participation by a qualified individual in an approved clinical trial;

(2) Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

(3) Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

C. A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

D. This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

E. This section shall not be construed to require a health carrier offering individual market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

F. Nothing in this section shall be construed to limit a health carrier's coverage with respect to clinical trials.

Section 16. Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements

A. (1) (a) If a health carrier offering individual market health insurance coverage under a health benefit plan requires or provides for the designation by a covered person of a participating primary health care professional, the health carrier shall permit each covered person to:

(i) Designate any participating primary care health care professional who is available to accept the covered person; and

(ii) For a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.

(b) The provisions of Subparagraph (a)(ii) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(2) (a) If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:

(i) Shall not require any covered person's, including a primary care health care professional's authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and

(ii) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to item (i), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

(b) (i) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.

(ii) For purposes of item (i), a health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.

(c) The provisions of Subparagraph (b)(i) shall not be construed to:

(i) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or

(ii) Preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

B. (1) A health carrier shall provide notice to covered persons of the terms and conditions of the health benefit plan related to the designation of a participating health care professional provided in Subsection A and of a covered person's rights with respect to those provisions.

(2) The notice described in Paragraph (1) shall be included whenever the health carrier provides a policyholder with a summary plan description or other similar description of benefits under the health benefit plan.

Section 17. Provision of Summary of Benefits and Coverage Explanation

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the Secretary under Section 2715(a) of the PHSA to:

(1) An applicant at the time of application;

(2) An enrollee prior to the time of enrollment or reenrollment, as applicable; and

(3) A policyholder at the time of issuance of the policy.

B. A health carrier described in Subsection A shall be deemed to have complied with Subsection A if the summary of benefits and coverage described in Section 2715(a) of the PHSA is provided in paper or electronic form, in accordance with the standards adopted by the Secretary under Section 2715(d) of the PHSA.

C. Except in connection with a policy renewal or reissuance, if a health carrier makes any material modifications in any of the terms of the coverage, as defined for purposes of Section 102 of ERISA, that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective.

Drafting Note: Under Section 2715(f) of the PHSA, a health carrier that willfully fails to provide the information required under Section 2715 of the PHSA is subject to a federal civil penalty of not more than $1,000 for each such failure. In addition, Section 2715(f) of the PHSA provides that such failure with respect to each covered person shall constitute a separate offense.

Drafting Note: The language of this section reflects the provisions of Section 2715 of the PHSA. Regulations issued by the Secretary related to Section 2715 of the PHSA provide more specific information and requirements not reflected in this section. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 18. Certification of Creditable Coverage

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide written certification of creditable coverage to individuals in accordance with Subsection B.

B. The certification of creditable coverage shall be provided:

(1) At the time an individual ceases to be covered under the health benefit plan; and

(2) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Subparagraph (a) or (b), whichever is later.

C. The certification described in this subsection is a written certification of:

(1) The period of creditable coverage of the individual under the health benefit plan; and

(2) The waiting period, if any, and affiliation period, if applicable, imposed on the individual for any coverage under the health benefit plan.

Drafting Note: Federal regulations issued pursuant to Section 2704(e) of the PHSA include additional information that must be included in a certificate of creditable coverage. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 19. Standards to Assure Fair Marketing

A. Subject to Section 6A of this Act, each health carrier providing individual market health insurance coverage shall actively market all health benefit plans sold by the carrier to eligible individuals in this state.

B. (1) Except as provided in Paragraph (2), a health carrier or a producer shall not, directly or indirectly, engage in the following activities:

(a) Encourage or direct individuals to refrain from filing an application for coverage with the carrier because of any health status-related factor or because of the industry, occupation or geographic location of the individual;

(b) Encourage or direct individuals to seek coverage from another carrier because of any health status-related factor or because of the industry, occupation or geographic location of the individual.

(2) The provisions of Paragraph (1) shall not apply with respect to information provided by a health carrier or producer to an individual regarding the established geographic service area or a restricted network provision of a health carrier.

C. (1) Except as provided in Paragraph (2), a health carrier shall not, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the individual or the individual's dependents.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer that does not vary because of any health status-related factor, industry, occupation or geographic area of the individual or the individual's dependents.

D. A health carrier shall not terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor, occupation or geographic location of any individual or the individual's dependents placed by the producer with the carrier.

E. Denial by a health carrier of an application for coverage from an individual shall be in writing or electronically provided and shall state the reason or reasons for the denial. Nothing in this subsection allows any denial by a health carrier that is not in compliance with Sections 6 and 7 of this Act.

F. The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans providing individual market health insurance coverage to individuals in this state.

G. (1) A violation of this section by a health carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a health carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans providing individual market health insurance coverage in this state, the third-party administrator shall be subject to this section as if it were a health carrier.

Drafting Note: States should be aware that the provisions of Section 19 of this Act are subject to change depending on whether federal regulations or guidance are issued on the topic.

Section 20. Quality of Care Reporting Requirements

A. (1) Health carriers offering health benefit plans providing individual market health insurance coverage in this state shall annually submit to the Secretary and the commissioner in each state the carrier is licensed and to policyholders under the coverage, a report on whether the benefits under the coverage satisfy the elements described in Subsection B.

(2) The report required under Paragraph (1) shall be made available to each policyholder under the coverage during each open enrollment period.

B. (1) For purposes of Subsection A, using the reporting requirements developed by the Secretary, a health carrier shall report on coverage benefits and health care provider reimbursement structures that:

(a) Improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model, as defined for purposes of Section 3602 of the Federal Act, for treatment or services under the coverage;

(b) Implement activities that prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;

(c) Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the coverage; and

(d) Implement wellness and health promotion activities.

(2) For purposes of Paragraph (1)(d), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

(a) Smoking cessation;

(b) Weight management;

(c) Stress management;

(d) Physical fitness;

(e) Nutrition;

(f) Heart disease prevention;

(g) Healthy lifestyle support; and

(h) Diabetes prevention.

Section 21. Risk Adjustment Mechanism

The Commissioner may establish an assessment and payment mechanism for health carriers providing individual market health insurance coverage to adjust for actuarial risk that is consistent with the criteria and methods developed by the Secretary in accordance with Section 1343(b) of the Federal Act.

Drafting Note: States should be aware that, in guidance issued by the U.S. Department of Health and Human Services (HHS), HHS indicated that it would operate the risk adjustment program in those states that do not establish a State-based Exchange (SBE).

Section 22. Regulations

The Commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 23. Severability

If any provision of this Act or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 24. Effective Date

This Act shall be effective on [insert date].

Public Health Service Act sections:

§ 2701 PHSA—Fair health insurance premiums
§ 2702 PHSA—Guaranteed availability of coverage
§ 2703 PHSA—Guaranteed renewability of coverage
§ 2704 PHSA—Prohibition on preexisting condition exclusions or other discrimination based on health status
§ 2705 PHSA—Prohibiting discrimination against individual participants and beneficiaries based on health status
§ 2706 PHSA—Non-discrimination in health care
§ 2707 PHSA—Comprehensive health insurance coverage
§ 2708 PHSA—Prohibition on excessive waiting periods
§ 2709 PHSA—Coverage for individuals participating in approved clinical trials
§ 2709 PHSA—Disclosure of Information
§ 2711 PHSA—No lifetime or annual limits

Public Health Service Act sections (cont.)

§ 2712 PHSA—Prohibition on rescissions
§ 2713 PHSA—Coverage of preventive health services
§ 2714 PHSA—Extension of dependent coverage
§ 2715 PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions
§ 2716 PHSA—Prohibition on discrimination in favor of highly compensated individuals
§ 2717 PHSA—Ensuring the quality of care
§ 2719A PHSA—Patient Protections

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2013 Proc. 1st Quarter 107-110, 121, 127, 184-214, 258, 590 (adopted).

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. INS. CODE § 10965.3 (2013/2019).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, §§ 3601 to 3613 (1983/2019).
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho			IDAHO CODE ANN. §§ 41-5201 to 41-5214 (1994/2019).
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE ANN. §§ 513C.1 to 513C.12 (1995/2017).
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.17A-230 (1998/2010) (prohibition against pre-existing condition and genetic information).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. ANN. § 62A.65 (1992/2013).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			BULLETIN 2013-1 (2013).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. 20:06:39:43 to 20:06:39:57 (2010/2013) (genetic testing restrictions and guaranteed availability).
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah			UTAH ADMIN. CODE r. 590-266 (2012/2018).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2013

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT (#36)

1. Description of the Project, Issues Addressed, etc.

At the 2011 Spring National Meeting, the Regulatory Framework (B) Task Force discussed a work plan to develop one or more new NAIC models that would incorporate the 2014 market reforms under the Patient Protection and Affordable Care Act (ACA) and its Sept. 23, 2010 immediate reform provisions. At the 2012 Spring National Meeting, the Regulatory Framework (B) Task Force decided to develop two new NAIC model acts: one for the non-group market and the second for the small group market. The Regulatory Framework (B) Task Force adopted the Individual Market Health Insurance Coverage Model Act Nov. 29 at the 2012 Fall National Meeting and presented it to the Health Insurance and Managed Care (B) Committee for its consideration. As part of the Task Force's report, the Health Insurance and Managed Care (B) Committee adopted the Individual Market Health Insurance Coverage Model Act on Nov. 30.

Major provisions in the model act include:

Provisions reflecting the ACA's 2014 market reforms:

- Restrictions Relating to Premium Rates (Section 5)
- Guaranteed Availability of Individual Market Health Insurance Coverage (Section 6)
- Guaranteed Renewability of Individual Market Health Insurance Coverage (Section 7)
- Prohibition of Preexisting Condition Exclusions (Section 9)
- Comprehensive Health Insurance Coverage Requirements (Section 13)
- Coverage for Participation in Approved Clinical Trials (Section 15)
- Provision of Summary of Benefits and Coverage Explanation (Section 17)
- Quality of Care Reporting Requirements (Section 20)

Provisions using the model language template language from the ACA's Sept. 23, 2010 immediate reform provisions:

- Extension of Dependent Coverage (Section 8)
- Prohibition on Lifetime and Annual Limits (Section 11)
- Prohibition on Rescissions of Coverage (Section 12)
- Coverage of Preventive Health Services (Section 14)
- Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements (Section 16)

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force drafted the model language. The members of the Task Force are: South Dakota, Chair, Idaho, Vice Chair, California, Colorado, District of Columbia, Florida, Illinois, Kansas, Kentucky, Maine, Minnesota, Montana, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, Virginia, Washington, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. The Task Force also has a specific charge to consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations affected by federal legislation and final federal regulations promulgated pursuant to such legislation.

After the enactment of the ACA in March 2010, consistent with its charges, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by the ACA or, as necessary, develop new NAIC models to assist the states in implementing the ACA. This proposed new NAIC model act is consistent with that directive.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model act was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2012 National Meetings and at a June 26, 2012 interim meeting during which the drafts and comments received on the drafts were discussed. The drafts and comments received on the drafts were also discussed during open conference calls held on Sept. 19, Oct. 24 and Nov. 19, 2012. All drafts and comments were posted on the Task Force's page on the NAIC Internet website. During these in-person meetings and open conference calls representatives from various stakeholder groups participated, including consumer representatives, such as Georgetown University Health Policy Institute, Consumers for Affordable Health Care, Center on Budget and Policy Priorities (CBPP), Consumers Union and Families USA; and industry representatives, such as America's Health Insurance Plans (AHIP), BlueCross and BlueShield Association (BCBSA), WellPoint and Golden Rule.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The model act was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2012 National Meetings and at a June 26, 2012 interim meeting during which the drafts and comments received on the drafts were discussed. The drafts and comments received on the drafts were also discussed during open conference calls held on Sept. 19, Oct. 24 and Nov. 19, 2012. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There were two significant issues of controversy discussed and resolved by the Task Force during the drafting process. One of the issues related to the exception to guaranteed availability for bona fide associations. Initially, the draft of the model act had removed this exception, which was derived from a requirement under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), because it was rendered moot by the ACA due to the ACA's guaranteed issue requirements in the individual market. HIPAA had included this exception to guaranteed issue for bona fide associations so that such associations would not be required to provide coverage to HIPAA-eligibles. However, given the guaranteed issue requirements for the individual market under the ACA, logically, it seemed that this HIPAA-imposed exception was no longer relevant. During the discussions of this issue, some urged the Task Force to retain the exception saying that it was not clear that the U.S. Department of Health and Human Services (HHS) had decided that this exception was moot, while others suggested that, given the ACA's individual market guaranteed availability provisions, it was clear that the exception was no longer relevant. The final draft of the model act deleted the specific exception for guaranteed issue for bona fide associations. However, this provision in the model act includes two drafting notes alerting the states to the controversy. The drafting notes highlight provisions contained in the proposed regulations issued by HHS, as published in the *Federal Register*, Nov. 26, 2012, which appear to require health carriers to offer plans to all individuals regardless of membership in a bona fide association. The drafting notes also suggest that, given these provisions, those states that have existing laws on this issue related to bona fide associations may wish to review that language and consider repealing it until HHS issues its final regulations and address the issue at that time.

The other significant issue the Task Force discussed and resolved during the drafting process concerned how to address, if at all, student health insurance coverage, which has been defined in federal regulations as a type of individual health insurance coverage. Initially, a draft of the model act had proposed not including student health insurance coverage in the model act by carving such coverage out of the definition of "individual health insurance coverage." This approach was suggested due to the possible complexities of trying to include it the model act because many provisions of the Public Health Service Act (PHSA) and the ACA do not apply to student health insurance coverage. The model act is intended to set out the requirements for individual health insurance coverage for which all of the requirements of the PHSA and ACA apply. During the discussions of this issue, some suggested that student health insurance coverage be included in the model act because of a concern that requirements related to such coverage would not be immediately addressed in other possible NAIC model acts or regulations. The Task Force reached a consensus and adopted compromise language adding student health insurance coverage to the model act.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of the Advertisements of Accident and Sickness Insurance Model Regulation is to establish minimum criteria to assure proper and accurate description and to protect prospective purchasers with respect to the advertisement of accident and sickness insurance in the same manner as the regulation governing advertisements of Medicare supplement insurance. This regulation assures the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as accident and sickness insurance by the establishment of standards of conduct in the advertising of accident and sickness insurance in a manner that prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance agents and companies.

Section 2. Applicability

A. This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 3B, G, H and I unless otherwise specified in this regulation, which the insurer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer or solicitor, as those terms are defined in the Insurance Code of this state.

Drafting Note: This regulation applies to group and blanket as well as individual accident and sickness insurance. Certain distinctions, however, are applicable to these categories. Among these distinctions is the insureds' level of familiarity with insurance and insurance terminology, a factor that is covered in Section 5C.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised.

C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Section 3. Definitions

A. (1) "Accident and sickness insurance policy" means a policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. An accident and sickness insurance policy does not include a Medicare supplement insurance policy, or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute.

(2) The language "except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts" means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental to the above contracts that contain only provisions that:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.

B. (1) "Advertisement" means:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other Internet displays or communications, other forms of electronic communications, billboards and similar displays;

(b) Descriptive literature and sales aids of all kinds issued by an insurer, agent, producer, broker or solicitor for presentation to members of the insurance-buying public, such as circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds; and

(c) Prepared sales talks, presentations and material for use by agents, brokers, producers and solicitors whether prepared by the insurer or the agent, broker, producer or solicitor.

(2) The definition of "advertisement" includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

(3) The definition of advertisement extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to the use of all media for communications by agents, brokers, producers and solicitors.

(4) The definition of advertisement does not include:

(a) Material used solely for the training and education of an insurer's employees, agents or brokers;

(b) Material used in-house by insurers;

(c) Communications within an insurer's own organization not intended for dissemination to the public;

(d) Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

(e) Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

(f) Court-approved material ordered by a court to be disseminated to policyholders; or

(g) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet and that the announcement does not describe the specific benefits under the contract or program nor describe advantages as to the purchase of the contract or program. This does not prohibit a general endorsement of the program by the sponsor.

C. "Certificate" meansa statement of the coverage and provisions of a policy of group accident and sickness insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

D. "Exception" means any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

E. "Insurer" means an individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity that is defined as an insurer in the insurance code of this state, and is engaged in the advertisement of itself or an accident and sickness insurance policy.

F. "Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

G. "Invitation to contract" means an advertisement that is neither an invitation to inquire nor an institutional advertisement.

H. "Invitation to inquire" means:

(1) An advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable but may contain:

(a) The dollar amount of benefits payable; and

(b) The period of time during which benefits are payable.

(2) An invitation to inquire may not refer to cost.

(3) An invitation to inquire shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

I. "Lead-generating device" means any communication directed to the publicthat, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of accident and sickness insurance.

J. "Limitation" means a provision that restricts coverage under the policy other than an exception or a reduction.

K. "Limited benefit health coverage" shall have the same meaning as defined in [insert reference to state law equivalent to Section 7L of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act].

L. Person" means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

M. "Prominently" or "conspicuously" means that the information to be disclosed prominently or conspicuously will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

N. "Reduction" means a provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable and the reduction has not been used.

Section 4. Method of Disclosure of Required Information

All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of the following methods of disclosure:

A. Disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits; or

B. Disclosure not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions Not Covered," and "Exceptions and Reductions." The use of captions such as the following are prohibited because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions," or "Minimum Limitations."

Drafting Note: In considering whether an advertisement complies with the disclosure requirements of this regulation, the regulation must be applied in conjunction with the form and content standards contained in Section 5.

Section 5. Form and Content of Advertisements

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions.

B. Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation.

C. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed.

Drafting Note: These subsections must be applied in conjunction with Sections 1 and 4. These subsections refer specifically to format and content of the advertisement and the overall impression created by the advertisement. This involves factors such as the size, color and prominence of type used to describe benefits.

D. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

Drafting Note: This subsection prohibits the use of incomplete statements and words or phrases that have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology. Therefore, words, phrases and illustrations used in an advertisement must be clear and unambiguous and, if the advertisement uses insurance terminology, sufficient description of a word, phrase or illustration shall be provided by definition or description in the context of the advertisement. As stated in Subsection C, distinctly different levels of comprehension of the subscribers of various publications may be anticipated.

E. An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

F. An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement:

(1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or

(2) Otherwise violates the provisions of this regulation.

G. An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this State for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement.

Section 6. Advertisements of Benefits Payable, Losses Covered or Premiums Payable

A. Covered Benefits.

(1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited.

Drafting Note: This broad provision may be deleted if your state has enacted an Unfair Trade Practices Act that contains the same prohibitions.

(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited.

(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(4) An advertisement shall not contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income," (when used to express loss of time benefits), or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy.

Drafting Note: An advertisement shall not state or imply by word, phrase or illustration that the benefits being offered will supplement any other insurance policy, health benefit plan, or governmental plan if that is not the fact.

(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you," or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.

(6) (a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited if:

(i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits;

(ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or

(iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.

(b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage, or disability income insurance.

(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited unless the actual amounts payable per day for the indemnity or benefits are stated.

(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim.

(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited.

(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited.

(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain are prohibited.

(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited unless the advertised policies expressly provide that the premiums will not be changed in the future.

(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective.

(14) An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited.

Drafting Note: For example, the phrase, "money back guarantee" is an exaggerated description of the free look right to examine the policy and is prohibited.

(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough," or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new.

(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited.

(17) An advertisement that contains statements such as "anyone can apply," or "anyone can join," other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited.

(18) An advertisement that states or implies immediate coverage of a policy is prohibited unless administrative procedures exist so that the policy is issued within fifteen (15) working days after the insurer receives the completed application.

(19) An advertisement that contains statements such as "here is all you do to apply," or "simply" or "merely" to refer to the act of applying for a policy that is not a guaranteed issue policy is prohibited unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response.

(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.

Drafting Note: Illustrations that depict paper currency or checks showing an amount payable are deceptive and misleading.

(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited.

(23) An advertisement that uses words such as "extra," "special" or "added" to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay," or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

Drafting Note: Although the regulation prohibits the use of the phrase "tax free," it does not prohibit the use of complete and accurate terminology explaining the Internal Revenue Service (IRS) regulations applicable to the taxation of accident and sickness benefits. The IRS regulations provide that the premiums paid for and the benefits received from hospital indemnity policies are subject to the same regulations as loss of time premiums and benefits and are not afforded the same favorable tax treatment as premiums for expense incurred hospital, medical and surgical benefit coverages. (Rev. Rul. 68-451 and Rev. Rul. 69-154.) Prominence either by caption, lead-in, boldface or large type shall not be given in any manner to statements relating to the tax status of the benefits.

Paragraphs 21 to 23 reflect the prohibition of advertising language that creates the impression of a profit or gain to be realized by the insured when enrolling in certain kinds of coverage. For example, a hospital indemnity advertisement shall not include language such as "pay for a trip to Florida," "buy a new television," or otherwise imply that the insured will make a profit on hospitalization.

(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement.

(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.

(27) An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses.

(28) An advertisement that describes any benefits that vary by age shall disclose that fact.

(29) An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact.

Drafting Note: This section recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised policy. Consequently, the terms (and those specified in the regulation do not represent a comprehensive list but are only examples) must be used with caution to avoid a tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases based on the terms or having the same effect must be similarly restricted: "pays hospital, surgical, etc., bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," "pays for financial needs," "provides for replacement of your lost paycheck," "replaces income" or "emergency paycheck." Other phrases may or may not be acceptable depending upon the nature of the coverage being advertised. For example, the phrase "this policy will help to replace your income" is acceptable in advertising for loss-of-time coverage but is prohibited in advertising for hospital confinement (including "hospital indemnity") coverage. In any advertisement the phrase "no lifetime maximum" may not be repeated under each policy benefit or otherwise overemphasized. However, this does not preclude the use of the general statement in an advertisement that describes the manner in which any lifetime maximum is applied under the coverage.

(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant.

(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

(32) An advertisement, including invitations to inquire or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are:

(a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents" without reference to the total population from which the statistics are drawn;

Drafting Note: As an example of a permissible device, data prepared by the American Cancer Society are acceptable provided their source is noted and they are not overemphasized.

(b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered;

(c) The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance;

(d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;

(e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills;

(f) The use of phrases such as "financial disaster," "financial distress," "financial shock," or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement;

(g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and

(h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly.

Drafting Note: This regulation prohibits words or phrases that exaggerate the effect of benefit payments on the insured's general well-being, such as "worry-free savings plan," "guaranteed savings," "financial peace of mind," and "you will never have to worry about hospital bills again."

B. Exceptions, Reductions and Limitations

(1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.

(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods.

Drafting Note: This paragraph imposes the same disclosure standards as Paragraph (1) with respect to policy provisions providing for waiting, elimination, probationary or similar time periods between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss. Where a policy has waiting, elimination, probationary or other limiting time periods, the provisions must be stated in negative terms.

(4) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions."

Drafting Note: The regulation requires a fair and accurate description of exceptions, limitations and reductions in a manner that does not minimize, render obscure or otherwise make them appear unimportant. Advertisements must state exceptions, limitations and reductions in the negative and must not understate any exception, limitation or reduction or qualify any exception, limitation or reduction to emphasize coverage described elsewhere (e.g., "Does not pay for [insert exception, limitation or reduction], however, Medicare pays this" is prohibited, nor is "Does not pay for the first four days in hospital for sickness, but pays for accident from first day."

(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited.

(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact.

(7) An advertisement that refers to "hospitalization for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries, or that refers to "whenever you are hospitalized," "when you go to the hospital" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness," if the policy excludes certain injuries or sickness, is prohibited. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.

(8) An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited.

(9) The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible.

Drafting Note: The term "confining sickness" is an abbreviated expression and requires explanation so as not to be misleading.

(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited.

(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS POLICY PROVIDES LIMITED BENEFITS," "THIS IS A CANCER ONLY POLICY," or "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

Drafting Note: An advertisement that is an invitation to contract must recite the exceptions, reductions, and limitations as required by this regulation and in a manner consistent with Section 4. If an exception, reduction or limitation is important enough to use in a policy, it is of sufficient importance that its existence in the policy should be referred to in the advertisement regardless of whether it may also be the subject matter of a provision of the Uniform Individual Accident and Sickness Provision Law.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner that does not minimize, render obscure or otherwise make them appear unimportant.

C. Preexisting Conditions

(1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

Drafting Note: This regulation requires in negative terms a description of the effect of a preexisting condition exclusion because this exclusion is a restriction on coverage. The use of the phrase "preexisting condition" without an appropriate definition or description of the term is prohibited, as well as stating a reduction in the statutory time limit (such as a reduction from three years to two years or to one year) as an affirmative benefit. The words "appropriate definition or description" mean that the term "preexisting condition" must be defined as the company's claims department uses it.

Negative features must be accurately set forth. Any limitation on benefits including preexisting conditions also must be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed elsewhere in the advertisement.

(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claimunder the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

Drafting Note: The phrase "no health questions" or words of similar import shall not be used if the policy excludes preexisting conditions. Use of a phrase such as "guaranteed issue" or "automatic issue," if the policy excludes preexisting conditions for a certain period, must be accompanied by a statement disclosing that fact in a manner that does not minimize, render obscure, or otherwise make it appear unimportant and is otherwise consistent with Section 4.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows:

"Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES"

Or substantially the following statement:

"I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past."

Drafting Note: Some states require approval of the application even when the application is not attached to the policy when issued. This regulation does not change the requirement. The text of this regulation should be modified to reflect the applicable regulation in the state.

Section 7. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

A. An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions.

B. Advertisements of cancellable accident and sickness insurance policies shall state that the contract is cancellable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, "This policy is renewable at the option of the company," or "The company has the right to refuse renewal of this policy," or "Renewable at the option of the insurer," or "This policy can be cancelled by the company at any time."

C. Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates if the policy so provides.

D. Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums, and (3) the establishment of aggregate limits.

(1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth.

(2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase.

Drafting Note: This regulation imposes the same disclosure standards with respect to policy provisions relating to renewability, cancellability and termination, modification of benefits, losses or premiums because of age or otherwise as stated in Section 6. This regulation requires that the qualifying conditions of renewability must be disclosed in a manner that does not minimize or render obscure the qualifying conditions of renewal. For example, "non-cancellable and guaranteed renewable" does not fulfill the requirement of the regulation if the policy contains a terminal age of sixty-five. In such a case, a proper statement would be "non-cancellable and guaranteed renewable to age sixty-five." If a guaranteed renewable policy reserves the right to increase premiums, the statement must be expanded into language similar to "guaranteed renewable to age sixty-five but the company reserves the right to increase premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase "subject to a maximum aggregate amount of $50,000" or similar language. A policy may have one or more of the three basic limitations and an advertisement must describe each of those that the policy contains. Over fifty percent of new individual policy issues are guaranteed renewable; therefore, the fact that a policy is guaranteed renewable shall not be exaggerated. With respect to noncancellable policies and guaranteed renewable policies, the regulation requires that a summary of the policy provisions with respect to renewability be set forth and defined where appropriate. The disclosure of provisions relating to renewability requires the use of language such as "noncancellable," "noncancellable and guaranteed renewable," or "guaranteed renewable." Unless otherwise modified by law or regulation in an individual state, the use of those terms and the definitions provided shall be consistent with the definitions of those terms adopted by the National Association of Insurance Commissioners (See 1960 *Proceedings of the NAIC* I 153).

Section 8. Standards for Marketing

A. An insurer, directly or through its agents or brokers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate;

(2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and

(3) Establish auditable procedures for verifying compliance with this subsection.

B. In addition to the practices prohibited in [insert reference to state law equivalent to the NAIC Unfair Trade Practices Act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer;

(2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

(3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Section 9. Testimonials or Endorsements by Third Parties

A. Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

Drafting Note: The regulation must be applied in conjunction with Section 10 and requires that all the statements must be genuine and not fictitious. Under the regulation, the manufacturing, substantive editing or "doctoring" of a testimonial is clearly prohibited as being false and misleading to the insurance-buying public. However, language that would be prohibited under this regulation must be edited out of a testimonial.

B. A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement:

(1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

(2) Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

(3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

(4) Is in any way directly or indirectly compensated for making a testimonial or endorsement.

Drafting Note: Reimbursement for substantial travel and entertainment expenses is also required to be disclosed; however, union scale wages required by union regulations are not required to be disclosed. Travel away from the home of the person giving the testimonial or endorsement to a distant location involving transportation expenses, lodging expenses or expenses for meals constitutes payment and must be reflected as a paid endorsement.

C. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence.

Drafting Note: This regulation requires both that approval or endorsement of a policy by an individual, group of individuals, society, association, or other organization be factual and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example, if the dividend under an association group case is payable to the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed.

D. The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances.

E. An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

F. When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

Section 10. Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans shall specifically so state.

(1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised.

(2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

Drafting Note: This regulation prohibits the use of statistics in a manner that is misleading and deceptive. This regulation requires the disclosure of all relevant facts and prohibits the use of irrelevant facts. Irrelevant facts include statistics that are out-of-date and no longer current. An advertisement that states the dollar amount of claims paid must also indicate the period over which the claims have been paid. If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement and, unless the state has issued a regulation otherwise defining the term, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in the advertisement.

Drafting Note: The regulation does not require that state-only statistics be used since statistics such as hospital charges and average stays may vary from state to state. When nationwide statistics are used the fact should be noted, unless the statistics on the particular point are substantially the same in a state to which the advertisement is directed. Statistics may be used only if they are credible. Statistics that are applicable to a broader array of illnesses or accidents than those covered under the policy cannot be used.

Section 11. Identification of Plan or Number of Policies

A. An advertisement that uses the word "plan" without prominently identifying it as an accident and sickness insurance policy is prohibited.

B. When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

C. When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies.

Section 12. Disparaging Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

A. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits."

B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.

C. Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited.

Drafting Note: The regulation prohibits disparaging, unfair or incomplete comparisons of policies or benefits that would have a tendency to deceive or mislead the public. The regulation does not preclude the use of comparisons by health maintenance organizations, prepaid health plans and other direct service organizations that describe the difference between their prepaid health benefits coverage and indemnity insurance coverage.

Section 13. Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

Drafting Note: This regulation prohibits advertisements that imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement that contains testimonials from persons who reside in a state in which the insurer is not licensed or that refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states and therefore is in violation of this regulation unless the advertisement states that the insurer is not licensed in those states.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public.

Drafting Note: Although the regulation permits a reference to an insurer being licensed in a state where the advertisement appears, it does not allow exaggeration of the fact of the licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

Section 14. Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

Drafting Note: The regulation recognizes the existence of holding companies. The requirement that the advertisement refer to the policy form number is applicable only to advertisements of individual and franchise policies that are invitations to contract.

B. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:

(1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

(2) That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers.

D. An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description.

E. An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

F. An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[ ] Medicare Department of the [ ] Insurance Company," or language of similar import.

G. An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement.

H. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.

I. The use of the name of an agency or "[ ] Underwriters" or "[ ] Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.

K. An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

L. Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used.

M. An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation.

Section 15. Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact.

B. This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

C. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

D. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when that is not the fact.

E. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

Drafting Note: The regulation prohibits the use of representations to any segment of the population that a particular policy or coverage is available only to that or similar segments of the population as preferred risks when actually the policy or coverage is available to members of the public at large at the same rates. For example, the regulation prohibits an advertisement labeled "Now for Readers of X Magazine."

Section 16. Introductory, Initial or Special Offers

A. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

Drafting Note: The regulation restricts the repetitive use of enrollment periods. The requirement of reasonable closing dates and waiting periods between enrollment periods was adopted to eliminate abuses that formerly existed. The regulation does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in the entire state until a specified number of months from the close of the enrollment period have expired. Thus, an insurer must choose whether to use enrollment periods or open enrollment for a product. (See Paragraph (4) for a definition of "a particular insurance product."). The regulation does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within this state as long as the enrollment periods for all the advertisements have the same expiration date.

The regulation does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of a specified number of months since the close of a preceding enrollment period that was open to the general public for the same product. The regulation does not require separation by a specified number of months of enrollment periods for the same insurance product in this state if the advertising material is directed by an admitted insurer to persons by direct solicitation on the basis that a common relationship exists with an entity, such as a bank and its depositors, a department store to its charge account customers or an oil company to its credit card holders, and more than one of the organizations is sponsoring the insurance product at different times if providing the insurance under this method is not otherwise prohibited by law. However, the [insert number] month regulation does apply to one specific sponsor to the same person in this state on the basis of his or her status as a customer of that one specific entity only.

The number of months was left open in this regulation because several states permit six months; several states allow three months, and other states prohibit certain periods of enrollment. Whether the enrollment periods should be permissible and the period of time between enrollments are items on which each state should make its decision on an individual basis and each state should modify the time limit in this regulation to comply with state law.

(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.

(4) The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

Drafting Note: This regulation defines the meaning of "a particular insurance product" and prohibits advertising of products having minor variations, such as different elimination periods or different amounts of daily hospital indemnity benefits, in a succession of enrollment periods.

B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

Drafting Note: Some states prohibit a reduced initial premium. Section 16B does not imply that the states that prohibit an initial premium are not in conformity with the model regulation. This is an item to be decided on a state-by-state basis.

C. Special awards, such as a "safe drivers' award," shall not be used in connection with advertisements of accident and sickness insurance.

Section 17. Statements about an Insurer

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

Drafting Note: This is closely related to the requirements of Section 10 concerning the use of statistics. The regulation prohibits insurers that have been organized for only a brief period of time advertising that they are "old" and also prohibits the use of images of a "home office" building in a manner that is misleading with respect to the actual size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations are irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors of an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession. For example, it is prohibited for an insurance company to advertise a policy offered to the general public as "the physician's policy" or "the doctor's plan" simply because there is a preponderance of physicians on the board of directors of the insurer. The regulation prohibits the use of a recommendation of a commercial rating system unless the purpose, meaning and limitations of the recommendation are clearly indicated.

Section 18. Enforcement Procedures

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance. Each insurer required to file an annual statement shall file with the commissioner, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer that states that, to the best of the officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation and the insurance laws of this state as implemented and interpreted by this regulation.

Drafting Note: Where the regulation was adopted on other than January 1 of the year, the required certification that all advertisements used in the preceding annual statement year complied with the regulation cannot be given. The respective insurance departments should consider remedying the problem in the Certificate of Compliance used for the calendar year in which the regulation was adopted.

Section 19. Severability Provision

If any section or portion of a section of this regulation, or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation, or the applicability of the provision to other persons or circumstances, shall not be affected.

Section 20. Filing for Prior Review

The commissioner may, at his or her discretion, require filing of any accident and sickness insurance advertising material for review prior to use.. The advertising material shall be filed by the insurer with the commissioner not less than thirty (30) days prior to the date the insurer desires to use the advertisement.

Drafting Note: This is an example of a regulation that may be used at the option of the commissioner in a state that elects to review advertisements prior to use. The NAIC takes no position on the question of whether advertising material should be subject to prior review by the commissioner.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1956 Proc. I 127, 130, 131-137, 148 (adopted)
1956 Proc. II 270, 301, 315 (interpretive guidelines established).
1957 Proc. I 76, 89-90, 99 (amended).
1972 Proc. I 15, 16, 555, 557, 563-580 (amended and reprinted).
1973 Proc. I 9, 11, 141, 224, 244-250 (amended and reprinted).
1974 Proc. II 8, 10, 380, 419, 420-441 (amended and reprinted).
1989 Proc. I 24-25, 702, 706-726 (amended and reprinted).
1998 Proc. 4th Quarter 16, 17, 652, 654, 688-712 (amended and reprinted).

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-013-.01 to 482-1-013-.22 (1972/2003).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE § 20-6-201 (1969/2007) (portions of model).		
Arkansas	ARK. ADMIN. CODE §§ 054.00.11-1 to 054.00.11-21 (1989) (portions of model).		ARK. ADMIN. CODE §§ 054.00.41-1 to 0054.00.41-21 (1989) (medicare supplement).
California	CAL. CODE REGS. tit. 10, §§ 2535.2 to 2537.2 (1972/1974) (portions of model).		
Colorado	3 COLO. CODE REGS. § 702-4:4-2-3 (1975/2020).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-819-1 to 38a-819-20 (1975/1992) (portions of model).		

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	18 DEL. ADMIN. CODE §§ 1302-1.0 to 1302-19.0 (1973/2003) (portions of model).		FORMS AND RATES BULLETIN 6 (1990/1992).
District of Columbia			D.C. MUN. REGS. tit. 26, § 211 (1972).
Florida	FLA. ADMIN. CODE ANN. r. 69O-150.001 to 69O-150.021 (1974/2000) (portions of model).		FLA. ADMIN. CODE ANN. r. 69O-150.101 to 69O-150.122 (1973/2000) (life insurance); 69O-150.201 to 69O-150.219 (1993/2000) (small employer).
Georgia	GA. COMP. R. & REGS. 120-2-12-.01 to 120-2-12-.22 (1965/2007) (portions of model).		GA. COMP. R. & REGS. 120-2-44-.08 (1989/1997).
Guam			12 GUAM ADMIN. R. & REGS § 1140 (1997).
Hawaii			HAW. REV. STAT. § 431:10A-310 (1989/2004) (medicare supplement).
Idaho	IDAHO ADMIN. CODE r. 18.01.24.002 to 18.01.24.026 (1993/2007) (portions of model).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2002.10 to 2002.190 (1975/2014) (portions of model).		215 ILL. COMP. STAT. 5/363a (2003) (medicare supplement).
Indiana	760 IND. ADMIN. CODE 18 (2007) (portions of model).		
Iowa	IOWA ADMIN. CODE r. §§ 191-15.1 to 191-15.13 (1997/2009) (portions of model).		IOWA CODE § 514D.5 (1980/2012) (medicare supplement).

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kansas	KAN. ADMIN. REGS. § 40-9-100 (1982/2001) (adopts model by reference with exceptions); § 40-4-37p (1991/1993) (long-term care).		
Kentucky	806 KY. ADMIN. REGS. 12:010 (1975).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XI.1301 to 37:XI.1337 (Rule 3) (1973) (portions of model).		LA. ADMIN. CODE tit. 37, § XI.101 (1991/2017) (medicare supplement).
Maine			02-031 ME. CODE R. ch. 140, §§ 1 to 11 (1973).
Maryland	MD. CODE REGS. §§ 31.15.02.01 to 31.15.02.18 (1956/2013).		
Massachusetts	211 MASS. CODE REGS. 40.01 to 40.16 (1996) (portions of model).		175 MASS. GEN. LAWS 110E (1973/1984).
Michigan	MICH. ADMIN. CODE R. 500.651 to R.500.668 (1975/1997) (portions of model).		
Minnesota			MINN. R. 2790 (2007).
Mississippi	19 MISS. ADMIN. CODE Pt. 3, R. 5.01 to 5.20 (portions of model).		MISS. CODE REG. § 88-105 (1989) (medicare supplement).
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-5.700 (1964/2003) (portions of model).		MO. CODE REGS. ANN. tit. 15, § 30-53.010 (1968/2009).
Montana			MONT. CODE ANN. § 33-18-203 (1959/2009).
Nebraska	210 NEB. ADMIN. CODE ch. 14, §§ 001 to 020 (1975/1994) (portions of model).		

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NEV. ADMIN. CODE §§ 689A.010 to 689A.270 (1972/2013) (portions of model).		NEV. ADMIN. CODE §§ 687B.225 to 687B.227 (1989/2009) (medicare supplement); BULLETIN 24 (1972).
New Hampshire	N.H. CODE ADMIN. R. INS. 2601.01 to 2601.20 (1996/2008).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-11.1 to 11:2-11.22 (1972/2001) (portions of model).		
New Mexico	N.M. ADMIN. CODE § 13.10.4 (1997) (portions of model).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 215.1 to 215.18 (Regulation 34) (1973/2009) (portions of model).		
North Carolina	11 N.C. ADMIN. CODE 12.0516 to 12.0536 (1978/2010) (portions of model).		
North Dakota		N.D. ADMIN. CODE 45-06-04-01 to 45-06-04-12 (1988).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-8-07 (2009) (portions of model).		OHIO REV. CODE ANN. § 3923.336 (medicare supplement); OHIO ADMIN. CODE 3901-8-09 (2009/2012) (medicare supplement).
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-3-1 to 365:10-3-20 (1973) (portions of model).		
Oregon	OR. ADMIN. R. 836-020-200 to 836-20-0295 (1973/2005) (portions of model).		

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	31 PA. CODE §§ 51.1 to 51.43 (1973/1976) (portions of model).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. § 20-30-1.12 (2001) (portions of model).		230 R.I. CODE R. § 20-30-8 (2009) (medicare supplement).
South Carolina	S.C. CODE ANN. REGS. 69-17 (1974) (portions of model).		
South Dakota	S.D. ADMIN. R. § 20:06:10 (1973/2012) (portions of model).		S.D. CODIFIED LAWS §§ 58-33A-1 to 58:33A-12 (2013).
Tennessee	TENN. COMP. R. & REGS. 0780-1-8-.01 to 0780-1-8-.20 (1974) (portions of model).		
Texas			28 TEX. ADMIN. CODE §§ 21.101 to 21.122 (1981/2010).
Utah	UTAH ADMIN. CODE R590-130 (1989/2010) (portions of model).		
Vermont	VT. ADMIN. CODE §§ 4-3-1:1 to 4-3-1:18 (Regulation 71-1) (1973) (portions of model).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-90-10 to 5-90-180 (1975/2009) (portions of model).		
Washington	WASH. ADMIN. CODE 284-50-010 to 284-50-230 (1973/1976) (portions of model).		

ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE R. §§ 114-10-1 to 114-10-20 (1973) (portions of model).		
Wisconsin			WIS. ADMIN. CODE INS. § 3.27 (1973/1999).
Wyoming	WYO. ADMIN. CODE 044.0002.21 §§ 1 to 19 (1974/2019).		

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Discretionary Clause Prohibition Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation or bulletin. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation or bulletin.

Section 2. Purpose and Intent

The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this Act shall be construed as imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

Section 3. Definitions

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Disability income protection coverage" is a policy, contract, certificate or agreement that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them.

C. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

D. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service cooperation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statute instead of, or in addition to, the insurance laws and regulations.

E. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or combination of the foregoing.

Section 4. Discretionary Clauses Prohibited

A. No policy, contract, certificate or agreement offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

B. No policy, contract, certificate or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

Section 5. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 6. Separability

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 7. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2001 Proc. 4th Quarter 215-216 (model adopted later is printed here).
2002 Proc.1st Quarter 12,176, 180-181 (adopted).
2004 Proc. 3rd Quarter 674-675, 677-678 (amended and reprinted, adopted by parent committee).
2004 Proc. 4th Quarter 57 (adopted by Plenary).

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

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Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. §§ 21.36.010 to 21.36.460 (2003/ 2011); § 21.42.130 (1996/1997).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	054.00.101 ARK. ADMIN. CODE §§ 1 to 7 (2013) (disability income protection).		
California			CAL. INS. CODE § 10110.6 (2011); LETTER OPINION 2-26-2004 (2004); INS. DEP'T NOTICE 2-27-2004 (2004).
Colorado			COLO. REV. STAT. § 10-3-1116 (2) (2008).
Connecticut			HEALTH CARE BULLETIN HC-67 (2008).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. ANN. §§ 431:13-101 to 431:13-108 (1987); MEMORANDUM 2004-13H (2004).
Idaho			IDAHO ADMIN. CODE r. 18.01.29.000 to 18.01.29.012 (2009).
Illinois	ILL. ADMIN. CODE tit. 50, § 2001.3 (2005).		BULLETIN 2010-5 (2010).
Indiana			BULLETIN 103 (2001).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			ADVISORY OPINION 2010-01 (2010).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 4303(11) (1995/2019) (managed care).
Maryland	MD. CODE ANN., INS. 12-211 (2011) (disability).		
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. ADMIN. CODE r. 500.2201 to 500.2202 (2007); 550.302 (2007).
Minnesota			MINN. STAT. § 62Q.107 (1998).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. 401.04 (2008/2009).
New Jersey			N.J. ADMIN. CODE §§ 11:4-58.1 to 11:4-58.4 (2007).
New Mexico	NO CURRENT ACTIVITY		
New York			CIRCULAR LETTER 2006-14 (2006).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 742.005 (1991/1999).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 9201 to 9204 (2011).		
Rhode Island			R.I. GEN. LAWS § 27-18-79 (2013); § 27-20.1-21 (2013) (dental); § 27-34.2-22 (2013) (long-term care).
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. 20:06:52:01 to 20:06:52:03 (2008).
Tennessee	NO CURRENT ACTIVITY		

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas			TEXAS CODE ANN. § 1271.057 (2011) (evidence of coverage); § 1701.062 (2011); 28 TEX. ADMIN. CODE §§ 3.1201 to 3.1203 (2010).
Utah			BULLETIN 2002-7 (2002).
Vermont	VT. STAT. ANN. tit. 8, § 4062f (2011).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. ADMIN. CODE 284-44-015 (2009) (health care); 284-46-015 (2009) (health maintenance organizations); 284-50-321 (2009) (disability); 284-96-012 (2009) (group).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. STAT. ANN. §§ 26-13-301 to 26-13-305 (2009).

PROJECT HISTORY – 2004

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT (#42)

1. Project Description

In 2002, the NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act (Model Act), which prohibits the use of such clauses in health insurance contracts. At the 2004 Spring National Meeting, the Consumer Protections Working Group of the Executive (EX) Committee decided that a public hearing should be held in conjunction with the Health Insurance and Managed Care (B) Committee during the 2004 Summer National Meeting. The hearing was intended to create a forum for interested parties to discuss whether the NAIC should expand the Model Act to include disability income insurance. The public hearing resulted in a request that staff draft amendments to the model act to prohibit the use of discretionary clauses in disability income insurance as well as health insurance for consideration by the Health Insurance and Managed Care (B) Committee. The draft amendments to the Model Act were adopted unanimously by the B Committee at the 2004 Fall National Meeting.

2. Group Responsible for Drafting Model and States Participating

The Health Insurance and Managed Care (B) Committee was responsible for drafting the Model Act, chaired by Commissioner Praeger. The following states were members of the Committee: Kansas, Montana, Arizona, Arkansas, California, Delaware, Florida, Georgia, Indiana, Maryland, Missouri, Wisconsin, and West Virginia.

3. Charge Authorizing Project

B Committee Charge: Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments. Report quarterly.

4. Description of Drafting Process

2004 Spring National Meeting – The Consumer Protections Working Group of the Executive (EX) Committee Health Insurance and the Managed Care (B) Committee decided that a joint public hearing should be held at the 2004 Summer National Meeting.

2004 Summer National Meeting – A joint public hearing of the Consumer Protections Working Group of the Executive (EX) Committee and Health Insurance and Managed Care (B) Committee was held. The following individuals testified at the hearing: Mary Ellen Signorille (AARP Foundation, Litigation); Terri Sorota (American Council of Life Insurers—ACLI); Richard E. Ramsay (America's Health Insurance Plans—AHIP); Brad Wegner (Association of California Life and Health Insurance Companies); Sonya Schwartz (Families USA); Mila Kofman (Georgetown University—Health Policy Institute); Teresa S. Renaker (Lewis & Feinberg, P.C.) and clients Joanna Baida, Mark Rosten, and Gregory Rowe; Ruth Silver Taube (Silver & Taube); Melvyn D. Silver (Silver & Taube); Lawrence Frank (Standard Insurance Company); Karrol Kitt (The University of Texas at Austin); and Cathey W. Steinberg (Women's Policy Group, Women's Policy Education Fund). Testimony and written submissions were collected and are included as part of the written record of the hearing. Following the hearing, staff was directed to draft and circulate amendments to the Prohibition on the Use Of Discretionary Clauses Model Act for consideration by the Health Insurance and Managed Care (B) Committee at the 2004 Fall National Meeting

August 2004 – Draft amendments were emailed to the B Committee and interested parties. Comments were requested. Comments were collected and emailed to B Committee and interested parties prior to the 2004 Fall National Meeting.

2004 Fall National Meeting – Draft amendments and comments were reviewed. After discussion in which regulators and interested parties participated, the B Committee unanimously voted to adopt the revisions to the model act.

Significant Issues Raised

- The current Prohibition on the Use of Discretionary Clauses Model Act prohibits the use of discretionary clauses in health insurance contracts. The inclusion of discretionary clauses in disability income insurance policies is as objectionable as their inclusion in health insurance policies.

- Insurers argued that a recent Supreme Court case, *Aetna v. Davila*, taken together with other cases, invalidated the ability of the state to prohibit the use of discretionary clauses. The *Davila* case, however, is about remedies under ERISA, not about a discretionary standard. Nothing in the *Davila* case overrules a prior Supreme Court opinion that states that discretionary clauses can be prohibited by state law.

PROJECT HISTORY – 2002

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT (#42)

1. Project Description

The working group reviewed the practice and case law on the issue of insurers using discretionary clauses in their insurance contracts. The ERISA Working Group agreed to develop a draft model act prohibiting the use of discretionary clauses in health insurance contracts.

2. Group Responsible for Drafting Model and States Participating

The ERISA Working Group of the Health Insurance & Managed Care (B) Committee was responsible for drafting the model. Wisconsin chaired the working group. The following states were members of the working group: Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Minnesota, Montana, Nebraska, Nevada, New Jersey, North Carolina, Pennsylvania, Texas, Utah, Vermont, Virginia, Washington and West Virginia.

3. Charge Authorizing Project

Working Group Charge: Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments. Report quarterly.

4. Description of Drafting Process

March 2001 National Meeting—ERISA WG reviews documents regarding issue in closed session (Indiana had reviewed issue; confidential document was provided to regulators). ERISA WG asked staff to draft a memorandum for next national meeting.

June 2001 National Meeting—ERISA WG reviews memorandum and agrees to develop a model act prohibiting such clauses. Reported to B Committee.

December 2001 National Meeting—ERISA WG reviews draft model act and comments received. Further comments requested. Reported to B Committee.

March 2001 National Meeting—ERISA WG recommends adoption of model to B Committee. B Committee adopts model. Interested parties comment at both meetings.

Significant Issues Raised

- Discretionary clauses purport to give an insurance company full and final discretion in interpreting benefits and administering an insurance contract.

- Circuit Courts of Appeals have generally concluded that courts must give deference to claims decisions by insurers **when** insurance contracts confer discretion to the insurer to interpret the terms of the contract. Consequently, it is an industry practice to use the clauses in contracts.

- Regulators found this particularly troubling given that most of the courts recognize that there is a substantial conflict of interest between the carrier's financial interest in deciding claims and the interest of claimants in obtaining coverage. Such an inherent conflict of interest makes the reservation of complete and final discretion to the insurer patently unfair and a de novo standard of review appropriate for the review of insurer's claim decisions.

- Several states have concluded that the inclusion of discretionary clauses in insurance contracts is considered inequitable, deceptive and misleading to consumers.

- Insurers argued that the model act is preempted under ERISA. However, states are **not** preempted by ERISA in prohibiting the use of discretionary clauses in insurance contracts because under ERISA states are free to regulate insurance, including the contents of insurance contracts.

- Insurers also argued that the model act will result increased litigation and health care costs. However, several states currently prohibit the use of discretionary clauses and industry failed to present evidence of a resulting increase in litigation or rise in the cost of health insurance in those states. In fact, prohibiting discretionary clauses has no effect on who may file a lawsuit, or when. Furthermore, as regulators pointed out, the majority of carriers pay claims that should be paid, and therefore it is only a small number of claims that are disputed. The claimant needs to show by a preponderance of the evidence that the claim should be paid. Plaintiffs can show this now, but with the presence of a discretionary clause, get thrown out of court because there is no abuse of discretion.

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the "Prepaid Limited Health Service Organization Act of [insert state]."

Section 2. Definitions

As used in this Act, unless otherwise defined in this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: This model uses the term "commissioner." Each state should use the title of its chief insurance supervisory official.

B. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

C. "Evidence of coverage" means the certificate, agreement or contract issued pursuant to Section 9 of this Act setting forth the coverage to which an enrollee is entitled.

D. "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as these services are provided incident to the limited health services set forth in the preceding sentence.

E. "Prepaid limited health service organization" means any corporation, partnership or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization does not include:

(1) An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) An entity that meets the requirements of Section 7 of this Act; or

(3) A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in Paragraph (1) or (2) of this definition.

Drafting Note: The primary objective of this model legislation is to provide the means to regulate limited health service plans, which currently escape regulation in many states. At the same time, this model act seeks to avoid unnecessary duplication of regulation for other entities, which currently are authorized pursuant to state law to provide limited health services on a prepayment or other basis or to indemnify for such services. Certain of these entities, however, which do not meet the prepaid limited health service organization definition, may provide limited health services on a per capita or fixed prepayment basis by fulfilling the requirements of Section 7.

Each state should consider whether the repeal of existing statutes governing single health care service organizations, *e.g.*, for-profit dental plan organization statutes, nonprofit dental service corporation statutes, vision care statutes, will advance the purpose of this Act in its own jurisdiction.

F. "Provider" means a physician, dentist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services.

H. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

Section 3. Certificate of Authority Required

No person, corporation, partnership or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this Act.

Section 4. Application for Certificate of Authority

An application for a certificate of authority to operate a prepaid limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

A. A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to these documents;

B. A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

C. A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

D. A statement generally describing the applicant, its facilities, personnel and the limited health services to be offered;

E. A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

F. A copy of the form of any contract made, or to be made between the applicant and any person listed in Subsection C of this section;

G. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

H. A copy of the form of any group contract that is to be issued to employers, unions, trustees or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

I. A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this Act;

J. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

K. A schedule of rates and charges;

L. A description of the proposed method of marketing;

M. A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with [insert citation to appropriate section of insurance code];

N. A description of the complaint procedures to be established and maintained as required under Section 13 of this Act;

O. A description of the quality assessment and utilization review procedures to be utilized by the applicant;

P. A description of how the applicant will comply with Section 18 of this Act;

Q. The fee for issuance of a certificate of authority provided in Section 24 of this Act; and

R. Such other information as the commissioner may reasonably require to make the determinations required by this Act.

Section 5. Issuance of Certificate of Authority; Denial

A. Following receipt of an application filed pursuant to Section 4, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of Section 4 have been fulfilled;

(2) The individuals responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(c) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(d) The manner in which the requirements of Section 18 of this Act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by Section 17 of this Act; and

(5) Any deficiencies identified by the commissioner have been corrected.

B. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of the notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 6. Effect on Organizations Operating on Effective Date of this Act

Within [insert number] days after the effective date of this Act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

Section 7. Filing Requirements for Authorized Entities

A. An entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and that is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by Section 4D, E, G, H, J, K, L and O and any subsequent material modification or addition thereto.

B. If the commissioner disapproves the filing, the procedures set forth in Section 5B of this Act shall be followed.

Drafting Note: This section enables specified entities, which already are authorized pursuant to state law to provide certain health benefits or services, to expand their product offerings to include limited health services on a per capita or fixed prepayment basis. To do so, the entities must file an attenuated application for approval pursuant to this Act. The attenuated filing is designed to provide the commissioner with the information essential to understanding the product offering. Of course, these entities remain subject to all of the financial and other requirements of their enabling legislation. Entities that already are authorized pursuant to state law to provide limited health services on a per capita or fixed prepayment basis fall outside the ambit of this Act.

Section 8. Changes in Rates and Benefits, Material Modifications; Addition of Limited Health Services

A. A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 4, together with supporting documents necessary to fully explain the change or modification. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

B. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by Section 4 (if different from that filed with the prepaid limited health service organization's application), and shall demonstrate compliance with Sections 17, 18 and 24. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

C. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 9. Evidence of Coverage

A. Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

B. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Section 10. Rates and Charges

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

Section 11. Construction with Other Laws

A. (1) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of [insert citation to the state's insurance holding company system regulatory act] unless specifically exempted in writing from one or more of the provisions of that act by the commissioner.

(2) A prepaid limited health service organization shall be subject to [insert citations to pertinent sections of state's unfair insurance trade practices act and penalty provisions governing insurance companies].

(3) No other provision of the insurance code shall apply to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

Drafting Note: Each state should review its unfair insurance trade practices act and penalty provisions governing insurance companies to determine if any of its provisions should not apply to prepaid limited health service organizations.

B. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this Act shall not be deemed to be the practice of medicine or other healing arts.

Drafting Note: The intent of Subsection B of this section is to specify that prepaid limited health service organizations and other entities operating pursuant to this Act are not involved in the practice of medicine or in the practice of any other form of health services. Since the statutes in a number of states define one or more types of health services as other than the practice of medicine, this exclusion should contain references to the applicable sections of a state's licensing provisions.

C. Solicitation to arrange for or provide limited health services in accordance with this Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Section 12. Nonduplication of Coverage

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services (whether in the form of services, supplies or reimbursement), insofar as the coverage or service is provided in accordance with this Act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

Drafting Note: A number of state laws mandate coverage for various health care benefits and services. Under current law, health maintenance organizations, accident and health insurance companies, nonprofit health, hospital or medical service corporations, and fraternal benefit societies must include the mandated benefit in a group policy or contract without exception. This section permits the exclusion of the mandated benefit or services from the policy or contract to the extent that it is provided as a limited health service. In this manner, the insureds/covered persons receive the benefit mandated by law, but there is no expensive duplication. Without this provision, employers would have to pay twice for mandated benefits for limited health services. Such a result would severely limit the development and competitiveness of plans providing limited health services, which would be to the detriment of employers and consumers.

Section 13. Complaint System

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

Section 14. Examination of Organization

A. The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every [insert number] years.

B. Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

C. The reasonable expenses of an examination under this section shall be charged to the organization being examined and remitted to the commissioner.

D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

Section 15. Investments

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines established by the National Association of Insurance Cmmissioners for investments by health maintenance organizations.

Section 16. Agents

No individual may apply, procure, negotiate or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

Section 17. Contracts with Providers

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

A. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of contract, the enrollees shall not be liable to the provider for any sums owed to the provider under the contract.

B. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

C. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

D. These provisions shall survive the termination of the contract, regardless of the reason giving rise to termination.

E. Termination of the contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed [insert number] days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of the contract.

F. Any amendment to these foregoing provisions of the contract must be submitted to and be approved by the commissioner prior to becoming effective.

Section 18. Protection Against Insolvency; Deposit

A. (1) Except as approved in accordance with Subsection D of this section, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(a) $50,000; or

(b) Two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of $50,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expense in excess of $50,000 in addition to the tangible net equity required by Subsection A(1) of this section.

B. For the purpose of this section, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

C. (1) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that is acceptable to the commissioner in an amount equal to $25,000 plus twenty-five percent (25%) of the tangible net equity required in Subsection A of this section; provided, however, that the deposit shall not be required to exceed $100,000.

(2) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(3) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

D. Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of Subsection A of this section for any period of time the commissioner deems proper upon a finding that either (1) the prepaid limited health service organization has a net equity of at least $5,000,000; or (2) an entity having a net equity of at least $5,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

E. For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

Drafting Note: Due to the limited scope of services provided and the limited underwriting risks associated with prepaid limited health service organizations, the tangible net equity requirements are lower than for full-service health maintenance organizations. In addition, this section provides suggested variable tangible net equity standards to take into account variations in plan size and amounts of uncovered expenses.

Section 19. Officers and Employees Fidelity Bond

A. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than [insert amount] or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with [insert citation to insurance code], shall satisfy the requirements of this subsection.

B. In lieu of the bond specified in Subsection A of this section, a prepaid limited health service organization may deposit with the [insert appropriate state authority] cash or securities or other investments of the types set forth in Section 15 of this Act. Such a deposit shall be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

Section 20. Reports

A. Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

B. The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this Act.

C. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this Act.

D. The commissioner may assess a fine of up to $100 per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Section 21. Suspension or Revocation of Certificate of Authority

A. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this Act upon determining that any of the following conditions exist:

(1) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 4 of this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges that do not comply with the requirements of Sections 9 and 10 of this Act;

(3) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the prepaid limited health service organization is less than that required by Section 18 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by Section 13 of this Act;

(7) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) The prepaid limited health service organization has otherwise failed to comply with this Act.

B. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with the [insert citation to state's administrative procedures act].

C. When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Section 22. Penalties

In lieu of any penalty specified elsewhere in this Act, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership or entity subject to this Act has been found, pursuant to [insert citation to the appropriate sections of the state's administrative procedures act] to have violated any provision of this Act, the commissioner may:

A. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

B. Impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Section 23. Rehabilitation, Conservation or Liquidation

A. Any rehabilitation, conservation or liquidation of a prepaid limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation of an insurance company and shall be conducted pursuant to [insert citations to statutory sections governing the rehabilitation, liquidation or conservation of insurance companies].

B. A prepaid limited health service organization shall not be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Section 24. Fees

Every prepaid limited health service organization subject to this Act shall pay to the commissioner the following fees:

A. For filing an application for a certificate of authority or amendment thereto—[insert amount];

B. For filing a material modification or addition of a limited health service—[insert amount];

C. For filing each annual report—[insert amount]; and

D. For filing periodic reports as required by the commissioner—[insert amount].

Section 25. Confidentiality

A. Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from the person or from a provider by a prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this Act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Act;

(2) Upon the express consent of the enrollee or applicant, provider or prepaid limited health service organization, as appropriate;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein the data or information is relevant.

B. With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.

C. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination shall be held in confidence.

Section 26. Taxes

The same [tax/tax rates] provided for in [insert citation to state's health maintenance organization act] shall be imposed upon each prepaid limited health service organization, and the organization also shall be entitled to the same tax deductions, reductions, abatements and credits that health maintenance organizations are entitled to receive.

Drafting Note: The bracketed language in the first sentence of this section acknowledges that there may be different types of health maintenance organization taxes. Each state should review the applicability and appropriateness of extending any health maintenance organization taxes or tax rates that are in place to prepaid limited health service organizations. This review should consider: (1) the goals of, and reasoning for, the health maintenance organization taxes; (2) the significantly lower average per enrollee revenue of prepaid limited health service organizations as compared with that of health maintenance organizations; and (3) the applicability of equivalent health maintenance organization deductions, reductions, abatements and credits to prepaid limited health service organizations.

Section 27. Severability

If any section, term or provision of this Act shall be adjudged invalid for any reason by a court of competent jurisdiction, the judgment shall not affect, impair or invalidate any other section, term or provision of this Act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Section 28. Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act.

Section 29. Effective Date

The effective date of this Act shall be [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1989 Proc. 1 9, 24-25, 703, 755, 796-804 (adopted).

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

The NAIC amended this model during the 2007 Summer National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2007 2nd Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the "Prepaid Limited Health Service Organization Act of [insert state]."

Section 2. Purpose and Intent

The purpose of this model Act is to provide the means to regulate limited health service organizations, including Medicare Prescription Drug Plans (PDPs), that is fair and efficient, and promotes the continued solvency of prepaid limited health service organizations. At the same time, this model act seeks to avoid unnecessary duplication of regulation for other entities, which currently are authorized pursuant to state law to provide limited health services on a prepayment or other basis or to indemnify for such services. Certain of these entities, however, which do not meet the prepaid limited health service organization definition, may provide limited health services on a per capita or fixed prepayment basis by fulfilling the requirements of Section 8 of this Act.

Each state should consider whether the repeal of existing statutes governing single health care service organizations, *e.g.*, for-profit dental plan organization statutes, nonprofit dental service corporation statutes, vision care statutes, will advance the purpose of this Act in its own jurisdiction.

This Act is designed to operate in conjunction with other state laws that establish standards for the regulation of health plans, such as, [insert state law equivalent to the Managed Care Plan Network Adequacy Model Act, the Quality Assessment and Improvement Model Act, the Health Care Professional Credentialing Verification Model Act, the Utilization Review Model Act, the Health Carrier Grievance Procedure Model Act, the Health Information Privacy Model Act, the Unfair Trade Practices Model Act, the Unfair Claims Settlement Practices Model Act, the Insurance Holding Company System Regulatory Act, and the Risk-Based Capital (RBC) for Health Organizations Model Act.

Section 3. Definitions

As used in this Act, unless otherwise defined in this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: This model uses the term "commissioner." Each state should use the title of its chief insurance supervisory official.

B. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

C. "Evidence of coverage" means the certificate, agreement or contract issued pursuant to Section 9 of this Act setting forth the coverage to which an enrollee is entitled.

D. (1) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services.

(2) Limited health service shall not include hospital, medical, surgical or emergency services except as these services are provided incident to the limited health services set forth in the preceding sentence.

E. (1) "Prepaid limited health service organization" means any corporation, partnership or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees.

(2) Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(b) An entity that meets the requirements of Section 8 of this Act; or

(c) A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in Subparagraph (a) or (b) of this Paragraph.

F. "Provider" means a physician, dentist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services.

G. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

Section 4. Certificate of Authority Required

No person, corporation, partnership or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this Act.

Section 5. Application for Certificate of Authority

A. An application for a certificate of authority to operate a prepaid limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner.

B. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(1). A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to these documents;

(2). A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3). A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4). A statement generally describing the applicant, its facilities, personnel and the limited health services to be offered;

(5). A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6). A copy of the form of any contract made, or to be made between the applicant and any person listed in Paragraph (3) of this section;

(7). A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

(8). A copy of the form of any group contract that is to be issued to employers, unions, trustees or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9). A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this Act;

(10). A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11). A schedule of rates and charges;

(12). A description of the proposed method of marketing;

(13). A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with [insert citation to appropriate section of insurance code];

(14). A description of the complaint procedures to be established and maintained as required under Section 14 of this Act;

(15). A description of the quality assessment and utilization review procedures to be utilized by the applicant;

(16). A description of how the applicant will comply with Section 19 of this Act;

(17). The fee for issuance of a certificate of authority provided in Section 25 of this Act; and

(18). Such other information as the commissioner may reasonably require to make the determinations required by this Act.

Section 6. Issuance of Certificate of Authority; Denial

A. Following receipt of an application filed pursuant to Section 5, the commissioner shall review the application and notify the applicant of any deficiencies.

B. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of Section 5 have been fulfilled;

(2) The individuals responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(c) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(d) The manner in which the requirements of Section 18 of this Act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by Section 18 of this Act; and

(5) Any deficiencies identified by the commissioner have been corrected.

C. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of the notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 7. Effect on Organizations Operating on Effective Date of this Act

Within [insert number] days after the effective date of this Act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate

during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

Section 8. Filing Requirements for Authorized Entities

A. An entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and that is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by Paragraphs (4), (5), (7), (8), (10), (11), (12) and (15) of Section 5B and any subsequent material modification or addition thereto.

B. If the commissioner disapproves the filing, the procedures set forth in Section 6C of this Act shall be followed.

Drafting Note: This section enables specified entities, which already are authorized pursuant to state law to provide certain health benefits or services, to expand their product offerings to include limited health services on a per capita or fixed prepayment basis. To do so, the entities must file an attenuated application for approval pursuant to this Act. The attenuated filing is designed to provide the commissioner with the information essential to understanding the product offering. Of course, these entities remain subject to all of the financial and other requirements of their enabling legislation. Entities that already are authorized pursuant to state law to provide limited health services on a per capita or fixed prepayment basis fall outside the ambit of this Act.

Section 9. Changes in Rates and Benefits, Material Modifications; Addition of Limited Health Services

A. A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 5 of this Act, together with supporting documents necessary to fully explain the change or modification. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

B. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by Section 4 (if different from that filed with the prepaid limited health service organization's application), and shall demonstrate compliance with Sections 18, 19 and 25 of this Act. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

C. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 10. Evidence of Coverage

A. Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

B. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Section 11. Rates and Charges

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

Section 12. Construction with Other Laws

A. (1) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of [insert citation to the state's insurance holding company system regulatory act] unless specifically exempted in writing from one or more of the provisions of that act by the commissioner.

(2) A prepaid limited health service organization shall be subject to [insert citations to pertinent sections of state's unfair insurance trade practices act and penalty provisions governing insurance companies].

(3) No other provision of the insurance code shall apply to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

Drafting Note: Each state should review its unfair insurance trade practices act and penalty provisions governing insurance companies to determine if any of its provisions should not apply to prepaid limited health service organizations.

B. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this Act shall not be deemed to be the practice of medicine or other healing arts.

Drafting Note: The intent of Subsection B of this section is to specify that prepaid limited health service organizations and other entities operating pursuant to this Act are not involved in the practice of medicine or in the practice of any other form of health services. Since the statutes in a number of states define one or more types of health services as other than the practice of medicine, this exclusion should contain references to the applicable sections of a state's licensing provisions.

C. Solicitation to arrange for or provide limited health services in accordance with this Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Section 13. Nonduplication of Coverage

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services (whether in the form of services, supplies or reimbursement), insofar as the coverage or service is provided in accordance with this Act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

Drafting Note: A number of state laws mandate coverage for various health care benefits and services. Under current law, health maintenance organizations, accident and health insurance companies, nonprofit health, hospital or medical service corporations, and fraternal benefit societies must include the mandated benefit in a group policy or contract without exception. This section permits the exclusion of the mandated benefit or services from the policy or contract to the extent that it is provided as a limited health service. In this manner, the insureds/covered persons receive the benefit mandated by law, but there is no expensive duplication. Without this provision, employers would have to pay twice for mandated benefits for limited health services. Such a result would severely limit the development and competitiveness of plans providing limited health services, which would be to the detriment of employers and consumers.

Section 14. Complaint System

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

Section 15. Examination of Organization

A. The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every [insert number] years.

B. Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

C. The reasonable expenses of an examination under this section shall be charged to the organization being examined and remitted to the commissioner.

D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

Section 16. Investments

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines established by the National Association of Insurance Cmmissioners for investments by health maintenance organizations.

Section 17. Agents

No individual may apply, procure, negotiate or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

Section 18. Contracts with Providers

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

A. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of contract, the enrollees shall not be liable to the provider for any sums owed to the provider under the contract.

B. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

C. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

D. These provisions shall survive the termination of the contract, regardless of the reason giving rise to termination.

E. Termination of the contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed [insert number] days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of the contract.

F. Any amendment to these foregoing provisions of the contract must be submitted to and be approved by the commissioner prior to becoming effective.

Section 19. Protection Against Insolvency; Deposit

A. A prepaid limited health service organization shall maintain a minimum tangible net equity equal to the greater of $100,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the Risk Based Capital for Health Organizations Model Act].

Drafting Note: The following alternate Subsection A, based on the 1989 version of the Prepaid Limited Health Service Organization Model Act, has been included for the benefit of states that have not adopted the Risk-Based Capital for Health Organizations Model Act:

B. (1) Except as approved in accordance with Subsection D of this section, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(a) $100,000; or

(b) Two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by Subsection (B)(1) of this section.

C. For the purpose of this section, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

D. (1) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that is acceptable to the commissioner in an amount equal to $50,000 plus twenty-five percent (25%) of the tangible net equity required in Subsection A of this section; provided, however, that the deposit shall not be required to exceed $200,000.

(2) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(3) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

E. Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of Subsection A of this section for any period of time the commissioner deems proper upon a finding that either (1) the prepaid limited health service organization has a net equity of at least $10,000,000; or (2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

F. For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

Drafting Note: Due to the limited scope of services provided and the limited underwriting risks associated with prepaid limited health service organizations, the tangible net equity requirements are lower than for full-service health maintenance organizations. In addition, this section provides suggested variable tangible net equity standards to take into account variations in plan size and amounts of uncovered expenses.

Section 20. Officers and Employees Fidelity Bond

A. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than [$20,000,000] or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with [insert citation to insurance code], shall satisfy the requirements of this subsection.

B. In lieu of the bond specified in Subsection A of this section, a prepaid limited health service organization may deposit with the [insert appropriate state authority] cash or securities or other investments of the types set forth in Section 16 of this Act. Such a deposit shall be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

Section 21. Reports

A. Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

B. The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this Act.

C. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this Act.

D. The commissioner may assess a fine of up to $100 per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Section 22. Suspension or Revocation of Certificate of Authority

A. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this Act upon determining that any of the following conditions exist:

(1) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 5 of this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges that do not comply with the requirements of Sections 10 and 11 of this Act;

(3) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the prepaid limited health service organization is less than that required by Section 19 of this Act or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by Section 14 of this Act;

(7) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) The prepaid limited health service organization has otherwise failed to comply with this Act.

B. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with the [insert citation to state's administrative procedures act].

C. When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Section 23. Penalties

In lieu of any penalty specified elsewhere in this Act, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership or entity subject to this Act has been found, pursuant to [insert citation to the appropriate sections of the state's administrative procedures act] to have violated any provision of this Act, the commissioner may:

A. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

B. Impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Section 24. Rehabilitation, Conservation or Liquidation

A. Any rehabilitation, conservation or liquidation of a prepaid limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation of an insurance company and shall be conducted pursuant to [insert citations to statutory sections governing the rehabilitation, liquidation or conservation of insurance companies].

B. A prepaid limited health service organization shall not be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Section 25. Fees

Every prepaid limited health service organization subject to this Act shall pay to the commissioner the following fees:

A. For filing an application for a certificate of authority or amendment thereto—[insert amount];

B. For filing a material modification or addition of a limited health service—[insert amount];

C. For filing each annual report—[insert amount]; and

D. For filing periodic reports as required by the commissioner—[insert amount].

Section 26. Confidentiality

A. Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from the person or from a provider by a prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this Act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Act;

(2) Upon the express consent of the enrollee or applicant, provider or prepaid limited health service organization, as appropriate;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein the data or information is relevant.

B. With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.

C. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination shall be held in confidence.

Section 27. Taxes

The same [tax/tax rates] provided for in [insert citation to state's health maintenance organization act] shall be imposed upon each prepaid limited health service organization, and the organization also shall be entitled to the same tax deductions, reductions, abatements and credits that health maintenance organizations are entitled to receive.

Drafting Note: The bracketed language in the first sentence of this section acknowledges that there may be different types of health maintenance organization taxes. Each state should review the applicability and appropriateness of extending any health maintenance organization taxes or tax rates that are in place to prepaid limited health service organizations. This review should consider: (1) the goals of, and reasoning for, the health maintenance organization taxes; (2) the significantly lower average per enrollee revenue of prepaid limited health service organizations as compared with that of health maintenance organizations; and (3) the applicability of equivalent health maintenance organization deductions, reductions, abatements and credits to prepaid limited health service organizations.

Section 28. Severability

If any section, term or provision of this Act shall be adjudged invalid for any reason by a court of competent jurisdiction, the judgment shall not affect, impair or invalidate any other section, term or provision of this Act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Section 29. Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act.

Section 30. Effective Date

The effective date of this Act shall be [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1989 Proc. I 9, 24-25, 703, 755, 796-804 (adopted).
2007 Proc. 2nd Quarter (adopted guideline amendment

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

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PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 22-21-360 to 22-21-391 (1982/2014) (dental).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1001 to 20-1019 (1977/2018) (dental); ARIZ. ADMIN. CODE §§ R20-6-1801 to R20-6-1813 (2002) (dental).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado			COLO. REV. STAT. §§ 10-16-501 to 10-16-512 (1992/2019) (dental).
Connecticut			CONN. GEN. STAT. §§ 38a-577 to 38a-590 (1988/2017) (dental).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. §§ 636.002 to 636.067 (1993/2017) (portions of model).		FLA. ADMIN. CODE ANN. §§ 69O-203.010 to 69O-203.100 (1994/2003).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAWAII REV. STAT. §§ 448D-1 to 448D-2 (1988) (dental).
Idaho			IDAHO CODE ANN. §§ 41-3901 to 41-3940 (1997/2015).
Illinois	215 ILL. COMP. STAT. 130/1001 to 130/4009 (1989/2019) (portions of model).		
Indiana	IND. CODE §§ 27-13-34-0.1 to 27-13-34-26 (1994/2018) (portions of model).		
Iowa			IOWA ADMIN. CODE r. §§ 191-41.1 to 191-41.21 (1999/2019).
Kansas			KAN. STAT. ANN. §§ 40-4201 to 40-4211 (1987/2015) (legal and dental).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. 31.11.12.01 to 31.11.12.12 (2005) (small employer market).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi			MISS. CODE ANN. §§ 83-41-301 to 83-41-365 (1995).

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri			MO. CODE REGS. ANN. tit. 20, § 200-1.050 (1990/2019) (dental).
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. REV. STAT. §§ 44-4701 to 44-4727 (1989/1993).		NEB. REV. STAT. §§ 44-3801 to 44-3826 (1982/1996) (dental).
Nevada	NEV. REV. STAT. §§ 695F.010 to 695F.430 (1991/1993).		NEV. ADMIN. CODE § 695F.010 to 695F.650 (1997/2004).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. STAT. ANN. §§ 17:48D-1 to 17:48D-24 (1979/2005) (dental).
New Mexico			N.M. STAT. ANN. §§ 59A-48-1 to 59A-48-19 (1984/2001) (dental).; N.M. CODE R. §§ 13.10.6 (2001) (dental).
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. CENT. CODE §§ 26.1-17.1-01 to 26.1-17.1-26 (1993/2001).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, §§ 6141 to 6157 (1983/1997) (dental).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. LAWS ANN. §§ 1901 to 1928 (1976).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. §§ 56-7-1701 to 56-7-1702 (1983) (dental); §§ 56-51-101 to 56-51-155 (2000/2016).
Texas			28 TEX. ADMIN. CODE §§ 11.2200 to 11.2208 (2005/2017).
Utah			UTAH CODE ANN. §§ 31A-8-101 to 31A-8-408 (1986/2017).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-4500 to 38.2-4523 (1986/2013) (dental and vision).
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE §§ 33-25D-1 to 33-25D-30 (1999/2009); W. VA. CODE R. §§ 114-56-1 to 114-56-11 (2000) (quality assurance standards).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2007

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT (#68)

1. Project Description

The Task Force was given a charge to review the Prepaid Limited Health Service Organization Model Act (Model #68) and determine whether it should be amended, particularly taking into account the new Medicare prescription drug plans (PDPs). Under the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), states may license PDPs. The Task Force was given this charge because states with laws similar to Model #68 may want to consider using its structure to license PDPs. Model #68, however, had not been updated since it was first adopted in 1989; it also did not reflect the Centers for Medicare and Medicaid Services (CMS) minimum solvency requirements for PDPs. Revisions were made to update the model in two ways. First, the model was revised to specifically reference Medicare Prescription Drug Plans (PDPs), so states that would like to, can more easily use this model as a vehicle for regulating Medicare PDPs. Second, the financial requirements were updated to require prepaid limited health service organizations to maintain a minimum tangible net equity equal to the greater of $100,000 or the amount necessary as required under the NAIC Risk Based Capital for Health Organizations Model Act.

2. Group Responsible for Drafting Model and States Participating

Regulatory Framework (B) Task Force:

Wisconsin, Chair	Montana
Maine	Nebraska
Arkansas	Nevada
California	New Hampshire
Colorado	Ohio
Delaware	Oregon
Florida	Rhode Island
District of Columbia	South Dakota
Idaho	Tennessee
Kansas	Utah
Kentucky	Vermont
Missouri	Virginia

3. Charge Authorizing Project

Charge given in 2006:

Review the Limited Prepaid Health Service Organization Model Act and determine whether it should be amended, particularly taking into account the new Medicare prescription drug plans. If appropriate, recommend revisions to the model.

4. Description of Drafting Process

2006 Winter National Meeting – A draft dated Dec. 10, 2006 was distributed at the Regulatory Framework Task Force meeting. The working group request comments on the draft by January 31, 2007.

2007 Spring National Meeting – Technical revisions had been made to the December draft and a new draft dated March 11, 2007, was distributed to the Regulatory Framework Task Force. The Task Force unanimously adopted the revised draft. The Health Insurance and Managed Care (B) Committee also adopted the draft.

Significant Issues Raised

None

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Care Professional Credentialing Verification Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

This Act requires a health carrier to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in this Act address the initial credentialing verification and subsequent re-credentialing process.

Drafting Note: The health care professional credentialing verification process is separate and distinct from the process that a health carrier may go through in deciding which health care professionals it will select as participating providers. The credentialing verification requirements are designed to ensure minimum clinical competency. Health carriers may utilize separate or additional criteria in selecting those health care professionals who will be allowed to participate in the health carrier's various health benefit plans.

Section 3. Definitions

For purposes of this Act:

A. "Closed plan" means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan.

B. "Commissioner" means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If jurisdiction of managed care organizations lies with some other state agency, or if dual regulation occurs, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

C. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

D. "Credentialing verification" is the process of obtaining and verifying information about a health care professional, and evaluating that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a health carrier.

E. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

F. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

G. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate persons."

H. "Health care provider" or "provider" means a health care professional or a facility.

I. "Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

J. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

K. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

L. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

M. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

N. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

O. "Primary verification" means verification by the health carrier of a health care professional's credentials based upon evidence obtained from the issuing source of the credential.

P. "Secondary verification" means verification by the health carrier of a health care professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of certificates provided by the applying health care professional).

Section 4. Applicability and Scope

This Act shall apply to health carriers that offer managed care plans.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity shall make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a managed care plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist.

Section 5. General Responsibilities of the Health Carrier

A. A health carrier shall:

(1) Establish written policies and procedures for credentialing verification of all health care professionals with whom the health carrier contracts and apply these standards consistently;

(2) Verify the credentials of a health care professional before entering into a contract with that health care professional. The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification;

(3) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification;

(4) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures;

(5) Retain all records and documents relating to a health care professional's credentialing verification process for at least [insert number] years; and

(6) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

B. Nothing in this Act shall be construed to require a health carrier to select a provider as a participating provider solely because the provider meets the health carrier's credentialing verification standards, or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

Drafting Note: In order to simplify the application process for health care professionals who are applying to multiple health carriers, it is recommended that states develop a basic uniform application to be used by all health carriers in the state. The basic application may then be augmented by the individual health carriers to obtain additional information as required by each health carrier.

Section 6. Verification Responsibilities of the Health Carrier

A health carrier shall:

A. Obtain primary verification of at least the following information about the applicant:

(1) Current [license, certificate of authority or registration] to practice [health care profession] in [insert state] and history of licensure;

(2) Current level of professional liability coverage (if applicable);

(3) Status of hospital privileges (if applicable);

(4) Specialty board certification status (if applicable);

(5) Current Drug Enforcement Agency (DEA) registration certificate (if applicable);

(6) Graduation from [health care professional] school; and

(7) Completion of post graduate training (if applicable).

Drafting Note: Some of these items may not be pertinent for health care professionals who are not physicians. This list is not comprehensive, but is considered a minimum. Certain health care professionals may not be "licensed" by a state but may instead be "certified" or "accredited" to provide the health care service. States will need to modify the language to reflect the variation encountered in their jurisdictions.

Drafting Note: There are currently several national databases (e.g. the National Practitioner Data Bank operated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services, the Physician Masterfile operated by the American Medical Association, and the Federation of State Medical Boards Physician Disciplinary Data Bank) which may provide supplemental verification of credentialing information as well as serve as a source for additional information on health professionals. There is substantial difference of opinion about the value of requiring a health carrier to query any or all of these databases. However, as the databases are constantly being upgraded and improved, it is suggested that any state considering adoption of these standards evaluate the benefit of requiring such an inquiry. In addition the health carrier may wish to inquire whether the applicant has ever been disqualified from participating in Medicare or Medicaid, or otherwise sanctioned under Medicare or Medicaid, or disqualified from or sanctioned under any other programs within the jurisdiction of the U.S. Department of Health and Human Services.

B. Obtain, subject to either primary or secondary verification at the health carrier's discretion:

(1) The health care professional's license history in this and all other states;

Drafting Note: The information required in the license history should include a chronological history of the health care professional's health care license, including dates and places of all applications for licensure, certification or registration, any action taken on the application, any challenges to licensure, certification or registration (state, Drug Enforcement Agency, etc.), the voluntary or involuntary relinquishment of a license or any other disciplinary action taken by the relevant state licensing board or agency.

(2) The health care professional's malpractice history; and

Drafting Note: The information required in the malpractice history should include any involvement in a professional liability action, but, at a minimum, any final judgment or settlement involving the individual health care professional.

(3) The health care professional's practice history.

Drafting Note: The information required in the practice history should include a chronological history of the health care professional's health care practice, including staff membership, practice privileges, professional associations, dates and places of practice, any action taken on practice privileges, and the voluntary or involuntary relinquishment, suspension, limitation, reduction or loss of staff membership or practice privileges.

C. At least every three (3) years obtain primary verification of a participating health care professional's:

(1) Current [license, certificate of authority or registration] to practice [health care profession] in [insert state];

(2) Current level of professional liability coverage (if applicable);

(3) Status of hospital privileges (if applicable);

(4) Current DEA registration certificate (if applicable); and

(5) Specialty board certification status (if applicable).

D. Require all participating providers to notify the health carrier of changes in the status of any of the items listed in this section at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this section.

Section 7. Health Care Professional's Right to Review Credentialing Verification Information

A health carrier shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application as set forth below.

A. Each health care professional who is subject to the credentialing verification process shall have the right to review all information, including the source of that information, obtained by the health carrier to satisfy the requirements of this Act during the health carrier's credentialing process.

B. A health carrier shall notify a health care professional of any information obtained during the health carrier's credentialing verification process that does not meet the health carrier's credentialing verification standards or that varies substantially from the information provided to the health carrier by the health care professional, except that the health carrier shall not be required to reveal the source of information if the information is not obtained to meet the requirements of this Act, or if disclosure is prohibited by law.

C. A health care professional shall have the right to correct any erroneous information. A health carrier shall have a formal process by which a health care professional may submit supplemental or corrected information to the health carrier's credentialing verification committee and request a reconsideration of the health care professional's credentialing verification application if the health care professional feels that the health carrier's credentialing verification committee has received information that is incorrect or misleading. Supplemental information shall be subject to confirmation by the health carrier.

Section 8. Contracting

Whenever a health carrier contracts to have another entity perform the credentialing functions required by this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this Act and applicable regulations are met.

Section 9. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 10. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 11. Separability

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 12. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 1st Quarter 29-30, 123, 625, 640, 657, 671-675 (adopted).

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION MODEL ACT

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 420-5-6-.11 (1957/2019).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-3451 to 20-3459 (2018).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado			COLO. REV. STAT. ANN. § 25-1-108.7 (2004/2019).
Connecticut	NO CURRENT ACTIVITY		
Delaware			18 DEL. ADMIN. CODE § 1403-11.0 (2007).
District of Columbia			D.C. CODE §§ 31-3251 to 31-3255 (2002).
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 77, § 240.60 (1990/2010); 410 ILL. COMP. STAT. 517/1 to 517/99 (1999) (credentialing data collection).
Indiana			IND. CODE § 27-8-11-7 (2005/2018).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.17A-576 (2008/2018).
Louisiana			LA. REV. STAT. ANN. § 22:1009 (2004/2015).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 4303 (1995/2019); 02-031 ME. CODE R. ch. 850, §§ 1 to 12 (1997/2012).
Maryland			MD. CODE REGS. 31.10.26.01 to 31.10.26.05 (2000).
Massachusetts			243 MASS. CODE REGS 3.01 to 3.14 (1993/1994); 52.10 (2001).
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	19-11 MISS. CODE R. Pt. 3, §§ 11.01 to 11.13 (98-1) (2012).		
Missouri			MO. CODE REGS. ANN. tit. 20, § 400-7.180 (1997/2019).
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. REV. STAT. §§ 44-7001 to 44-7013 (1999).		

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. § 629.095 (2003/2012) (form for credentialing); NEV. ADMIN. CODE 679B.0405 (2004).
New Hampshire	N.H. REV. STAT. ANN. §§ 420-J:1 to 420-J:4 (2007) (portions of model).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. ADMIN. CODE § 13.10.21 (2009).
New York			N.Y. INS. LAW § 4803 (1996/2017); N.Y. PUBLIC HEALTH LAW § 4406-d (1996/2009).
North Carolina			N.C. GEN. STAT. § 58-3-230 (2001/2009).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3963.05 to 3963.06 (2008).
Oklahoma			OKLA. STAT. tit. 36, § 4405.1 (2001/2015).
Oregon			OR. ADMIN. R. 409-045-0055 (2014/2019).
Pennsylvania			40 PA. STAT. ANN. §§ 991.2111 (1998); 28 PA. CODE §§ 9.761 to 9.763 (2001).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			230 R.I. ADMIN. CODE R. § 20-30-9.8 (2018).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. ADMIN. R. 20:06:56:14 (2013) (incorporation by reference).		

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 1457.001 to 1457.002 (2005); 28 TEX. ADMIN. CODE § 21.3201 (2002/2005).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. ADMIN. CODE §§ 4-5-3:1 to 4-5-3:6 (2009/2017).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			12 VA. ADMIN. CODE § 5-408-170 (2012/2017).
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE § 33-25A-17a (1996); W. VA. CODE §§ 16-1A-1 to 16-1A-10 (2001/2010); W. VA. CODE R. §§ 114-53-1 to 114-53-10 (1999/2003).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Quality Assessment and Improvement Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

This Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans and for the quality improvement activities of health carriers issuing closed plans or combination plans that have a closed component. The purpose of the criteria is to enable health carriers to evaluate, maintain and improve the quality of health care services provided to covered persons.

Section 3. Definitions

A. "Closed plan" means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan.

B. "Commissioner" means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If jurisdiction of managed care organizations lies with some other state agency, or if dual regulation occurs, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

C. "Consumer" means someone in the general public who may or may not be a covered person or a purchaser of health care, including employers.

D. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

E. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

F. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

G. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

H. "Health care provider" or "provider" means a health care professional or a facility.

I. "Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

J. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

K. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

L. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

M. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

N. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

O. "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups or populations.

P. "Quality improvement" means the effort to improve the processes and outcomes related to the provision of care within the health plan.

Section 4. Applicability and Scope

Except as otherwise specified, this Act shall apply to all health carriers that offer managed care plans.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity shall make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a managed care plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist.

Section 5. Quality Assessment Standards

A health carrier that provides managed care plans shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. A health carrier shall:

A. Establish a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system shall include systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements;

Drafting Note: The level of quality assessment activities undertaken by a health plan will vary based on the plan's structure. For example, PPO plans and HMOs will have different quality assessment programs and techniques.

B. Communicate findings in a timely manner to applicable regulatory agencies, providers and consumers as provided in Section 8;

C. Report to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. A health carrier acting in good faith shall be granted immunity from any cause of action under state law in making the report; and

D. File a written description of the quality assessment program with the commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets the requirements of this Act.

Section 6. Quality Improvement Standards for Closed Plans

A health carrier that issues a closed plan, or a combination plan having a closed component, shall, in addition to complying with the requirements of Section 5, develop and maintain the internal structures and activities necessary to improve quality as required by this section. A health carrier subject to the requirements of this section shall:

A. Establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement;

B. Use the findings generated by the system to work, on a continuing basis, with participating providers and other staff within the closed plan or closed component to improve the health care delivered to covered persons;

C. Develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program filed with the commissioner and consistent with the provisions of this Act. This program shall be under the direction of the Chief Medical Officer or Clinical Director. The organizational program shall include:

(1) A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities and an annual effectiveness review of the quality improvement program;

(2) A written quality improvement plan that describes how the health carrier intends to:

(a) Analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

(b) Identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the health carrier shall consider practices and diagnoses that affect a substantial number of the plan's covered persons, or that could place covered persons at serious risk. This section shall not be construed to require a health carrier to review every disease, illness and condition that may affect a member of a managed care plan offered by the health carrier;

Drafting Note: This paragraph seeks to ensure that the diagnoses and patterns of care that a health carrier monitors in any given year are chosen because of their importance and appropriateness to the population served by the closed plan.

(c) Use a range of appropriate methods to analyze quality, including:

(i) Collection and analysis of information on over-utilization and under-utilization of services;

(ii) Evaluation of courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases such as current medical research, knowledge, standards and practice guidelines; and

(iii) Collection and analysis of information specific to a covered person or persons or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of covered persons;

(d) Compare program findings with past performance, as appropriate, and with internal goals and external standards, where available, adopted by the health carrier;

(e) Measure the performance of participating providers and conduct peer review activities, such as:

(i) Identifying practices that do not meet the health carrier's standards;

(ii) Taking appropriate action to correct deficiencies;

(iii) Monitoring participating providers to determine whether they have implemented corrective action; and

(iv) Taking appropriate action when the participating provider has not implemented corrective action;

(f) Utilize treatment protocols and practice parameters developed with appropriate clinical input and using the evaluations described in Paragraphs (2)(a) and (2)(b) above, or utilize acquired treatment protocols developed with appropriate clinical input; and provide participating providers with sufficient information about the protocols to enable participating providers to meet the standards established by these protocols;

(g) Evaluate access to care for covered persons according to standards established by statute, regulation or the commissioner. The quality improvement plan shall describe the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies;

Drafting Note: Health carriers are not expected to duplicate the services provided by public health agencies, but health carriers should ensure that their plans facilitate the achievement of local public health goals and initiatives. Examples of these initiatives include immunization goals, goals to increase the use of preventive diagnostic services such as Pap smears and mammograms, and efforts to increase the use of seat belts and bicycle helmets. Most states support or maintain health care facilities designed to meet the needs of special populations. These facilities may include migrant worker clinics, community health centers in metropolitan areas, and public health hospitals. States should consider methods of assisting these facilities in developing the capacity to meet health carrier standards for participation in health care networks to preserve this public health infrastructure and avoid conflicting requirements between insurance regulation and public managed care programs. Health carriers should evaluate the compliance of their access provisions with standards set forth in [insert reference to state law similar to the NAIC s Provider Network Adequacy and Contracting Model Act].

(h) Implement improvement strategies related to program findings; and

(i) Evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in Subparagraph (h);

D. Assure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system; and

E. Provide covered persons the opportunity to comment on the quality improvement process.

Section 7. Corporate Oversight

The Chief Medical Officer or Clinical Director of the health carrier shall have primary responsibility for the quality assessment and quality improvement activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act are met. The Chief Medical Officer or Clinical Director shall approve the written quality assessment and quality improvement programs, as applicable, implemented in compliance with this Act, and shall periodically review and revise the program document and act to assure ongoing appropriateness. Not less than semi-annually, the Chief Medical Officer or Clinical Director shall review reports of quality assessment and quality improvement activities. The commissioner shall hold the health carrier responsible for the actions of the Chief Medical Officer or Clinical Director carried out on behalf of the health carrier and shall hold the health carrier responsible for ensuring that all requirements of this Act are met.

Section 8. Reporting and Disclosure Requirements

A. A health carrier shall document and communicate information, as specified below, about its quality assessment program and its quality improvement program, if it has one, and shall:

(1) Include a summary of its quality assessment and quality improvement programs in marketing materials;

(2) Include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons; and

(3) Make available annually to providers and covered persons findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

Drafting Note: A state should review its applicable state law addressing data reporting requirements and confidentiality issues to ensure that the requirements of this section are consistent with those laws. The NAIC is developing models to address data reporting and confidentiality.

B. (1) A health carrier shall certify to the commissioner annually that its quality assessment program and its quality improvement program, if it has one, along with the materials provided to providers and consumers in accordance with Subsection A, meet the requirements of this Act.

(2) A health carrier shall make available for review by the public upon request, subject to a reasonable fee, the materials certified in Paragraph (1), except for the materials subject to the confidentiality requirements of Section 9, and materials that are proprietary to the health plan. A health carrier shall retain all certified materials for at least three (3) years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

Section 9. Confidentiality

A. Data or information pertaining to the diagnosis, treatment or health of a covered person obtained from the person or from a provider by a health carrier is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law; or upon the express consent of the covered person; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of a claim or litigation between the covered person and the health carrier where the data or information is pertinent, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer retrievable form. If any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant is disclosed pursuant to the provisions of this subsection, the health carrier making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data. A health carrier shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health carrier is entitled to claim.

B. A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agent or employee of a health carrier's quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, or who furnishes any records, information or assistance to a quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, shall not be subject to liability for civil damages or any legal action in consequence of his or her action, nor shall the health carrier that established the quality committee or the officers, directors, employees or agents of the health carrier be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

C. (1) The information considered by a quality committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the quality committee's findings or recommendations. No member of a quality committee, or officer, director or other member of a health carrier or its staff engaged in assisting the quality committee, or engaged in the health carrier's quality assessment or quality improvement activities, or any person assisting or furnishing information to the quality committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.

(2) Information considered by a quality committee and the records of its actions and proceedings that are used pursuant to Subsection C(1) by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a quality committee.

D. To fulfill its obligations under this section, the health carrier shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any covered person.

Section 10. Contracting

Whenever a health carrier contracts to have another entity perform the quality assessment or quality improvement functions required by this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this Act and applicable regulations are met.

Section 11. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 12. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 13. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1996 Proc. 1st Quarter 29-30, 123, 626, 640, 656, 667-671 (adopted).

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSI	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE § 420-5-6-.07 (1987/1999).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. §§ 23-99-701 to 23-99-706 (1999/2019).
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. §§ 641.51 to 641.511 (1987/2019).
Georgia			GA. CODE ANN. 33-20A-5 (1996/2019); GA. COMP. R. & REGS. 120-2-80 (1998).
Guam	NO CURRENT ACTIVITY		

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE. tit. 77, § 240.60 (1990).
Indiana			IND. CODE § 27-13-2-5 (1994/2018).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.17A-545 (1998/2010).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. § 4204 (2014).
Maryland			MD. CODE ANN., INS. §§ 19-705.8 (1999) (quality assurance unit in health dept); 15-10C-01 to 15-10C-04 (1999) (duties of medical directors).
Massachusetts			211 MASS. CODE REGS. 52.09 (2005/2008).
Michigan			MICH. COMP. LAWS ANN. § 500.3508 (1956/2016).
Minnesota			MINN. STAT. §§ 4685.1105 to 4685.1300 (1993).
Mississippi			MISS. CODE ANN. § 83-41-313 (1995).
Missouri	NO CURRENT ACTIVITY		
Montana	MONT. CODE ANN. §§ 33-36-301 to 33-36-402 (1999) (portions of model).		
Nebraska	NEB. REV. STAT. §§ 44-7201 to 44-7215 (1998).		

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. § 695F.110 (1991/2009); §§ 695G.180 to 695G.190 (1997/2003); NEV. ADMIN. CODE §§ 695C.400 to 695C.430 (1995).
New Hampshire			N.H. REV. STAT. ANN. §§ 420-J:1 to 420-J:14 (1998/2013).
New Jersey			N.J. STAT. ANN. § 26:2S-6 (1997) (medical directors).
New Mexico			N.M. STAT. ANN. § 59A-46-7 (1993).
New York			N.Y. PUBLIC HEALTH LAW § 4410 (1996); N.Y. COMP. CODES R. & REGS. tit. 10, §§ 98.12 to 98.13 (1985).
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE § 26.1-18.1-06 (1993).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. 1751.73 to 1751.75 (1997).
Oklahoma			OKLA. STAT. ANN. tit. 36, § 6907 (2003).
Oregon			OR. REV. STAT. § 743B.200 (1997/2018); OR. ADMIN. R. 836-053-1170 (1998) (small groups).
Pennsylvania			28 PA. CODE § 9.674 (2001).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 9351 to 9360 (2011).		
Rhode Island			R.I. GEN. LAWS § 27-41-16 (1983/1995).
South Carolina	NO CURRENT ACTIVITY		

QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota			S.D. CODIFIED LAWS §§ 58-17G-1 to 58-17G-7 (2011).
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 847.001 to 847.010 (2005).
Utah			UTAH ADMIN. CODE r. 590-76-9 (1989/2009).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 32.1-137.2 to 32.1-137.6 (1998/2013).
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE § 33-25A-17a (1998).
Wisconsin			WIS. ADMIN. CODE INS. §§ 9.40 to 9.42 (2000).
Wyoming			WYO. STAT. ANN. § 26-34-108 (1995/2019).

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Carrier Grievance Procedure Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

The purpose of this Act is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this Act.

Drafting Note: States are strongly encouraged to adopt both this Health Carrier Grievance Procedure Model Act and the NAIC's Utilization Review and Benefit Determination Model Act. The Utilization Review and Benefit Determination Model Act sets out the process for making utilization review and benefit determinations with respect to requests for health care services. This Act assumes the existence of the utilization review and benefit determination process in the Utilization Review and Benefit Determination Model Act and adverse determinations made under that Act with respect to requests for health care services.

Drafting Note: The definition of "adverse determination" found in Section 3A of this Act has been revised to conform with the provisions of the federal Department of Labor (DOL) claims procedure final regulation (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, which establishes standards for the processing of claims for benefits under group health plans. Specifically, the definition of "adverse determination" was revised to be consistent with the term "adverse benefit determination" used in the DOL final rule in order to include determinations that may involve eligibility issues in addition to medical necessity issues and any other determination that results in a denial, reduction or termination of a benefit or a failure to provide payment, in whole or in part, for a benefit. The definition of "adverse determination" has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010.

Section 3. Definitions

For purposes of this Act:

A. (1) "Adverse determination" means:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(2) "Adverse determination" includes a rescission of coverage determination.

Drafting Note: The DOL final rule uses the term "adverse benefit determination." This model act uses the term "adverse determination." The NAIC has chosen to continue to use the term "adverse determination" in this model act instead of using the DOL final rule's term "adverse benefit determination" because the term "adverse determination" is referenced in several other NAIC model acts in addition to this model act. If the terminology were changed, this would necessitate revising several NAIC model acts to reflect this change in terminology. The definition of "adverse determination" in Subsection A has been revised, however, to be consistent with the DOL final rule's definition for the term "adverse benefit determination." The definition of "adverse determination" has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, published in the *Federal Register*, July 23, 2010.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Act;

(2) A person authorized by law to provide substituted consent for a covered person;

(3) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(5) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

D. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

F. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Drafting Note: States may wish to define "clinical peer" more broadly to include a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

G. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

H. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

I. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

J. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term "concurrent claim" instead of "concurrent review." The DOL final rule does not define "concurrent claim." However, given the use of the term in the substantive provisions of the DOL final rule and the way the term is used substantively in this model, the definition of "concurrent review," as defined in Subsection J, is consistent with the term "concurrent claim."

K. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

L. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

M. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

N. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Drafting Note: The definition of "emergency medical condition" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

O. "Emergency services" means, with respect to an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

Drafting Note: The definition of "emergency services" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

P. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Q. "Final adverse determination" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under Section 7 or Section 10 of this Act or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 6A(2) of this Act.

Drafting Note: The interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010, use the term "final internal adverse determination." For consistency with the NAIC Uniform Health Carrier External Review Model Act the term as been defined as "final adverse determination" in this Act.

R. "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

S. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term "health insurance coverage." "Health benefit plan," as defined in this model act, is intended to be consistent with the definition of "health insurance coverage" contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses "excepted benefits," i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

(2) "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(3) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(6) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

T. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

U. "Health care provider" or "provider" means a health care professional or a facility.

V. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

W. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: The Affordable Care Act uses the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" is consistent with the term "health insurance issuer."

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

X. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

Y. (1) "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

(2) "Managed care plan" includes:

(a) A closed plan, as defined in Subsection H; and

(b) An open plan, as defined in Subsection AA.

Drafting Note: The definition of "managed care plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. Such standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.

Z. "Network" means the group of participating providers providing services to a managed care plan.

AA. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

BB. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

CC. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

DD. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals external review processes published in the *Federal Register*, July 23, 2010, uses the term "pre-service claim" instead of "prospective review." The DOL final rule defines a "pre-service claim" as "any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care." The definition of "prospective review," as defined in Subsection DD, has been amended to be consistent with the intent of the definition of "pre-service claim" because both require prior approval of the benefit prior to its provision. The DOL final rule does not state what process the claimant must complete to obtain the approval, but, given the definition of "adverse benefit determination" in the DOL final rule, it is reasonable to conclude that performing utilization review would be an acceptable means to determine whether the provision of a health care service will be approved.

EE. (1) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(2) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Drafting Note: The definition of "rescission" is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

FF. (1) "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

(2) "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term "post-service claim" instead of "retrospective review." The DOL final rule defines a "post-service claim" as "any claim for a benefit under a group health plan that is not a pre-service claim," as that term is defined under the DOL final rule. To reflect this broad definition of "post-service claim," the definition of "retrospective review," in Subsection FF, has been revised to be consistent with the definition of "post-service claim."

GG. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

HH. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman delivered, including the placenta.

Drafting Note: The definition of "stabilized" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

II. (1) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(b) In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(2) (a) Except as provided in Subparagraph (b) of this paragraph, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(b) Any request that an attending health care professional with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.

JJ. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

KK. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

Section 4. Applicability and Scope

Except as otherwise specified, this Act shall apply to all health carriers offering a health benefit plan.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a health carrier has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist. States should periodically review a health carrier's private accreditation and eligibility for deemed compliance.

Drafting Note: The provisions of this Act are consistent with the provisions in the interim final regulations on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010 and, as those regulations were amended by the interim final regulations published in the *Federal Register* June 24, 2011. However, states should be aware that the Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

Section 5. Grievance Reporting and Recordkeeping Requirements

A. (1) A health carrier shall maintain written records to document all grievances received, including the notices and claims associated with the grievances, during a calendar year (the register).

(2) (a) Notwithstanding the provisions under Subsection F, a health carrier shall maintain the records required under Paragraph (1) for at least six (6) years related to the notices provided under Section 7H and Section 10H of this Act.

(b) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

B. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with Section 7 of this Act shall be included in the register.

C. A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to Section 9 of this Act shall be included in the register.

D. For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance;

Drafting Note: The commissioner may wish to prescribe specific categories. If so, they should be listed here. In prescribing categories the commissioner should refer to the NAIC's Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act to ensure that the prescribed categories are consistent with that regulation.

(2) The date received;

(3) The date of each review or, if applicable, review meeting;

(4) Resolution at each level of the grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

(6) Name of the covered person for whom the grievance was filed.

E. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

F. (1) Subject to the provisions of Subsection A, a health carrier shall retain the register compiled for a calendar year for the longer of three (3) years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

(2) (a) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(b) The report shall include for each type of health benefit plan offered by the health carrier

(i) The certificate of compliance required by Section 6 of this Act;

(ii) The number of covered lives;

(iii) The total number of grievances;

(iv) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to Section 9 of this Act;

(v) The number of grievances resolved at each level, if applicable, and their resolution;

(vi) The number of grievances appealed to the commissioner of which the health carrier has been informed;

(vii) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(viii) A synopsis of actions being taken to correct problems identified.

Drafting Note: This section requires health carriers to maintain detailed written records and imposes specific reporting requirements with respect to all grievances, including grievances involving an adverse determination. The DOL final rule, as published in the *Federal Register*, Nov. 21, 2000, did not include such requirements. However, the interim final rules related on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010, revised the DOL final rule to include a requirement that records of all claims and notices associated with the internal claims and appeals processes be retained for at least six years. The revisions to this section reflect this new recordkeeping requirement.

Section 6. Grievance Review Procedures

A. (1) Except as specified in Section 10 of this Act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in Sections 7, 8 and 9 of this Act.

(2) (a) Whenever a health carrier fails to adhere to the requirements of section 7 or section 10 of this Act with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Act and may take action under subparagraph (b) of this paragraph.

(b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act].

(ii) In addition to item (i), a covered person is entitled to pursue any available remedies under State or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(3) (a) Notwithstanding paragraph (2), the provisions of section 7 or section 10 of this Act shall not be deemed exhausted based on a *de minimus* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person.

(b) The exception provided in subparagraph (a) of this paragraph does not apply if the violation is part of a pattern or practice of violations by the health carrier.

(c) (i) A covered person may request a written explanation of the violation from the health carrier.

(ii) The health carrier shall:

(I) Provide the written explanation within ten (10) days of receiving the request; and

(II) Include in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of this Act to be exhausted.

(d) (i) If an independent reviewer or a court of competent jurisdiction rejects the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception provided in subparagraph (a) of this paragraph, the covered person has the right to resubmit and pursue a review of the grievance under this Act.

(ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, but not exceeding ten (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this Act].

(iii) For purposes of calculating the time period for re-filing the benefit request or claim under this subparagraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative receipt of the notice of opportunity to resubmit.

B. (1) A health carrier shall file a copy of the procedures required under Subsection A, including all forms used to process requests made pursuant to Section 7, 8 and 9 of this Act, with the commissioner. Any subsequent material modifications to the documents also shall be filed.

(2) The commissioner may disapprove a filing received in accordance with Paragraph (1) that fails to comply with this Act or applicable regulations.

C. In addition to Subsection B, a health carrier shall file annually with the commissioner, as part of its annual report required by Section 5 of this Act, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this Act.

D. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

E. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office or ombudsman's office for assistance at any time. The statement shall include the telephone number and address of the commissioner or ombudsman's office.

Drafting Note: States may need to revise subsection E above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Section 7. First Level Reviews of Grievances Involving an Adverse Determination

Drafting Note: This section is intended to satisfy the "full and fair review" requirements of section 503 of the Employee Retirement Income Security Act of 1974 (ERISA), as set out in the DOL final rule. Specifically, under those requirements, employee welfare benefit plans, in accordance with regulations of the Department of Labor (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, must provide adequate notice in writing to every participant or beneficiary whose claim for benefits under the plan has been denied. The notice must set forth the specific reasons for the denial (known as an adverse benefit determination) and written in a manner calculated to be understood by the participant. In addition, under section 503 of ERISA, plans must afford any participant, whose claim for benefits has been denied, a full and fair review by the appropriate named fiduciary of that adverse determination. Section 9 of this Act, which establishes a voluntary review procedure for grievances that involve an adverse determination, is intended to be an additional review procedure that covered persons may voluntarily use to resolve an adverse determination that remains in dispute at the completion of the first level review under this section prior to seeking judicial or other available remedies. Section 9 of this Act is not intended to be, and should not be considered, part of the "full and fair review" of an adverse benefit determination that plans are required to afford participants pursuant to section 503 of ERISA, as set out in the DOL final rule.

A. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to [insert reference in state law equivalent to the Utilization Review and Benefit Determination Model Act], a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination.

B. (1) The health carrier shall provide the covered person with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.

(2) (a) In providing for a first level review under this section, the health carrier shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision.

(b) In ensuring the independence and impartially of individuals involved in making the first level review decision, the health carrier shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

C. (1) (a) In the case of an adverse determination involving utilization review, the health carrier shall designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer shall not have been involved in the initial adverse determination.

(b) In designating an appropriate clinical peer or peers pursuant to Subparagraph (a) of this paragraph, the health carrier shall ensure that, if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

Drafting Note: States should be aware that, with respect to appeals of adverse determinations that are based in whole or in part on a medical judgment, the DOL final rule requires group health plans to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Paragraph (1) is more stringent than the DOL final rule. It requires health carriers to designate a clinical peer or peers of the same or similar specialty to review the adverse determination. Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (1).

(2) In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

D. (1) (a) A covered person does not have the right to attend, or to have a representative in attendance, at the first level review, but the covered person or, if applicable, the covered person's authorized representative is entitled to:

(i) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(ii) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

(b) For purposes of Subparagraph (a)(ii) of this paragraph, a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

(iii) Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

(2) The health carrier shall make the provisions of Paragraph (1) known to the covered person or, if applicable, the covered person's authorized representative within three (3) working days after the date of receipt of the grievance.

Drafting Note: Paragraph (2) requires a health carrier to inform a covered person or the covered person's authorized representative of the health carrier's appeal procedures within three working days after the date the health carrier receives the grievance. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

Drafting Note: States that have adopted the NAIC Utilization Review and Benefit Determination Model Act may want to consider whether to include the requirements of Paragraph (2) because of the notice requirements contained in that model act.

E. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Subsection F, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

F. (1) A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in Paragraph (2) or (3).

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.

Drafting Note: In adopting Subsection F, states should be aware that the DOL final rule permits a group health plan to provide for two levels of mandatory review of an adverse determination involving a prospective review request and an adverse determination involving a retrospective review request. In the case of a prospective review request, a maximum of 15 days is provided for a benefit determination at each level. In the case of a retrospective review request a maximum of 30 days is provided for a benefit determination at each level. For example, if a covered person decides to request a review of an adverse determination involving a prospective review request, and the group health plan provides for two levels of mandatory review, the plan must make a benefit determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after receipt of the appeal. If that benefit request is again denied at the first level of mandatory review and the covered person appeals that denial to the second level of mandatory review, the plan must again make a determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after the plan's receipt of the covered person's second level review request.

Drafting Note: The interim final regulations on internal claims and appeals published in the *Federal Register* July 23, 2010, requires health carriers for individual health benefit plans to require the claimant to complete only one level of internal review before issuing a final adverse determination.

G. (1) Prior to issuing a decision in accordance with the timeframes provided in subsection F, the health carrier shall provide free of charge to covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

(2) Before the health carrier issues or provides notice of a final adverse determination in accordance with the timeframes provided in subsection F that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

H. The decision issued pursuant to Subsection F shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

(3) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, a health carrier: (a) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (b) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

(4) A statement of the reviewers' understanding of the covered person's grievance;

(5) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(6) A reference to the evidence or documentation used as the basis for the decision;

(7) For a first level review decision issued pursuant to Section F that upholds the grievance:

(a) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(b) The reference to the specific plan provisions on which the determination is based;

(c) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection D(1)(b), to the covered person's benefit request;

(d) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as provided in Subparagraph (d) of this paragraph; and

(ii) The written statement of the scientific or clinical rationale for the determination, as provided in Subparagraph (e) of this paragraph;

(8) If applicable, a statement indicating:

(a) A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to Section 9 of this Act;

(b) The written procedures governing the voluntary review, including any required time frame for the review;

(c) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act] if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and

Drafting Note: The language in Subparagraph (c) should be adopted by states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act and, in accordance with that law, permit a covered person to file a request for external review after completion of one level of the health carrier's internal grievance review process. Those states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act, but require the covered person to complete more than one level of a health carrier's internal grievance review process prior to filing a request for external review, should not adopt the language in Subparagraph (c). Instead, these states may want to modify the language in this paragraph to provide covered persons with specific notice of this exhaustion requirement. States should be aware that in accordance with the interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010, for individual health insurance coverage, health carriers for individual health benefit plans may only require covered persons to complete one level of internal review.

(d) The covered person's right to bring a civil action in a court of competent jurisdiction;

(9) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(10) Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise paragraph (10) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Paragraph (10): "Notice of the covered person's right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner's office."

Drafting Note: States should be aware that the DOL final rule sets out certain information that must be included in any notice to a claimant that involves an adverse benefit determination. Some of the information required to be provided in the notice under Subsection H, particularly the information required in Subsection H(1), (4), (5) and (6) is not specifically required by the DOL final rule. For example, the DOL final rule does not require group health plans to automatically provide the title and qualifying credentials of medical experts participating in the first level review, as provided in Subsection H(1). The DOL final rule requires group health plans to provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination. The DOL final rule does not address the other requirements in Subsection H(4) through (6). Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, in revising this section, the NAIC has chosen to retain the provisions in Subsection H.

I. (1) A health carrier shall provide the notice required under subsection H in a culturally and linguistically appropriate manner in accordance with federal regulations.

(2) To be considered to meet the requirements of paragraph (1), the health carrier shall:

(a) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

(b) Provide, upon request, a notice in any applicable non-English language; and

(c) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.

(3) For purposes of this subsection, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Section 8. Standard Reviews of Grievances Not Involving an Adverse Determination

Drafting Note: States should be aware that this section is not required under the DOL final rule published in the *Federal Register*, Nov. 21, 2000 or the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010.

A. A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

B. (1) The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under this section.

(2) (a) A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to Subsection C to consider when conducting the review.

(b) The health carrier shall make the provisions of Subparagraph (a) of this paragraph known to the covered person or, if applicable, the covered person's authorized representative within three (3) working days after the date of receiving the grievance.

C. (1) Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance.

(2) The health carrier shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

(3) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

D. (1) The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within twenty (20) working days after the date of receipt of the request for a standard review of a grievance filed pursuant to Subsection B.

(2) (a) Subject to Subparagraph (b) of this paragraph, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to Paragraph (1) within twenty (20) working days, the health carrier may take up to an additional ten (10) working days to issue a written decision.

(b) A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with Subparagraph (a) of this paragraph, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative of the extension and the reasons for the delay.

E. The written decision issued pursuant to Subsection D shall contain:

(1) The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) If applicable, a statement indicating:

(a) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to Section 9 of this Act; and

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(6) Notice of the covered person's right, at any time, to contact the commissioner's office, including the telephone number and address of the commissioner's office.

Section 9. Voluntary Level of Reviews of Grievances

Drafting Note: Although this section requires health carriers that offer managed care plans to establish an additional voluntary review process for its managed care plans, the decision to file a request for the additional voluntary review of a grievance involving an adverse determination rests solely within the discretion of the covered person. This section is intended to be an optional additional level of review that the covered person may voluntarily use to resolve the issue in dispute after receiving an adverse determination upon completion of the review conducted under Section 7 of this Act. This section is not intended to be, and should not be considered to be, part of the requirements for the "full and fair review" of claim denials (known as adverse benefit determinations) under Section 503 of ERISA, as specified in the DOL final rule. As such, thissection is not required to be included in any internal claims and appeals process for purposes of complying with the DOL final rule published in the *Federal Register*, Nov. 21, 2000 or the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010.

A. (1) A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first level review decision made pursuant to Section 7 of this Act, or who are dissatisfied with the standard review decision made pursuant to Section 8 of this Act, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier.

(2) This section shall not apply to health indemnity plans.

B. (1) A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to Section 7G(6) or Section 8E(5) of this Act, as appropriate, of the option to file a request with the health carrier for an additional voluntary review of the first level review decision received under Section 7 of this Act or the standard review decision received under Section 8 of this Act.

(2) Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

(a) Request, within the time frame specified in Paragraph (3)(a), the opportunity to appear in person before a review panel of the health carrier's designated representatives;

(b) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;

(c) Present the covered person's case to the review panel;

(d) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(e) If applicable, ask questions of any representative of the health carrier on the review panel; and

(f) Be assisted or represented by an individual of the covered person's choice.

(3) (a) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within five (5) working days after the date of receipt of the notice sent in accordance with Paragraph (2).

(b) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

C. (1) (a) With respect to a voluntary review of a first level review decision made pursuant to Section 7 of this Act, a health carrier shall appoint a review panel to review the request.

(b) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to Subsection B(2), without regard to whether the information was submitted or considered in reaching the first level review decision.

(c) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2) (a) Except as provided in Subparagraph (b) of this paragraph, a majority of the panel shall be comprised of individuals who were not involved in the in the first level review decision made pursuant to Section 7 of this Act.

(b) An individual who was involved with the first level review decision may be a member of the panel or appear before the panel to present information or answer questions.

(c) The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to Section 7 of this Act are health care professionals who have appropriate expertise.

(d) Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, the reviewing health care professional shall not:

(i) Be a provider in the covered person's health benefit plan; and

(ii) Have a financial interest in the outcome of the review.

D. (1) (a) With respect to a voluntary review of a standard review decision made pursuant to Section 8 of this Act , a health carrier shall appoint a review panel to review the request.

(b) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2) (a) Except as provided in Subparagraph (b) of this paragraph, a majority of the panel shall be comprised of employees or representatives of the health carrier who were not involved in the standard review decision made pursuant to Section 8 of this Act.

(b) An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions.

E. (1) (a) Whenever a covered person or the covered person's authorized representative requests within the time frame specified in Subsection B(3)(a) the opportunity to appear in person before the review panel appointed pursuant to Subsection C or Subsection D, the procedures for conducting the review shall include the provisions described in this paragraph.

Drafting Note: Subsection E(1)(a) requires a covered person affirmatively to exercise the option to request a review meeting. A state may prefer to require a health carrier to provide a meeting unless a covered person acts to waive that right.

(b) (i) The review panel shall schedule and hold a review meeting within forty-five (45) working days after the date of receipt of the request.

(ii) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least fifteen (15) working days in advance of the date of the review meeting.

(iii) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative.

(c) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.

(d) In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or, if applicable, the covered person's authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.

(e) If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative at least fifteen (15) working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own.

Drafting Note: States may want to require the covered person or, if applicable, the covered person's authorized representative to notify the health carrier in advance of the review meeting date if the covered person plans to bring an attorney to the review meeting.

(f) The review panel shall issue a written decision, as provided in Subsection F, to the covered person or, if applicable, the covered person's authorized representative within five (5) working days of completing the review meeting.

(2) Whenever the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified timeframe provided under Subsection B(3)(a), the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in Subsection F, in writing or electronically, within forty-five (45) working days after the earlier of:

(a) The date the covered person or the covered person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or

(b) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to Subsection B(3)(a).

(3) For purposes of calculating the time periods within which a decision is required to be made and notice provided under Paragraphs (1) and (2), the time period shall begin on the date the request for an additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

F. A decision issued pursuant to Subsection E shall include:

(1) The titles and qualifying credentials of the members of the review panel;

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(3) The rationale for the review panel's decision;

(4) A reference to evidence or documentation considered by the review panel in making that decision;

(5) In cases concerning a grievance involving an adverse determination:

(a) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(b) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act]; and

Drafting Note: Subparagraph (b) should be adopted by states that have enacted an external review law equivalent to the NAIC Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Subparagraph (b).

(6) Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise paragraph (6) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Paragraph (6): "Notice of the covered person's right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner's office."

Section 10. Expedited Reviews of Grievances Involving An Adverse Determination

A. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

B. In addition to Subsection A, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

C. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

D. A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

Drafting Note: States should be aware that, with respect to appeals of adverse benefit determinations that are based in whole or in part on a medical judgment, the DOL final rule requires group health plans to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Subsection D is more stringent than the DOL final rule. It requires health carriers to designate a clinical peer or peers of the same or similar specialty to review the adverse determination. Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Subsection D.

E. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile or the most expeditious method available.

F. (1) An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with Subsection H as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

(2) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

Drafting Note: If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review request, Paragraph (2) requires that the health care service that is the subject of the adverse determination be continued without liability to the covered person until the covered person has been notified of the determination. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

G. For purposes of calculating the time periods within which a decision is required to be made under Subsection F, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

H. (1) A notification of a decision under this section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

(b) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

(c) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

(d) A statement of the reviewers' understanding of the covered person's grievance;

(e) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(f) A reference to the evidence or documentation used as the basis for the decision; and

(g) If the decision involves a final adverse determination, the notice shall provide:

(i) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

(v) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(vi) If applicable, instructions for requesting:

(I) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with Item (iv); or

(II) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Item (v);

(vii) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

Drafting Note: The language in Item (vii) should be adopted by states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Item (vii).

(viii) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

(ix) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(x) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to the any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise item (x) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Item (x): "Notice of the covered person's right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner's office."

Drafting Note: States should be aware that the DOL final rule sets out certain information that must be included in any notice to a claimant that involves an adverse benefit determination. Some of the information required to be provided in a notice under Subsection H(1), particularly the information required in Subsection H(1)(a) and (d) through (f), is not specifically required by the DOL final rule. For example, the DOL final rule does not require group health plans to automatically provide the title and qualifying credentials of medical experts participating in the first level review, as provided in Subsection H(1)(a). The DOL final rule requires group health plans to provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination. The DOL final rule does not address the other requirements in Subsection H(1)(a) and (d) through (f). Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, in revising this section, the NAIC has chosen to retain the provisions in Subsection H(1).

(2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

(b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:

(i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

(ii) Provide, upon request, a notice in any applicable non-English language; and

(iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.

(c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

(3) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.

(b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Section 11. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 12. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 13. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 14. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 769, 794-802 (adopted).
2002 Proc. 4th Quarter 281, 347-363 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174-175 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 15 (adopted by Plenary).
2010 Proc. 3rd Quarter, Vol. I, 115, 119, 130, 241, 606, 740-970 (amended).
2012 Proc. 1st Quarter, Vol. I, 98, 113, 116, 276-344 (amended).

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 420-5-6-.08 (1987).
Alaska			ALASKA ADMIN. CODE §§ 28.930 to 28.938 (2018).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. HEALTH & SAFETY CODE §§ 1368 to 1368.04 (1995/2020); §§ 1374.30 to 1374.35 (2000/2014); CAL. CODE REGS. tit. 10, § 1300.68 (1996); CAL. INS. CODE § 10169 (2000); NOTICE 11-5-2012 (2012).
Colorado			COLO. REV. STAT. §§ 10-16-113 to 10-16-113.7 (1997/2013); BULLETIN B-4.20 REVISED #4 (2017).
Connecticut			CONN. GEN. STAT. § 38a-182 (1990).
Delaware			18 DEL. ADMIN. CODE §§ 1301.1.0 to 1301-14.0 (2018).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. CODE §§ 44-301.01 to 44-304.01 (1998/2012).
Florida		FLA. STAT. § 641.511 (1991/2019).	
Georgia			GA. CODE ANN. § 33-20A-5 (1996); GA. COMP. R. & REGS. 120-2-80 (1998).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. § 41-3918 (1974).
Illinois			215 ILL. COMP. STAT. 130/3002 (1989).
Indiana			IND. CODE §§ 27-8-28-6 to 27-8-28-20 (2001/2003); 760 IND. ADMIN CODE 1-59-1 to 1-59-15 (1999/2003).
Iowa			IOWA ADMIN. CODE r. 441-88.8 (1986).
Kansas			KAN. ADMIN. REGS § 40-4-42g (1999).
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. § 22:267 (2009).
Maine	NO CURRENT ACTIVITY		
Maryland			MD. ANN. CODE §§ 15-10A-01 to 15-10A-10 (1999/2004); MD. ADMIN. CODE §§ 31.10.18.02 to 31.10.18.12 (1999/2005).
Massachusetts			958 MASS. CODE REGS. §§ 3.001 to 3.700 (2014).

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan			MICH. COMP. LAWS §§ 500.2213 to 500.2213c (1996/2013).
Minnesota			MINN. STAT. ANN. §§ 62Q.68 to 62Q.731 (2002).
Mississippi			MISS. CODE ANN. § 83-41-321 (1995).
Missouri			MO. REV. STAT. §§ 376.1350 to 376.1389 (1997); MO. REV. STAT. § 354.445 (1983).
Montana			MONT. CODE ANN. §§ 33-32-205 to 33-32-309 (2015).
Nebraska		NEB. REV. STAT. §§ 44-7301 to 44-7315 (1998/2013).	
Nevada			NEV. REV. STAT. §§ 695F.110 (1991); 695G.200 to 695G.230 (1997/2004); NEV. ADMIN. CODE § 689B.250 (1999).
New Hampshire			N.H. REV. STAT. ANN. §§ 420-J:1 to 420-J:6 (1998/2005).
New Jersey			N.J. STAT. ANN.§ 30:4D-7ff (4c) (2022) (grievance procedure).
New Mexico			N.M. STAT. ANN. § 59A-46-11 (1993); § 59A-57-6 (1998); N.M. CODE R. §§ 13.10.17.1 to 13.10.17.41 (2000/2016).
New York			N.Y. INS. LAW § 4802 (1996); N.Y. PUBLIC HEALTH LAW § 4408-a (1996); N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.14 (1985/1991).
North Carolina			N.C. GEN. STAT. § 58-50-62 (1998/2013).
North Dakota			N.D. CENT. CODE § 26.1-18.1-10 (1993).

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, § 6911 (2003).
Oregon			OR. REV. STAT. §§ 743B.250 to 743B.258 (1997/2003); OR. ADMIN R. 836-053-1060 to 836-053-1110 (1998).
Pennsylvania			40 PA. STAT. ANN. §§ 991.2161 to 991.2163 (1998); PA. CODE §§ 154.11 to 154.18 (2000).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. 20:06:34:10 to 20:06:34:12 (2003/2004).
Tennessee		TENN. CODE ANN. §§ 56-61-101 to 56-61-125 (2010).	
Texas	NO CURRENT ACTIVITY		
Utah			UTAH ADMIN. CODE R590-203-1 to R590-203-10 (2002/2005).
Vermont			VT. STAT. ANN. tit. 8, § 5102a (1993); VT. CODE R. § H-99-1 (1999).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-5804 (1998/2006); § 32.1-137.6 (1998).

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington			WASH. ADMIN. CODE §§ 284-43-4000 to 284-43-4040 (1999/2001).
West Virginia	W. VA. CODE R. § 114-96-1 to 114-96-8 (2014).		W. VA. CODE § 33-25A-12 (1995/2005); W. VA. CODE R. § 114-46-5 (1996).
Wisconsin			WIS. STAT. § 632.83 (1985); WIS. ADMIN. CODE INS. §§ 18.02 to 18.06 (2001/2006).
Wyoming			WYO. STAT. ANN. § 26-34-112 (1985/1995).

PROJECT HISTORY - 2012

REVISIONS TO HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT (#72)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Health Carrier Grievance Procedure Model Act* (#72) were made to reflect the provisions of the interim final regulations for internal claims and appeals and external review processes published in the *Federal Register* July 23, 2010, as revised by the interim final regulations published in the *Federal Register* June 24, 2011.

The interim final regulations published in the *Federal Register* June 24, 2011 made four changes to the interim final regulations published in the *Federal Register* July 23, 2010, that impacted this model and the *Utilization Review and Benefit Determination Model Act* (#73). The first change, which impacted the *Utilization Review and Benefit Determination Model Act* (#73) only, amended the interim final regulations to return to the requirement that a health insurance issuer make an initial determination for a claim involving an urgent care request within 72 hours. The second change, which impacted both models, eliminated the requirement that health insurance issuers automatically provide the diagnosis and treatment codes as part of a notice of an adverse benefit determination or final adverse benefit determination. The issuer must, however, notify claimants of their opportunity to request the codes.

The third change, which also impacted both models, revised the deemed exhaustion provisions in the interim final regulations to provide that, if a health insurance issuer's failure to strictly adhere to the internal claims and appeals procedure is de minimus—i.e., not reflective of a pattern—then there is no deemed exhaustion. The amendments also provide that the claimant be notified of his or her right to obtain an explanation of the issuer's basis that the failure to follow the procedure was de minimus. The last change, which also impacted both models, amends a provision in the interim final regulations related to the requirement that certain notices be provided to claimants in a culturally and linguistically appropriate manner. The amendment establishes for both the group and individual markets the trigger for when notices must be provided to a claimant in a culturally and linguistically appropriate manner—when 10% or more of the population residing in a claimant's county are literate only in the same non-English language. The amendment also requires a health insurance issuer to include in each notice sent to a claimant a one-sentence statement in the relevant non-English language about the availability of language services. Issuers are also required to provide a customer assistance process, such as a telephone hotline, with oral language services in the non-English language and to provide written notices in the non-English language.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force is responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair, Nebraska, Vice Chair, Alabama, Arkansas, California, Colorado, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Minnesota, Missouri, Montana, Nevada, New Jersey, N. Mariana Islands, Ohio, Oklahoma, Oregon, Utah, Vermont, Virginia, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. After the enactment of PPACA in March 2010, consistent with this charge, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by PPACA or, as necessary, develop new NAIC models to assist the states in implementing PPACA.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The revisions were drafted by the Regulatory Framework (B) Task Force. The Task Force held a conference call Sept. 1, 2011 and a person-to-person meeting at the 2011 Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Regulatory Framework (B) Task Force held a conference call Sept. 1, 2011 and a person-to-person meeting at the 2011 Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2010

REVISIONS TO HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT (#72)

1. Description of the Project, Issues Addressed, etc.

At the Summer National Meeting, the Regulatory Framework (B) Task Force adopted a work plan to revise NAIC models impacted by the Sept. 23 immediate reform provisions of the Patient Protection and Affordable Care Act (PPACA) and, for those PPACA Sept. 23 immediate reform provisions that do not fit into any existing NAIC model, to develop model language templates to assist the states in implementing those provisions. The revisions to the *Health Carrier Grievance Procedure Model Act* (#72) reflect the provisions of section 2719 of the Public Health Service Act (PHSA) of PPACA and the interim final regulations for internal claims and appeals and external review processes published in the *Federal Register* July 23. This model was revised in 2001 for consistency with the final regulations promulgated by the U.S. Department of Labor (DOL) in 2000 for the handling of health insurance claims under employer benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). The interim final regulations published in the *Federal Register* July 23 revise the DOL regulations; the revisions to the model reflect those revisions.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force is responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair, Idaho, Vice Chair, Alabama, Arkansas, California, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Minnesota, Montana, Nebraska, Nevada, New Hampshire, Ohio, Oregon, Pennsylvania, Utah, Vermont, Virginia, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. After the enactment of PPACA in March 2010, consistent with this charge, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by PPACA or, as necessary, develop new NAIC models to assist the states in implementing PPACA.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The revisions were drafted by the Regulatory Framework (B) Task Force. The Task Force held conference calls Sept. 13, 20 and 27, Oct. 4 and Nov. 1, 8 and 15 and a person-to-person meeting at the Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Regulatory Framework (B) Task Force held conference calls Sept. 13, 20 and 27, Oct. 4 and Nov. 1, 8 and 15 and a person-to-person meeting at the Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Utilization Review and Benefit Determination Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

This Act establishes standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

Section 3. Definitions

For purposes of this Act:

A. (1) "Adverse determination" means:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(2) "Adverse determination" includes a rescission of coverage determination.

Drafting Note: The federal Department of Labor's claims procedure final regulation (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, which establishes standards for the processing of claims under group health plans, uses the term "adverse benefit determination." This model act uses the term "adverse determination." The NAIC has chosen to continue to use the term "adverse determination" in this model act instead of using the DOL final rule's term "adverse benefit determination" because the term "adverse determination" is referenced in several other NAIC model acts in addition to this model act. If the terminology were changed, this would necessitate revising several NAIC model acts to reflect this change in terminology. The definition of "adverse determination" in Subsection A has been revised, however, to be consistent with the DOL final rule's definition for the term "adverse benefit determination." The definition of "adverse determination" has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, published in the *Federal Register*, July 23, 2010.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Act;

(2) A person authorized by law to provide substituted consent for a covered person;

(3) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(5) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

D. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

F. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Drafting Note: States may wish to define "clinical peer" more broadly to include a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

G. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

H. "Commissioner" means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

I. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term "concurrent claim" instead of "concurrent review." The DOL final rule does not define "concurrent claim." However, given the use of the term in the substantive provisions of the DOL final rule and the way the term is used substantively in this model, the definition of "concurrent review," as defined in Subsection I, is consistent with the term "concurrent claim."

J. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

K. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

L. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

M. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Drafting Note: The definition of "emergency medical condition" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

N. "Emergency services" means, with respect to an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

Drafting Note: The definition of "emergency services" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

O. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

P. (1) "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term "health insurance coverage." "Health benefit plan," as defined in this model act, is intended to be consistent with the definition of "health insurance coverage" contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses "excepted benefits," i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

(2) "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(3) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(6) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

Q. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not "corporate persons."

R. "Health care provider" or "provider" means a health care professional or a facility.

S. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

T. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: The Affordable Care Act uses the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" is consistent with the term "health insurance issuer."

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

U. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

V. "Network" means the group of participating providers providing services to a managed care plan.

W. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

X. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

Y. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term "pre-service claim" instead of "prospective review." The DOL final rule defines a "pre-service claim" as "any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care." The definition of "prospective review," as defined in Subsection Y, has been amended to be consistent with the intent of the definition of "pre-service claim" because both require prior approval of the benefit prior to its provision. The DOL final rule does not state what process the claimant must complete to obtain the approval, but, given the definition of "adverse benefit determination" in the DOL final rule, it is reasonable to conclude that performing utilization review would be an acceptable means to determine whether the provision of a health care service will be approved.

Z. (1) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(2) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Drafting Note: The definition of "rescission" is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

AA. (1) "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

(2) "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Drafting Note: The DOL final rule uses the term "post-service claim" instead of "retrospective review." The DOL final rule defines a "post-service claim" as "any claim for a benefit under a group health plan that is not a pre-service claim," as that term is defined under the DOL final rule. To reflect this broad definition of "post-service claim," the definition of "retrospective review," in Subsection AA, has been revised to be consistent with the definition of "post-service claim."

BB. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

CC. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

Drafting Note: The definition of "stabilized" is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

DD. (1) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(b) In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(2) (a) Except as provided in Subparagraph (b) of this paragraph, in determining whether a request is be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(b) Any request that an attending health care professional with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.

EE. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

FF. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

Section 4. Applicability and Scope

This Act shall apply to a health carrier offering a health benefit plan that provides or performs utilization review services. The requirements of this Act also shall apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf. This Act also shall apply to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations.

Drafting Note: The DOL final rule expands the scope and application of this model to include initial benefit determinations based on whether a covered person is eligible to participate in the health carrier's health benefit plan, as well as any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit. To be consistent with the DOL final rule, this section was revised to include these types of determinations as well as utilization review determinations that involve medical necessity. The definition of "adverse determination" in Section 3A has been revised to reflect the DOL final rule's definition of "adverse benefit determination." That term has also been revised to reflect the inclusion of rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010. Any denial, reduction, termination of or failure to provide or make payment, in whole or in part, based on a determination of the covered person's eligibility to participate in the health carrier's health benefit plan and any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit will be an adverse determination under this Act and, consequently, eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act. Rescission of coverage determinations are also eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act.

Drafting Note: The provisions of this Act are consistent with the provisions in the interim final regulations on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010 and, as those regulations were amended by the interim final regulations published in the *Federal Register* June 24, 2011. However, states should be aware that the Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

Drafting Note: States that regulate utilization review organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the appropriate commissioner instead of, or in addition to, the insurance commissioner

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a health carrier has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist. States should periodically review a health carrier's private accreditation and eligibility for deemed compliance.

Drafting Note: States that have defined and regulated limited benefit plans should compare their regulatory structure with the requirements of this Act and may want to exempt limited benefit plans from certain requirements that duplicate the existing structure or that are not appropriate for limited benefit plans because their services are less comprehensive. States that have not defined or regulated limited benefit plans may want to adopt a definition similar to the one above and decide which of the requirements of this Act are feasible and appropriate for these plans. Exemptions from the requirements of this Act should only be granted where the limited benefit plan does not perform the activity to which the requirement applies or where the technology necessary to comply does not exist for limited benefit plans. Exemptions should not be granted merely because compliance with the requirement would be expensive or inconvenient for the limited benefit plan.

States also may wish to consider whether Medicare supplement, long-term care of disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance is appropriate for inclusion in this Act.

Section 5. Corporate oversight of Utilization Review Program

A health carrier shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act and applicable regulations are met. The health carrier also shall ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Section 6. Contracting

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this Act and applicable regulations are met.

Section 7. Scope and Content of Utilization Review Program

A. (1) A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and non-delegated for:

(a) The filing of benefit requests;

(b) The notification of utilization review and benefit determinations; and

(c) The review of adverse determinations in accordance with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) The program document shall describe the following:

(a) Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;

(b) Data sources and clinical review criteria used in decision-making;

(c) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(d) Data collection processes and analytical methods used in assessing utilization of health care services;

(e) Provisions for assuring confidentiality of clinical and proprietary information;

(f) The organizational structure (e.g. utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and

(g) The staff position functionally responsible for day-to-day program management.

Section 8. Operational Requirements

A. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies.

Drafting Note: Each state should identify the agencies authorized to request a health carrier's clinical review criteria.

B. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

C. (1) A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of Sections 9 and 10 of this Act.

(2) (a) Whenever a health carrier fails to adhere to the requirements of section 9 or section 10 of this Act with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this Act and may take action under subparagraph (b) of this paragraph.

(b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act].

(ii) In addition to item (i), a covered person is entitled to pursue any available remedies under State or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(3) (a) Notwithstanding paragraph (2), the provisions of section 9 or section 10 of this Act shall not be deemed exhausted based on a *de minimus* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person or, if applicable, the covered person's authorized representative.

(b) The exception provided in subparagraph (a) of this paragraph does not apply if the violation is part of a pattern or practice of violations by the health carrier.

(c) (i) A covered person may request a written explanation of the violation from the health carrier.

(ii) The health carrier shall:

(I) Provide the written explanation within ten (10) days of receiving the request; and

(II) Include in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of this Act to be exhausted.

(d) (i) If an independent reviewer or a court of competent jurisdiction rejects the benefit request or claim for immediate review on the basis that the health carrier met the requirements of the exception provided in subparagraph (a) of this paragraph, the covered person has the right to resubmit and, as appropriate, pursue a review of the benefit request or claim under this Act or file a grievance pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].

(ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the benefit request or claim for immediate review, but not exceeding ten (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the benefit request or claim under this Act or file a grievance pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].

(iii) For purposes of calculating the time period for re-filing the benefit request or claim under this subparagraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative's receipt of the notice of opportunity to resubmit.

D. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

E. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

F. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

G. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

H. The health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction and risk management.

I. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

J. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination

K. (1) In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

(2) In ensuring the independence and impartially of individuals involved in making the utilization review or benefit determination, the health carrier shall not make decisions regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Section 9. Procedures for Standard Utilization Review and Benefit Determinations

A. A health carrier shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified time frames required under this section.

B. (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.

(ii) Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection F.

(b) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to Subparagraph (a) of this paragraph may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(ii) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(c) If the extension under Subparagraph (b) of this paragraph is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(i) Specifically describe the required information necessary to complete the request; and

(ii) Give the covered person or, if applicable, the covered person's authorized representative at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

(2) (a) Whenever the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

(b) (i) The notice required under Subparagraph (a) of this paragraph shall be provided, as soon as possible, but in no event later than five (5) days following the date of the failure.

(ii) The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing.

(c) The provisions of this paragraph shall apply only in the case of a failure that:

(i) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

C. (1) For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(a) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(b) The health carrier shall notify the covered person of the adverse determination in accordance with Subsection F at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act] and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

(2) The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person with respect to the internal review request made pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: Paragraph (2) requires health carriers to continue the health care service or treatment that is the subject of the adverse determination without liability to the covered person until the covered person has been notified of the determination made with respect to the appeal of the adverse determination involving a concurrent review request. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

D. (1) (a) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request.

(b) If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with Subsection F.

(2) (a) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to Paragraph (1) may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(ii) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(b) If the extension under Subparagraph (a) of this paragraph is necessary due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(i) Specifically describe the required information necessary to complete the request; and

(ii) Give the covered person or, if applicable, the covered person's authorized representative at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

E. (1) For purposes of calculating the time periods within which a determination is required to be made under Subsections B and D, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to Section 7 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(2) (a) If the time period for making the determination under Subsection B or D is extended due to the covered person's or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i) The date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

(ii) The date on which the specified information was to have been submitted.

(b) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in Subsection B or D, the health carrier may deny the certification of the requested benefit.

Drafting Note: The DOL final rule does not specifically state what actions a group health plan may take if the claimant or the claimant's authorized representative fails to submit the information requested before the end of the period of the extension. However, the provisions of Subsection E(2)(b), which would permit the health carrier to deny certification of the requested benefit if the covered person or the covered person's authorized representative does not submit the requested information within the specified time frame, are consistent with provisions of the DOL final rule. Therefore, the NAIC has chosen to retain the provisions of Subsection E(2)(b).

F. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(a) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

(b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], or a request for external review;

(c) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(d) Reference to the specific plan provisions on which the determination is based;

(e) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

(f) A description of the health carrier's grievance procedures established pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures;

(g) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

(h) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (g) of this paragraph; or

(j) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (h) of this paragraph; and

(k) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act], to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise subparagraph (k) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

(2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

(b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:

(i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

(ii) Provide, upon request, a notice in any applicable non-English language; and

(iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.

(c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

(3) If the adverse determination is a rescission, the health carrier shall provide in the advance notice of the rescission determination required to be provided under [insert reference to provision in State law or regulation related to the advance notice requirement of a proposed rescission], in addition to any applicable disclosures required under paragraph (1):

(a) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

(b) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act];

(d) A description of the health carrier's grievance procedures established pursuant to [insert reference in State law to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures; and

(e) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

(4) A health carrier may provide the notice required under this section in writing or electronically.

Drafting Note: Section 2719 of the PHSA of the Patient Protection and Affordable Care Act, and the interim final regulations implementing that section, as published in the *Federal Register* July 23, 2010, establish the NAIC's Uniform Health Carrier External Review Model Act as the minimum standard for state external review processes. Because the Uniform Health Carrier External Review Model Act references the procedures and timeframes in this Act and the NAIC's Health Carrier Grievance Procedure Model Act, states are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act. The Health Carrier Grievance Procedure Model Act sets out a process, including timeframes, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier under this Act.

Section 10. Procedures for Expedited Utilization Review and Benefit Determinations

A. (1) A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

(2) (a) As part of the procedures required under Paragraph (1), a health carrier shall provide that, in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request, the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

(b) The notice required under Subparagraph (a) of this paragraph:

(i) Shall be provided to the covered person or the covered person's authorized representative, as appropriate, as soon as possible, but not later than twenty-four (24) hours after receipt of the request; and

(ii) May be oral, unless the covered person or the covered person's authorized representative requests the notice in writing.

(c) The provisions of this paragraph apply only in the case of a failure that:

(i) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

B. (1) (a) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the health carrier.

(b) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

(2) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.

(b) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in Subparagraph (a) of this paragraph.

(c) The health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

(i) The health carrier's receipt of the requested specified information; or

(ii) The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified information.

(d) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in Subparagraph (b) of this paragraph, the health carrier may deny the certification of the requested benefit.

Drafting Note: The DOL final rule does not specifically state what actions a group health plan may take if the claimant or the claimant's authorized representative fails to submit the information requested by the plan before the end of the period of the extension. However, the provisions of Subsection B(2)(d), which would permit a health carrier to deny certification of the requested benefit if the covered person or the covered person's authorized representative does not submit the requested information within the specified time frame, are consistent with the provisions of the DOL final rule. Therefore, the NAIC has chosen to retain the provisions of Subsection B(2)(d).

(e) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

C. (1) For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the health carrier's receipt of the request.

(2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

D. For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 7 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

E. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(a) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

(b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], or a request for external review;

(c) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(d) Reference to the specific plan provisions on which the determination is based;

(e) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(f) A description of the health carrier's internal review procedures established pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures;

(g) A description of the health carrier's expedited review procedures established pursuant to [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act].

(h) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

(i) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(j) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with Subparagraph (h) of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Subparagraph (i) of this paragraph; and

(k) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act], to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise subparagraph (k) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

(2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

(b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:

(i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

(ii) Provide, upon request, a notice in any applicable non-English language; and

(iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.

(c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

(3) If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required under paragraph (1):

(a) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

(b) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) The date the health carrier made the decision to rescind the coverage; and

(d) The date when the advance notice of the health carrier's decision to rescind the coverage ends.

(4) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.

(b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Drafting Note: Section 2719 of the PHSA of the Patient Protection and Affordable Care Act, and the interim final regulations implementing that section, as published in the *Federal Register* July 23, 2010, establish the NAIC's Uniform Health Carrier External Review Model Act as the minimum standard for state external review processes. Because the Uniform Health Carrier External Review Model Act references the procedures and timeframes in this Act and the NAIC's Health Carrier Grievance Procedure Model Act, states are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act. The Health Carrier Grievance Procedure Model Act sets out a process, including timeframes, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier under this Act.

Section 11. Emergency Services

A. When conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

B. A health carrier shall cover emergency services to screen and stabilize a covered person in the following manner:

(1) Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

(2) Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;

(3) If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(4) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of subsection C(2); and

(5) Without regard to any other term or condition of coverage, other than:

(a) The exclusion of or coordination of benefits;

(b) An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act (PHSA); or

(c) Applicable cost-sharing, as provided in subsection C(1) or subsection C(2).

C. (1) For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.

(2) (a) For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

(b) Notwithstanding subparagraph (a) of this paragraph, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this subparagraph.

Drafting Note: The provisions of subparagraph (b) above would permit an out-of-network provider to balance bill the covered person for the excess of the amount the provider charged over the amount the health carrier paid, as provided in the interim final regulations on emergency services published in the *Federal Register* June 28, 2010. States should be aware that some states do not permit this practice under certain circumstances and may continue to prohibit such a practice based on the Affordable Care Act's preemption standards, which permit states to impose more stringent requirements to protect consumers.

(c) A health carrier complies with the requirements of this paragraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(i) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(ii) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(iii) The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

(d) (i) For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, subparagraph (c)(i) of this paragraph does not apply.

(ii) If a heath benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subparagraph (c)(i) of this paragraph is the median of these negotiated amounts.

(3) (a) Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

(b) A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.

(c) If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.

D. For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to designated representative twenty-four (24) hours a day, seven (7) days a week, to facilitate review.

Section 12. Confidentiality Requirements

A health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

Drafting Note: The NAIC's Health Information Privacy Model Act establishes more detailed standards.

Section 13. Disclosure Requirements

A. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

B. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

C. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

Section 14. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rule making and review of regulations].

Section 15. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 16. Separability

If any provisions of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 770, 802-809 (adopted).
2002 Proc. 4th Quarter 281, 333-347 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174-175 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 16 (adopted by Plenary).
2010 Proc. 3rd Quarter, Vol. I, 115, 119, 130, 242, 606, 740-953 (amended).
2012 Proc. 1st Quarter, Vol. I, 98-99, 113-116, 276, 285-344 (amended).

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-3A-1 to 27-3A-6 (1994).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.900 to 28.918 (2018).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-2501 to 20-2511 (1993/2014).
Arkansas			ARK. CODE. ANN. §§ 20-9-901 to 20-9-914 (1989/2019).
California			CAL. HEALTH & SAFETY CODE § 1363.5 (1999/2000); § 1367.01 (2000/2010).
Colorado		3 COLO. CODE REGS. § 702-4:4-2-17 (1997/2019).	COLO. REV. STAT. §§ 10-16-112 to 10-16-113 (1993/2019); § 10-4-115 (1993/2003); BULLETIN B-4.20 (REVISED #4) (2017).
Connecticut			CONN. GEN. STAT. §§ 38a-591 to 38a-591n (2011/2019); CONN. AGENCIES REGS. § 38a-591 (2012/2017).
Delaware			18 DEL. ADMIN. CODE §§ 1301-1.0 to 1301-14.0 (2007/2018).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. §§ 33-46-1 to 33-46-14 (1990/1996); GA. COMP. R. & REGS. 120-2-58 (1996/2002); 120-2-80 (1998/2002).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAWAII REV. STAT. §§ 334B-1 to 334B-8 (1991).
Idaho			IDAHO CODE ANN. §§ 41-5903 to 41-5917 (2009/2011).
Illinois			215 ILL. COMP. STAT. 134/85 (2000/2016).
Indiana			IND. CODE §§ 27-8-17-1 to 27-8-17-20 (1992/2015); 760 IND. ADMIN. CODE §§ 1-46-1 to 1-46-11 (2007/2013).
Iowa			IOWA CODE §§ 514F.1 to 514F.5 (1986/2010); IOWA ADMIN. CODE r. 191-70.1 to 191-70.9 (1992/1997).
Kansas			KAN. STAT. ANN. §§ 40-22a01 to 40-22a12 (1994/2014); KAN. ADMIN. REGS. § 40-4-41(1995/2016).
Kentucky			KY. REV. STAT. ANN. §§ 304.17A-600 to 304.17A-633 (2000/2017).
Louisiana			LA. REV. STAT. ANN. §§ 22:2391 to 22:2453 (2013/2017).

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine		02-031 ME. CODE R. ch. 850, §§ 1 to 12 (1997/2012).	ME. REV. STAT. ANN. tit. 24, §§ 2342 to 2345 (1989/1995); tit. 24-A, §§ 2771 to 2774 (1989/2015); 24-A, § 4304 (1995/2019); BULLETIN 265 (1997); BULLETIN 397 (2014).
Maryland			MD. CODE ANN., INS. §§ 15-10B-01 to 15-10B-14 (1988/2016); MD. CODE REGS. 31.10.21.01 to 31.10.21.12 (1994/2018); 31.10.18.01 to 31.10.18.12 (1999/2005).
Massachusetts			211 MASS. CODE REGS. 52.01 to 52.18 (2005/2017).
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 62M.01 to 62M.16 (1992/2017).
Mississippi			MISS. CODE ANN. §§ 41-83-1 to 41-83-31 (1990/1998).
Missouri		MO. REV. STAT. §§ 376.1350 to 376.1372 (1998/2019).	MO. CODE REGS. ANN. tit. 20, § 700-4.100 (1991/2007); tit. 20, §§ 400-10.010 to 400-10.250 (1997/2005).
Montana	MONT. CODE ANN. §§ 33-32-202 to 33-32-217 (1991/2019).		
Nebraska		NEB. REV. STAT. §§ 44-5416 to 44-5431 (1992/1998).	
Nevada			NEV. REV. STAT. §§ 683A.375 to 683A.379 (1991/2015); NEV. ADMIN. CODE §§ 683A.280 to 683.295 (1992/2010).
New Hampshire			N.H. REV. STAT. ANN. §§ 420-E:1 to 420-E:9 (1992/2016); N.H. CODE ADMIN. R. ANN. INS. 2001.01 to 2001.19 (1994/2018).

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. STAT. ANN. § 59A-57-4 (1998).
New York			N.Y. INS. LAW §§ 4900 to 4908 (1996/2019); N.Y. PUBLIC HEALTH LAW §§ 4900 to 4908 (1996/2019).
North Carolina			N.C. GEN. STAT. ANN. §§ 58-50-61 to 58-50-62 (1997/2013).
North Dakota			N.D. ADMIN. CODE §§ 26.1-26.4-01 to 26.1-26.4-05 (1991/2015); BULLETIN 92-1 (1992).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. §§ 1751.77 to 1751.86 (1997/2019).	OHIO REV. CODE ANN. § 1753.28 (1997) (emergency services).
Oklahoma			OKLA. STAT. tit. 36, §§ 6551 to 6565 (1991); OKLA. ADMIN. CODE. §§ 365:10-15-1 to 365:10-15-7 (1997/2010).
Oregon			OR. REV. STAT. §§ 743B.420 to 743B.425 (1997/2019); OR. ADMIN. R. §§ 836-053-1130 to 836-053-1140 (1998/2013) (small group).
Pennsylvania			40 PA. STAT. ANN. § 991.2152 (1921/1999).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 9421 to 9434 (2012) (previous version of model).
Rhode Island			R.I. GEN. LAWS §§ 27-18.9-1 to 27-18.9-15 (2017/2018).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina		S.C. CODE ANN. §§ 38-71-1920 to 2060 (2000/2001).	S.C. CODE ANN. §§ 38-70-10 to 38-70-60 (1990/1994); S.C. CODE ANN. REGS. 69-47 (1995).
South Dakota		S.D. CODIFIED LAWS §§ 58-17H-1 to 58-17H-52 (2011/2015).	S.D. ADMIN. R. 20:06:33 (1999/2013).
Tennessee			TENN. CODE ANN. §§ 56-6-701 to 56-6-706 (1992/2014).
Texas			28 TEX. ADMIN. CODE §§ 19-1701 to 19.1719 (2013/2019).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, § 4089a (1994/2013) (mental health review agents).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 32.1-137.7 to 32.1-137.17 (1998/2011).
Washington			WASH. ADMIN. CODE §§ 284-43-3000 to 284-43-3190 (2011/2016).
West Virginia	W. VA. CODE R. §§ 114-95-1 to 114-95-12 (2014).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2012

REVISIONS TO UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT (#73)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Utilization Review and Benefit Determination Model Act* (#73) were made to reflect the provisions of the interim final regulations for internal claims and appeals and external review processes published in the *Federal Register* July 23, 2010, as revised by the interim final regulations published in the *Federal Register* June 24, 2011.

The interim final regulations published in the *Federal Register* June 24, 2011 made four changes to the interim final regulations published in the *Federal Register* July 23, 2010, that impacted this model and the *Health Carrier Grievance Procedure Model Act* (#72) The first change, which impacted this model only, amended the interim final regulations to return to the requirement that a health insurance issuer make an initial determination for a claim involving an urgent care request within 72 hours. The second change, which impacted both models, eliminated the requirement that health insurance issuers automatically provide the diagnosis and treatment codes as part of a notice of an adverse benefit determination or final adverse benefit determination. The issuer must, however, notify claimants of their opportunity to request the codes.

The third change, which also impacted both models, revised the deemed exhaustion provisions in the interim final regulations to provide that, if a health insurance issuer's failure to strictly adhere to the internal claims and appeals procedure is de minimus—i.e., not reflective of a pattern—then there is no deemed exhaustion. The amendments also provide that the claimant be notified of his or her right to obtain an explanation of the issuer's basis that the failure to follow the procedure was de minimus. The last change, which also impacted both models, amends a provision in the interim final regulations related to the requirement that certain notices be provided to claimants in a culturally and linguistically appropriate manner. The amendment establishes for both the group and individual markets the trigger for when notices must be provided to a claimant in a culturally and linguistically appropriate manner—when 10% or more of the population residing in a claimant's county are literate only in the same non-English language. The amendment also requires a health insurance issuer to include in each notice sent to a claimant a one-sentence statement in the relevant non-English language about the availability of language services. Issuers are also required to provide a customer assistance process, such as a telephone hotline, with oral language services in the non-English language and to provide written notices in the non-English language.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force is responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair, Nebraska, Vice Chair, Alabama, Arkansas, California, Colorado, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Minnesota, Missouri, Montana, Nevada, New Jersey, N. Mariana Islands, Ohio, Oklahoma, Oregon, Utah, Vermont, Virginia, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. After the enactment of PPACA in March 2010, consistent with this charge, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by PPACA or, as necessary, develop new NAIC models to assist the states in implementing PPACA.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The revisions were drafted by the Regulatory Framework (B) Task Force. The Task Force held a conference call Sept. 1, 2011 and a person-to-person meeting at the 2011 Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Regulatory Framework (B) Task Force held a conference call Sept. 1, 2011 and a person-to-person meeting at the 2011 Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2010

REVISIONS TO UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT (#73)

1. Description of the Project, Issues Addressed, etc.

At the Summer National Meeting, the Regulatory Framework (B) Task Force adopted a work plan to revise NAIC models impacted by the Sept. 23 immediate reform provisions of the Patient Protection and Affordable Care Act (PPACA) and, for those PPACA Sept. 23 immediate reform provisions that do not fit into any existing NAIC model, to develop model language templates to assist the states in implementing those provisions. The revisions to the *Utilization Review and Benefit Determination Model Act* (#73) reflect the provisions of section 2719 of the Public Health Service Act (PHSA) of PPACA and the interim final regulations for internal claims and appeals and external review processes published in the *Federal Register* July 23. This model was revised in 2001 for consistency with the final regulations promulgated by the U.S. Department of Labor (DOL) in 2000 for the handling of health insurance claims under employer benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). The interim final regulations published in the *Federal Register* July 23 revised the DOL regulations. The revisions to the model reflect those revisions. In addition, the revisions to Section 11 of the model reflect the provisions of 2719A of the PHSA of PPACA related to emergency services and the interim final regulations published in the *Federal Register* June 28.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force is responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair, Idaho, Vice Chair, Alabama, Arkansas, California, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Minnesota, Montana, Nebraska, Nevada, New Hampshire, Ohio, Oregon, Pennsylvania, Utah, Vermont, Virginia, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. After the enactment of PPACA in March 2010, consistent with this charge, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by PPACA or, as necessary, develop new NAIC models to assist the states in implementing PPACA.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The revisions were drafted by the Regulatory Framework (B) Task Force. The Task Force held conference calls Sept. 13, 20 and 27, Oct. 4 and Nov. 1, 8 and 15 and a person-to-person meeting at the Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Regulatory Framework (B) Task Force held conference calls Sept. 13, 20 and 27, Oct. 4 and Nov. 1, 8 and 15 and a person-to-person meeting at the Fall National Meeting during which the draft and comments received on it were discussed. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY REPORT - 2003

UTILIZATION REVIEW AND HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT (#73)

1. Description of the project, issues addressed, etc.

The proposed amendments revise these model acts for compliance with the Department of Labor claims procedure final rule in order to avoid federal preemption. The Department of Labor claims procedure final rule became effective January 20, 2001. Group health plans must be in compliance with the final rule for claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but no later than January 1, 2003.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair
Arizona
California
Delaware
District of Columbia
Florida
Hawaii
Idaho
Illinois
Indiana
Kansas
Maryland
Mississippi
Missouri
Montana
New Hampshire
New Mexico
North Carolina
Ohio
Oklahoma
Pennsylvania
South Dakota
Vermont
Virginia
Washington

3. Project authorized by what charge and date first given to the group:

The following charge was given to the Regulatory Framework (B) Task Force in 2002:

Consider revisions to the Utilization Review Model Act and the Health Carrier Grievance Procedure Model Act as a result of the adoption of the Health Carrier External Review Model Act and the adoption of any pertinent federal law or regulation. Report by Winter 2002 National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The amendments were drafted by the task force. Numerous interested parties participated, including insurance industry representatives, such as the American Association of Health Plans (AAHP) and the Blue Cross and Blue Shield Association (BCBSA); and consumer groups, such as the Western Minnesota Legal Services.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Beginning with the 2001 Winter National Meeting, drafts of the amendments were reviewed and discussed at each National Meeting. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the amendments to the model acts were posted on the NAIC website.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

There were no significant discussion issues raised during the drafting process, except for the general issue of whether the NAIC models should be revised to mirror the exact language in the DOL final rule. The task force chose to revise the models to reflect the DOL final rule provisions only when necessary to avoid federal preemption. Provisions already contained in the models that were more protective of consumers were retained.

7. Any other important information (e.g., amending an accreditation standard).

None.

HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to:

A. Establish standards for the creation and maintenance of networks by health carriers; and

B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered services to covered persons; and

(2) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with Section 5 of this Act, including any requirements in Section 5E of this Act related to its availability to the public.

Drafting Note: In states that regulate prepaid health services, this Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons.

Section 3. Definitions

For purposes of this Act:

A. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

B. "Balance billing" means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.

C. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

D. "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

E. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

F. "Emergency medical condition" means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual's physical, mental or behavioral health or, with respect to a pregnant woman, the woman's or her [fetus'] [unborn child's] health in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or

(4) With respect to a pregnant woman who is having contractions:

(a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) That transfer to another hospital may pose a threat to the health or safety of the woman or [fetus] [unborn child].

G. "Emergency services" means, with respect to an emergency condition, as defined in Subsection F:

(1) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(2) Any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Drafting Note: States should be aware that the definition of "emergency services" above is derived from the federal definition for the term. Some states have developed a broader definition of "emergency services." For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state. States should be aware that if they use this definition of "emergency services," it could mean that emergency transportation is excluded from the special out-of-network cost-sharing protections applied to emergency services.

H. "Essential community provider" or "ECP" means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Pub.L.111-8.

Drafting Note: States should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers (ECPs) in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

I. "Facility" means an institution providing [physical, mental or behavioral] health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Drafting Note: States that regulate Medicaid managed care plans may wish to broaden this definition.

J. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

K. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified [physical, mental or behavioral] health care services consistent with their scope of practice under state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

L. "Health care provider" or "provider" means a health care professional, a pharmacy or a facility.

Drafting Note: A pharmacy is an entity where prescription drugs are prepared, compounded, preserved or dispensed. Many types of pharmacies provide a broad range of access for prescription drug benefits in the health care services delivered to a covered person. Any determination of network sufficiency should consider the broad range of pharmacy access points available to covered persons and that certain provisions of this Act may not apply to pharmacy. States should take note of the federal rules implementing the federal Affordable Care Act (ACA) that go into effect Jan. 1, 2017, which will require carriers providing essential health benefits (EHBs) in the individual and small group markets to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies (see Title 45 CFR – Subpart B – Essential Health Benefits Section 156.122(e)).

M. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance use disorders.

N. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the PHSA defines the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" above is consistent with the definition of "health insurance issuer" in Section 2791(b)(2) of the PHSA.

O. "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

P. "Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, dental benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope dental plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

Q. "Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, vision benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope vision plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

R. "Network" means the group or groups of participating providers providing services under a network plan.

S. "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

Drafting Note: The definition of "network plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other innovative delivery system models.

T. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

U. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

V. "Primary care" means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

Drafting Note: Many states may have an existing definition of "primary care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "primary care" needs to be defined for purposes of this Act using the definition above for "primary care" or the state's existing definition of "primary care."

W. "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

X. (1) "Specialist" means a physician or non-physician health care professional who:

(a) Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

(b) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

Y. "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

Drafting Note: Some states may have an existing definition of "specialty care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "specialty care" needs to be defined for purposes of this Act using the definition above for "specialty care" or the state's existing definition of "specialty care."

Z. "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

Drafting Note: States should review the definition of "telemedicine" or "telehealth" for consistency with any state laws or regulations related to telemedicine or telehealth.

AA. "Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Drafting Note: Health carriers may use different terms other than the term "tier" to refer to the type of network described in the definition above. State insurance regulators should be aware of this for purposes of the definition above and any changes a state may want to make to the definition above as a result, such as using another term or terms in place of or in addition to the term "tier."

BB. "To stabilize" means with respect to an emergency medical condition, as defined in Subsection F, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

Drafting Note: States should be aware that if they decide not to include the definition of "emergency services" using the language provided in Subsection G, it may not be necessary to include this definition.

CC. "Transfer" means, for purposes of Subsection BB, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(1) Has been declared dead; or

(2) Leaves the facility without the permission of any such person.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act applies to all health carriers that offer network plans.

B. The following provisions of this Act shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 5A(2) of this Act;

(2) Section 5F(7)(e), (8)(b) and (11) of this Act;

(3) Section 6L(2)(a)(i)(I) and (III) and (c)(iii)(III) of this Act;

(4) Section 8 of this Act;

(5) Section 9B(2) and (3) of this Act; and

(6) Section 9C(1)(a) and (b), (2) and (3) of this Act.

Drafting Note: In addition to Subsection B, states will need to consider what other types of health benefit plans subject to the insurance laws and regulations of this state that use networks should be subject to the requirements of this Act.

Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act's requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity or health carrier should provide the state with documentation that the health carrier and its networks have been accredited by the entity and make the underlying accreditation files available to the state upon request.

Section 5. Network Adequacy

A. (1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

Drafting Note: Particular attention should be given to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider. State insurance regulators should carefully review filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

Drafting Note: When determining criteria for evaluating network sufficiency provided in Subsection B, state insurance regulators also may want to consider a number of additional factors, such as the extent to which participating providers are accepting new patients, the degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care. State insurance regulators also may conduct or review available periodic surveys of covered persons and providers to help inform their monitoring of network adequacy and may choose to make the results publicly available.

Drafting Note: State insurance regulators should consider establishing network sufficiency and accessibility standards that are specific to limited scope dental and/or vision plans. Certain network sufficiency and accessibility requirements for comprehensive health benefit plans may not be appropriate for these type benefit plans. For example, hours of operation for dental offices are traditionally standard business hours and are not utilized to illustrate network sufficiency, nor is telehealth widely utilized in the dental and vision industry.

Drafting Note: Some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), limits on travel distance to providers, limits on travel time to providers and limits on waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

Drafting Note: For purposes of this paragraph, "specialized health care services or medical services" include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(b) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (2) as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

Drafting Note: In order to determine what may be considered "in a timely fashion," state insurance regulators may want to review the timeframes and notification requirements provided in its utilization review law or regulation.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Act nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Drafting Note: It is presumed that the health carrier shall make its process under this subsection available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify.

D. (1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

Drafting Note: If the commissioner determines that there is a deficiency in access to care for a limited scope dental and /or vision plan, the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

E. (1) Beginning [insert effective date], a health carrier shall file with the commissioner [for review] [for approval] prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act.

Drafting Note: States will establish different requirements for the access plan. Paragraph (1) provides for this by giving states the option to require a health carrier to file the access plan with the commissioner for approval before use. Paragraph (1) also gives states the option to require a health carrier to file the access plan with the commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In states that require a health carrier to file access plans with the commissioner for review, the commissioner may want to consider, for example, whether access to specific types of providers or health care services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

(b) For the purposes of this subsection, information is [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information.

Drafting Note: State insurance regulators should be aware that the intent of Paragraph (2) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is [proprietary, competitive or trade information] and, as such, no provision of the plan may be made public. State insurance regulators should review their open records laws in determining whether a particular provision, if any, of an access plan is [proprietary, competitive or trade secret] information and should not be made public based on information received from the health carrier supporting its request. For purposes of this paragraph, state insurance regulators also should review their laws or regulations to determine which term "proprietary," "competitive" or "trade secret" is appropriate to use or if some other term is more appropriate. State insurance regulators should rely on the state law or regulation that defines "trade secret" or "proprietary."

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

Drafting Note: State insurance regulators may want to consider defining "material change" for purposes of Paragraph (3) above. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material could include: 1) a significant reduction in the number of primary or specialty care physicians available in a network; 2) a reduction in a specific type of provider such that a specific covered service is no longer available; 3) a change to the tiered, multi-tiered, layered or multi-level network plan structure; or 4) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

Drafting Note: State insurance regulators should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

F. The access plan shall describe or contain at least the following:

(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:

(a) The plan's grievance and appeals procedures;

(b) Its process for choosing and changing providers;

(c) Its process for updating its provider directories for each of its network plans;

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(e) Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

Drafting Note: State insurance regulators should ensure that limited scope dental plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.

Drafting Note: Some states may have an existing definition of "urgent care" in their state laws or regulations. Those states that have an existing definition of "urgent care" may want to consider including that definition in this Act.

(8) The health carrier's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians; and

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

(12) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called "access plan" for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term "access plan."

Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a network plan shall satisfy all the requirements contained in this section.

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

Drafting Note: The reference to termination of coverage in Paragraph (1) above is meant to encompass all the ways a covered person's coverage can be terminated. The grounds, conditions and effective date of termination are dictated by other provisions of law, which are outside the scope of this Act, such as for nonpayment of premium or the performance of an act or practice that constitutes fraud or an intentional misrepresentation of material fact in connection with the coverage. State insurance regulators should keep this in mind in implementing Paragraph (1).

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

Drafting Note: Subsection D above provides that the obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under Subsection L.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F. (1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3) (a) Selection [and tiering] criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

(b) (i) In addition to Subparagraph (a) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (b)(i) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

Drafting Note: States should be aware that the provisions of Subparagraph (b) above are based in large part on the provisions of Section 2706(a) of the Public Health Service Act (PHSA). The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, issued on May 26, 2015, sub-regulatory guidance in the form of frequently asked questions (FAQs), which provides an enforcement safe harbor for health insurance issuers subject to Section 2706(a) of the PHSA. Specifically, in the Affordable Care Act Implementation FAQs Part XXVII, Q4 and Q5 issued May 26, 2015, the Departments restated their current enforcement approach to Section 2706(a) of the PHSA which is to not take any enforcement action against a health insurance issuer offering group or individual coverage, with respect to implementing the requirements of Section 2706(a) of the PHSA as long as the issuer is using a good faith, reasonable interpretation of the statutory provision.

(4) Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

Drafting Note: State insurance regulators should review how a health carrier markets or represents its network plans to consumers particularly for those network plans that carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

Drafting Note: The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law.

H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

I. A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

Drafting Note: States should be aware that the term "participating provider" is meant to include a health care professional acting within the scope of their authority who may not be in the typical physician office setting or hospital setting, and may include licensed, accredited or certified staff, such as patient care coordinators, operating under the supervision of a participating provider.

K. Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their of medical and health records.

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

Drafting Note: In addition to when a provider is removed or leaves the network without cause, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with Subparagraph (a) of this paragraph to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(c) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with Subparagraph (a) of this paragraph, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) For purposes of this paragraph, the following terms have the meanings indicated:

(i) "Active course of treatment" means:

(I) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;

(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) "Life-threatening health condition" means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) "Serious acute condition" means a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

(b) For purposes of Subparagraph (a)(i) of this paragraph, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an "active course of treatment."

(c) (i) When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under Paragraph (1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier's Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered person or the treating provider;

b. [Ninety (90) days] unless the Medical Director determines that a longer period is necessary;

c. The date that care is successfully transitioned to a participating provider;

d. Benefit limitations under the plan are met or exceeded; or

e. Care is not medically necessary.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When determining the length of time for the continuity of care period, states should consider the number of providers, especially specialty providers who are available to treat serious health conditions in their states. States that have relatively few specialists or where consumers face significant wait times for appointments may want to adjust the continuity of care time frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

(I) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

(II) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision plan participating provider, the commissioner may work with the plan's health carrier for approval of in-network benefits provided to the covered person until the episode of care is concluded.

Drafting Note: States may want to review other state laws and regulations and consider adding special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to have been a participating provider at the time of enrollment or when a participating provider was listed as accepting new patients, but was not accepting new patients at the time of enrollment.

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

Drafting Note: There are situations that may arise when using the mechanism established in accordance with Subsection Q above when a participating provider has verified an individual's eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation that may arise due to enrollment timing issues and other issues under the federal Affordable Care Act (ACA). Providers in this situation are permitted to bill the individual for payment of services provided. States may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility.

R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

T. (1) (a) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(b) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(c) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers

A. For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility's general business operations, and a covered person or the covered person's health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

Drafting Note: States should carefully review the definition of "facility-based provider" above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.

B. Non-emergency out-of-network services.

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

(b) That those facility-based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;

(c) That the service(s) therefore will be provided on an out-of-network basis;

(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;

(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and

(f) A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B of this Act.

(2) At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in Paragraph (1), and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

C. Out-of-network emergency services.

(1) For out-of-network emergency services, the non-participating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan's allowable amount is more than [$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a non-participating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act* (#73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

(4) This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in Subsection F.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

(3) Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

(5) A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.

Drafting Note: In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non-participating facility-based provider.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to facility-based health care professionals who are not in the same network as the facility. States may want to consider developing appropriate laws and regulations to apply notice and disclosure standards to facilities to advise covered persons of the potential for balance billing by non-participating providers performing covered services at those facilities.

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

Section 9. Provider Directories

A. (1) (a) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in Subsection C.

(b) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) (a) The health carrier shall update each network plan provider directory at least monthly.

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as participating providers who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; and 2) closely monitoring consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating that the provider is a participating provider, state insurance regulators should refer the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

(b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(a) In plain language, a description of the criteria the carrier has used to build its provider network;

(b) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(c) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(d) If applicable, note that authorization or referral may be required to access some providers.

(5) (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to Subsections B, C and D in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Participating office location(s);

(d) Specialty, if applicable;

(e) Medical group affiliations, if applicable;

(f) Facility affiliations, if applicable;

(g) Participating facility affiliations, if applicable;

(h) Languages spoken other than English, if applicable; and

(i) Whether accepting new patients.

(2) For hospitals:

(a) Hospital name;

(b) Hospital type (*i.e.* acute, rehabilitation, children's, cancer);

(c) Participating hospital location; and

(d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(a) Facility name;

(b) Facility type;

(c) Types of services performed; and

(d) Participating facility location(s).

C. For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Subsection B:

(1) For health care professionals:

(a) Contact information;

(b) Board certification(s); and

(c) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

D. (1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(a) For health care professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(b) For hospitals:

(i) Hospital name;

(ii) Hospital type (*i.e.* acute, rehabilitation, children's, cancer); and

(iii) Participating hospital location and telephone number; and

(c) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in Paragraph (1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain current provider directory information.

Drafting Note: In addition to the information provided in Subsections B, C and D health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination and diagnostic equipment and availability of programmatic accessibility.

Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision plans.

Section 10. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

I. Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

Section 11. Filing Requirements and State Administration

A. At the time a health carrier files its access plan, the health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

Drafting Note: States may want to review their open records laws to determine whether the sample contract forms filed under Subsection A are considered public information.

B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner [for approval] at least [cite period of time in the form approval statute] days prior to use.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file contracts and material changes for prior approval. A state should choose which option is appropriate for the state.

Drafting Note: States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person's access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

[C. If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, the contract or change is deemed approved.]

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 12. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 13. Enforcement

A. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

Drafting Note: The reference to requiring the health carrier to modify the access plan instead of instituting a corrective action is to reflect the idea that sometimes the network changes through no fault of the health carrier and in those instances, the commissioner may require the health carrier to modify the access plan to bring the health carrier into compliance with the network adequacy requirements of this Act.

Drafting Note: State insurance regulators may use a variety of tools and/or methods to determine a health carrier's ongoing compliance with the provisions of this Act and whether the health carrier's provider network is sufficient and provides covered persons with reasonable access to covered benefits. Such tools and/or methods include consumer surveys, reviewing and tracking consumer complaints and data collection on the use of out-of-network benefits.

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

Section 14. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 15. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 16. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

D. Transition period for compliance with amended Section 5 of this Act.

Option 1.

For states with access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.

Option 2.

For states without access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of Act or effective date of amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 767, 770-777 (adopted).
2015 Proc. 3rd Quarter 255-288 (amended)..

HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH BENEFI PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 420-5-6-.06 (1987/1999).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. ADMIN. CODE R20-6-1901 to R20-6-1921 (2005).
Arkansas		ARK. ADMIN. CODE 054.00.106-1 to 054.00.106-8 (2014).	
California			CAL. CODE REGS. tit. 10, §§ 2240 to 2240.7 (2008/2016).
Colorado	3 COLO. CODE REGS. § 702-4:4-2-53; § 702-4:4-2-54 (2017).		COLO. REV. STAT. §§ 10-16-701 to 10-16-709 (1997/2019); BULLETIN B-4.54 (2013).
Connecticut	CONN. GEN. STAT. § 38A-472F (2018).		
Delaware			DEL. CODE ANN. tit. 18, § 3371 (2017); 18 DEL. ADMIN. CODE § 1403-11.0 (2017) (managed care organizations).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 641.512 (1991/2003).
Georgia			GA. CODE ANN. §§ 33-20C-1 to 33-20C-6 (2016/2018) (provider directories).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431: 26-101 to 431: 26-110 (2017/2019) (portions of model).		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 77, § 240.60 (1990/2010); 215 ILL. COMP. STAT. ANN. §§ 124/1 to 124/99 (2017/2018) (portions of model).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. §§ 40-4601 to 40-4609 (1997/2001).
Kentucky			KY. REV. STAT. ANN. §§ 304.17A-500 to 304.17A-590 (1998/2018).
Louisiana			LA. REV. STAT. ANN. §§ 22:1019.1 to 22:1019.3 (2013).
Maine			02-031 ME. CODE R. ch. 850 §§ 1 to 12 (1997/2012); ME. REV. STAT. ANN. tit. 24-A, § 4303-D (2017) (provider directories).

HEALTH BENEFI PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland			MD. CODE REGS. §§ 31.10.44.01 to 31.10.44.09 (2017) (portions of model); MD. CODE ANN. INS. § 15-112.3 (1997/2016) (provider directory); § 19-705.1 (1986/2019); MD. CODE ANN. INS. §14-205.1 (2007/2018); §15-112 (1997/2018); §15-830 (1999/2019); § 31-115 (2011/2016); MD. CODE ANN. HEALTH – GEN. § 15-102.3 (1996/2019).
Massachusetts			211 MASS. CODE REGS. § 52.12 (2013/2017); BULLETIN B-2018-1 (2018).
Michigan			MICH. COMP. LAWS § 500.3428 (1956/2016).
Minnesota		MINN. STAT § 62K.01 to 62K.15 (2013/2019).	
Mississippi		19 MISS. ADMIN. CODE Pt. 3, §§ R. 14.1 to R. 14.13 (2014).	
Missouri		MO. REV. STAT. §§ 354.600 to 354.636 (1997/2018).	
Montana		MONT. CODE ANN. §§ 33-36-101 to 33-36-213 (1997/2003).	
Nebraska		NEB. REV. STAT. §§ 44-7101 to 44-7112 (1998/2007).	
Nevada			NEV. ADMIN. CODE §§ 687B.750 to 687B.784 (2016/2019) (portions of model).
New Hampshire			N.H. REV. STAT. ANN. §§ 420-J:1 to 420-J:14 (1998/2019).
New Jersey		N.J. ADMIN. CODE § 11:4-37.4 (1998/2019).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico			N.M. CODE R. § 13.10.22 (2009).
New York			N.Y. INS. LAW § 4804 (1996).
North Carolina			N.C. GEN. STAT. § 58-50-56(g) (1998/2018); § 58-3-245 (2001/2013); 11 N.C. ADMIN. CODE 20.0301 to 20.0304 (1996).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. ANN. tit. 36, § 6055 (O) (1971/2009).
Oregon			OR. REV. STAT. § 743B.202 (1997/2015); § 743B.505 (2015/2017); OR. ADMIN. R. 836-053-1190 (1998/2014).
Pennsylvania			40 PA. CONS. STAT. § 764a (1994); §§ 991.2101 to 991.2194 (1998/2006); §§ 1551 to 1567 (1972/2014); 31 PA. CODE §§ 154.1 to 154.18 (2000).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 9461 to 9471 (2011).	
Rhode Island			R.I. GEN. LAWS §§ 27-18.8-1 to 27-18.8-10 (1996/2017).
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS §§ 58-17F-1 to 58-17F-21 (2011/2015).
Tennessee		TENN. CODE ANN. § 56-7-2356 (1998/2008).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas			TEX. INS. CODE §§ 1301.005 to 1301.006 (2011); §§ 1301.0055 to 1301.0056 (2011); § 843.078(k) (2003) (HMO); § 843.082(1)(A)(i) (2001) (HMO); § 843.151(1)(B) (2001) (HMO); 28 TEX. ADMIN. CODE § 3.3704(f); § 3.3710 (2013); § 3.3722(c)(9) (2013); § 11.1607 (2021) (HMO); § 11.1610 (2021) (HMO).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington		WASH. ADMIN. CODE §§ 284-170-200 to 284-170-390 (1998/2016).	
West Virginia	W. VA. CODE §§ 33-55-1 to 33-55-10 (2020) (portions of model).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2015

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT (#74)

1. Description of the Project, Issues Addressed, etc.

In 2013, the Regulatory Framework (B) Task Force was charged to review NAIC existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, it was clear that revising the *Managed Care Plan Network Adequacy Model Act* (#74) was a priority for regulators, carriers and consumers. In addition, revising Model #74 became even more of a priority because of the concern that the federal Center for Consumer Information and Insurance Oversight (CCIIO) was, and still is, considering adopting regulations to establish federal network adequacy standards; i.e., a possible "one-size-fits-all" national standard. A federal one-size-fits-all national standard would not benefit consumers or health carriers. State insurance regulators are best positioned to balance cost, access and geographic considerations when developing network adequacy standards to ensure networks are sufficient so that consumers can access promised services without unreasonable delay.

In March 2014, the Regulatory Framework (B) Task Force established the Network Adequacy Model Review (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #74. In May 2014, the Subgroup began weekly calls—which became twice weekly calls—to receive input from various interested groups and consider possible revisions to Model #74. In November 2014, the Subgroup released an initial draft of proposed revisions to Model #74 with a Jan. 12, 2015, comment deadline. In response to the Subgroup's request for comment, the Subgroup received more than 100 comment letters. In February 2015, the Subgroup began meeting again via conference call twice weekly to review and discuss the comments. During its conference calls, the Subgroup discussed myriad issues, including how to deal with tiered networks, provider directory information and accuracy, "surprise bills" received by consumers for out-of-network services provided at participating facilities, essential community providers (ECPs) and limited scope dental and visions benefit plans. The Subgroup finished its review of the comments in August 2015 and released a second draft of proposed revisions to Model #74 with a Sept. 22, 2015, comment deadline. The Subgroup held three conference calls to discuss the comments received. The Subgroup adopted the proposed revisions to Model #74 Oct. 12, 2015, via conference call and submitted the draft to the Regulatory Framework (B) Task Force for its consideration. The Regulatory Framework (B) Task Force adopted the proposed revisions Oct. 22, 2015. The Health Insurance and Managed Care (B) Committee adopted the revisions Nov. 3, 2015.

The proposed revisions to Model #74 include a number of enhancements, including more specific requirements in Section 5—Network Adequacy concerning network sufficiency, how network sufficiency is to be determined and who is to determine network sufficiency. The revisions also add a new section concerning provider directories. This section describes what information must be included in both print and electronic directories to help consumers select a health benefit plan. It also includes a requirement for health carriers to periodically audit their provider directories for accuracy. The proposed revisions to Model #74 also include a new section, Section 7—Requirements for Participating Facility Providers with Out-of-Network Facility-Based Providers. This section addresses a narrow aspect of the so-called "surprise bill" issue (balanced billing) by establishing a mechanism for consumers to deal with bills they received for services provided by out-of-network facility-based providers while receiving treatment at an in-network facility. Section 7 also includes a provider mediation process for payment of out-of-network facility-based provider remittances for those providers who object to the amount of the payment they received for the out-of-network services they provided using the established payment rate. The proposed revisions to Model #74 also add a specific new section concerning provider directories. This new section establishes requirements for health carriers concerning the specific information that must be included in the directories for health care professionals, hospitals and other types of facilities to assist consumers in selecting a health benefit plan. It also includes requirements for carriers to help ensure the accuracy of the directories, including a periodic audit requirement.

2. Name of Group Responsible for Drafting the Model and States Participating

Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed revisions to Model #74. The members of the Subgroup were: Wisconsin, Chair; California; Colorado; Missouri; Montana; Nebraska; Nevada; New Mexico; Oregon; Rhode Island; Tennessee; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

Based on the charge below, the Regulatory Framework (B) Task Force established the Network Adequacy Model Review (B) Subgroup in March 2014 to consider revisions to Model #74.

"Continue to review the model law review recommendations of NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group to revise the NAIC model(s) prioritized for revision in 2014.—*Important*"

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2014 and ending in October 2015, the Subgroup reviewed and discussed all of the comments received as part of the drafting process. More than 100 different interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call twice weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2014 and ending in October 2015, the Subgroup reviewed and discussed all of the comments received. More than 100 different interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions with public comment deadlines was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call twice weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

A number of significant issues were raised and addressed. One of the issues was whether to, and if so, in what manner exempt limited scope dental and vision plans because the focus of Model #74 is on health benefit plans that provide major medical benefits. After several discussions, the Subgroup reviewed the draft and decided to exempt these types of limited benefit plans from specific provisions in Model #74 that would not make any sense to be applied to such plans.

Another major issue the Subgroup encountered was addressing the issue of "surprise bills." These are bills that consumers receive for services provided by non-participating providers in situations where the consumer may be in a participating facility, but while in the participating facility received services from a non-participating provider. The Subgroup decided to address one narrow aspect of the "surprise bill" issue in adding Section 7—Requirements for Participating Facilities with Non-Participating Facility-Based Providers. Section 7 sets out a process for payment of bills that consumers receive from non-participating facility-based providers for services provided at a participating facility.

The Subgroup also encountered a number of issues related to provider tiering. The Subgroup did not include specific provisions related to provider tiering, but included references to provider tiering throughout the draft, including a definition of "tiered network." The proposed revisions also include requirements in Section 9—Provider Directories for health carriers to include information in their directories identifying the tier within which each specific provider, hospital or other type of facility in the network is placed.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

Section-by-Section Summary of Proposed Revisions

Section 1. Short Title

The proposed revisions to Model #74 change the title to "Health Benefit Plan Network Access and Adequacy Act" in order to reflect network adequacy requirements apply to any health benefit plan that uses a network to provide covered benefits to covered persons, not just managed care plans.

Section 2. Purpose and Intent

The proposed revisions to Model #74 make clarifying revisions to this section. In addition, the revisions add language to this section specifically requiring health carriers to maintain and follow the access plans required under Section 5.

Section 3. Definitions

The proposed revisions to Model #74 add, revise and delete definitions to reflect the substantive changes made in the other sections of the Act. Among the new definitions are definitions of the terms "balance billing," "essential community provider," "limited scope dental plan," "limited scope vision plan," "network plan," and "telehealth or telemedicine." The proposed revisions to Model #74 delete definitions for the terms "closed plan," "health indemnity plan," "managed care plan" and "open plan."

Section 4. Applicability and Scope

The proposed revisions to Model #74 revise this section to have the model's provisions apply to all health carriers that offer network plans. In addition, the revisions include a carve out from having to comply with certain provisions of Model #74 for limited scope dental plans or limited scope vision plans because those provisions, which are focused on health benefit plans that offer comprehensive major medical benefits, are not suitable for the these types of limited benefit plans.

Section 5. Network Adequacy

The proposed revisions to Model #74 enhance the existing provisions of this section to more clearly state what will be considered a sufficient network and specifically require the domiciliary commissioner to determine network sufficiency in accordance with the requirements of this section. The proposed revisions include a requirement that health carriers have a process to ensure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or make other arrangements acceptable to the domiciliary commissioner, when: 1) the carrier has a sufficient network but does not have the type of participating provider available to provide the covered benefit or it does not have a participating provider available without unreasonable travel or delay; or 2) the carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay. The proposed revisions also enhance the type of information that carriers much describe or include in their access plans submitted to the domiciliary commissioner. The proposed revisions give the domiciliary commissioner the option to require health carriers to submit the access plan for prior approval or for review.

Section 6. Requirements for Health Carriers and Participating Providers

The proposed revisions to Model #74 clarify the provisions in this section concerning the continuity of care both in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause. The proposed revisions also add provider tiering to the health carrier selection standards and add an option for insurance commissioners not only review the standards, but also approve the standards. In addition, the proposed revisions require that a description in plain language of the standards that a health carrier uses for selecting and tiering participating providers be made available to the public.

The proposed revisions to Model #74 also require that at the time a contract is signed, a health carrier and, if appropriate, its intermediary, shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract. While the contract is in force, the carrier also is required to timely notify a participating provider of any changes to those provisions or documents that could result in material changes in the contract. The proposed revisions also require the health carrier to timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers

The proposed revisions to Model #74 add this section. This section sets out the requirements for addressing one narrow aspect of the so-called "surprise bill" issue in the situation where a covered person may receive for services provided at a participating facility by a non-participating facility-based provider. "Facility-based provider" is defined in this section as a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient facility or ambulatory facility setting. This section establishes limitations on balance billing for non-participating facility-based providers if the difference in the billed charge and the plan's allowable amount is more than $500. Health carriers are required to develop a program for payment of non-participating facility-based provider bills submitted to the carrier from the covered person. Under this program, the health carrier can elect to pay the non-participating facility-based provider bill as submitted or the health carrier may pay in accordance with the benchmark established in this section. The benchmark, which a state will set, for non-participating facility-based provider payments is presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [xx] percentage of the Medicare payment rate for the same or similar services in the same geographic area. In the drafting note for this section related to the benchmark, the proposed revisions discuss having a state use other default reimbursement methodologies, such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.

The proposed revisions to Model #74 also include an enforcement provision recognizing that some of the provisions of this section will have to be enforced by other appropriate state agencies in addition to the state insurance department. Similar language also is included in the provision concerning the adoption of regulations.

Section 8. Disclosure and Notice Requirements

The proposed revisions to Model #74 add this section. This section requires health carriers to develop a written disclosure or notice to be provided to covered persons at the time of pre-certification that the facility that is in the covered person's network there is the possibility that the covered person could be treated by a health care professional that is not in the same network. This section also specifies what information is to be included in the disclosure or notice, including informing covered persons of the options available to access covered services from a participating provider.

This section also requires a facility, as part of its contract with a health carrier, to develop a written disclosure or notice to be provided to covered persons within 10 days of an appointment for in-patient or outpatient services at the facility, or at the time of a non-emergency admission at the facility, confirming that the facility is a participating provider of the covered person's network plan and informing covered persons that certain health care professionals who may provide services to the covered person at the facility may not be a participating provider in the same network.

Section 9. Provider Directories

The proposed revisions to Model #74 add this section. This section establishes requirements for health carriers related to electronic and print provider directories. This section describes what general and specific information must be included in both print and electronic directories to enable consumers select a health benefit plan most appropriate to their needs. It also includes a requirement for health carriers to update their provider directories at least monthly and to periodically audit them for accuracy.

Section 10. Intermediaries

The proposed revisions to Model #74 add one new provision to this section specifying that to the extent a health carrier delegates its responsibilities under this model to an intermediary, the health carrier retains full responsibility for the intermediary's compliance with the requirements of this model.

Section 11. Filing Requirements and State Administration

The proposed revisions to Model #74 make a few clarifying changes to this section concerning the timing of filing sample contract forms. The revisions also provide options for each state to decide whether to require health carriers to file the sample contract forms and any material changes with the domiciliary commissioner for informational purposes or prior approval.

Section 12. Contracting

The proposed revisions to Model #74 make no changes to this section.

Section 13. Enforcement

The proposed revisions to Model #74 make clarifying changes to this section to require that if the domiciliary commissioner determines that a health carrier has not contracted with a sufficient number of participating providers, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with Model #74, or that a health carrier has not complied with a provision of this model, the domiciliary commissioner shall require the health carrier to modify its access plan or institute a corrective action plan, as appropriate, or the domiciliary commissioner may use any of the commissioner's other enforcement powers to obtain compliance with this model.

Section 14. Regulations

The proposed revisions to Model #74 make no changes to this section.

Section 15. Penalties

The proposed revisions to Model #74 make no changes to this section.

Section 16. Separability

The proposed revisions to Model #74 make no changes to this section.

Section 17. Effective Date

The proposed revisions to Model #74 add a transition period for compliance with the amended provisions of Section 5 of this model.

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Carrier External Review Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Act.

Drafting Note: This Act governs the processes relating to external review procedures only. For processes related to a health carrier's internal grievance procedures, see the NAIC Health Carrier Grievance Procedure Model Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier's internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a "final adverse determination," as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier's internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC's Utilization Review and Benefit Determination Model Act.

Section 3. Definitions

For purposes of this Act:

A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Drafting Note: The definition of "adverse determination" should be interpreted broadly to ensure that all adverse determinations where the covered person believes the treatment or service is medically necessary are eligible for external review in accordance with the provisions of this Act. It includes, for example, adverse determinations regarding cosmetic procedures, when the covered person requests the health care service on medical necessity grounds rather than for cosmetic reasons. It also includes adverse determinations related to out-of-network services, when the covered person requests health care services from a provider that does not participate in the health carrier's provider network because the clinical expertise of the provider may be medically necessary for treatment of the covered person's medical condition and that expertise is not available in the health carrier's provider network. States may wish to consider carving out adverse determinations related to out-of-network services depending on their regulatory structure relating to utilization review and out-of-network treatment decisions, including any concurrent jurisdiction among state agencies that may be applicable, in determining the scope of the external review process.

Denials of coverage based on a determination that a recommended or requested health care service or treatment is experimental also are adverse determinations. The NAIC believes, however, that the review of these denials should be subject to separate external review standards and procedures. Section 10 of this Act sets out external review standards and procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or treatment is experimental.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

D. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

F. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

G. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

H. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

I. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

J. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

K. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

L. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

M. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

N. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

O. "Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

P. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: States that do not require covered persons to exhaust a health carrier's internal grievance process procedures before filing a request for an external review should not adopt the definition of "final adverse determination" in Subsection P and should not use the term in the rest of the law.

Q. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

S. "Health care provider" or "provider" means a health care professional or a facility.

T. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

V. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) The provision of health care services to an individual; or

(3) Payment for the provision of health care services to an individual.

W. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

X. "Medical or scientific evidence" means evidence found in the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act

(4) The following standard reference compendia:

(a) The American Hospital Formulary Service–Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia–Drug Information;

(5) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) The federal Agency for Healthcare Research and Quality;

(b) The National Institutes of Health;

(c) The National Cancer Institute;

(d) The National Academy of Sciences;

(e) The Centers for Medicare & Medicaid Services;

(f) The federal Food and Drug Administration; and

(g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) Any other medical or scientific evidence that is comparable to the sources listed in Paragraphs (1) through (5).

Y. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

Z. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

AA. "Protected health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

BB. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

CC. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

DD. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

EE. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act shall apply to all health carriers that provide or perform utilization review.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Notice of Right to External Review

A. (1) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to Section 8, 9 or 10 of this Act and include the appropriate statements and information set forth in Subsection B at the time the health carrier sends written notice of:

(a) An adverse determination upon completion of the health carrier's utilization review process set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act]; and

(b) A final adverse determination.

(2) As part of the written notice required under Paragraph (1), a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]."

Drafting Note: States that have not established an external review program in the office of the commissioner, such as those states that adopt Option 3 in Sections 8 and 9 of this Act, should alter the language in Paragraph (2) as appropriate.

B. (1) The health carrier shall include in the notice required under Subsection A:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to Section 9 of this Act, or Section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(ii) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in [insert reference in state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section 6 of this Act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Section 7 of this Act; and

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 9 of this Act; or

(ii) If the final adverse determination concerns:

(I) An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Section 9 of this Act; or

(II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Section 10 of this Act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under Section 10 of this Act.

(2) In addition to the information to be provided pursuant to Paragraph (1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to Section 18 of this Act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

Drafting Note: States may wish to specify more particularly the information that must be included in the written notice.

(3) As part of any forms provided under Paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in [insert reference to state law equivalent to Section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

Option 1.

Drafting Note: The following Option 1 for Section 6A applies to states that choose to establish the external grievance process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner.

A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the commissioner.

Option 2.

Drafting Note: The following Option 2 for Section 6A applies to states that choose to establish responsibility for the external grievance process with the health carrier and require that covered persons file requests for external review with the health carrier.

A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the health carrier.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Section 7. Exhaustion of Internal Grievance Process

A. (1) Except as provided in Subsection B, a request for an external review pursuant to Section 8, 9 or 10 of this Act shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(a) Has filed a grievance involving an adverse determination pursuant to [insert reference in state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act]; and

(b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(3) Notwithstanding Paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to [insert reference in state law equivalent to the Utilization Review and Benefit Determination Model Act] until the covered person has exhausted the health carrier's internal grievance process.

B. (1) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) Under Section 9 of this Act if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) Under Section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review under Subparagraph (a), the independent review organization conducting the external review in accordance with the provisions of Section 9 or 10 of this Act shall determine whether the covered person shall be required to complete the expedited review process set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] before it conducts the expedited external review.

(c) Upon a determination made pursuant to Subparagraph (b) that the covered person must first complete the expedited grievance review process set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 9 of this Act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the heath carrier's internal grievance procedures as set forth in [insert reference to state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act] whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under Subsection B(2), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Section 8 or 10 of this Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier's internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a "final adverse determination," as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier's internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC's Utilization Review and Benefit Determination Model Act.

Drafting Note: States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this section.

Section 8. Standard External Review

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the external review process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. The commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan. After completion of the review, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Upon receipt of a request for an external review pursuant to Paragraph (1), the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

B. Within five (5) days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the assigned independent review organization shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.

D. (1) At the time a request is accepted for external review pursuant to Subsection C, the commissioner shall assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.

(2) In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier.

F. (1) The assigned independent review organization, shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person , if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) The independent review organization assigned pursuant to Subsection D shall provide its recommendation to the commissioner within thirty (30) days after the date of receipt of the request for an external review.

(2) The independent review organization shall include in its recommendation provided pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its recommendation;

(e) The principal reason or reasons for its recommendation;

(f) The rationale for its recommendation; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

(3) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

J. (1) The commissioner shall notify the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the decision to uphold or reverse the adverse determination or the final adverse determination within fifteen (15) days after the date of receipt of the selected independent review organization's recommendation provided pursuant to Subsection I(1).

(2) The commissioner shall include in the notice sent pursuant to Paragraph (1):

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided by the selected independent review organization in regard to its recommendation pursuant to Subsection I(2); and

(b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Upon receipt of a request for an external review pursuant to Paragraph (1), the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

B. Within five (5) days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meeting the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.

D. (1) At the time a request for external review is accepted pursuant to Subsection C, the commissioner shall assign an independent review organization to conduct the external review that has been approved pursuant to Section 13 of this Act.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person , if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the documents or information is available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or final adverse determination to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the external review process with the health carrier and require that covered persons file requests for external review with the health carrier. This option also requires the health carrier to assign an independent review organization from the list of approved independent review organizations compiled by the commissioner to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier.

(2) Upon receipt of a request for external review pursuant to Paragraph (1), the health carrier shall send a copy of the request to the commissioner.

B. At the time the health carrier receives a request for an external review, the health carrier shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 12 of this Act to conduct a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Within five (5) days after receipt of the request for external review, the independent review organization assigned pursuant to Subsection B shall complete the preliminary review and immediately notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) The assigned independent review organization shall include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review.

(3) If the request:

(a) Is not complete, the assigned independent review organization shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the assigned independent review organization shall inform the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner in writing of the reasons for its nonacceptance.

D. (1) Whenever a request for external review is accepted for external review following the preliminary review conducted pursuant to Subsection C, the assigned independent review organization shall notify the health carrier and the commissioner.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model and Benefit Determination Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Section D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to Subsection C(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), the assigned independent review organization immediately shall forward the information to the health carrier.

G. (1) Upon receipt of the information, if any, required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person , if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the health carrier to conduct the preliminary review of the external review request;

(c) The date the external review was conducted, if appropriate;

(d) The date of its decision;

(e) The principal reason or reasons for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 9. Expedited External Review

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the expedited external review process in the office of the commissioner and require covered persons make all requests for an expedited external review with the commissioner. This option requires the commissioner to assign the conduct of the expedited external review to an independent review organization if the request has met specified requirements to be eligible for an expedited external review. The assigned independent review organization is required to provide to the commissioner with a recommendation on whether to uphold or reverse the adverse determination or final adverse determination.

A. Except as provided in Subsection H, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:

(1) Notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request; and

(2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the expedited external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

C. In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

D. At the time the health carrier receives the notice pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

E. In addition to the documents and information provided or transmitted pursuant to Subsection D, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

F. (1) The assigned independent review organization shall provide its recommendation to the commissioner as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than forty-eight (48) hours after the date the commissioner received the request for an expedited external review pursuant to Subsection A.

(2) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

G. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than twenty-four (24) hours after receiving the recommendation of the assigned independent review organization as required pursuant to Subsection F, the commissioner shall complete the review of the independent review organization's recommendation and notify the covered person, if applicable, the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or final adverse determination.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the commissioner shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier; and

(b) Include the information set forth in Section 8J(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

H. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons make all requests for an expedited external review with the commissioner. If the request has met specified requirements to be eligible for an expedited external review, the commissioner then immediately assigns an independent review organization to conduct the expedited external review.

A. Except as provided in Subsection G, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:

(1) Notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request; and

(2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 13 of this Act to conduct the review and to make a decision to uphold or reverse the adverse determination or final adverse determination.

C. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

D. At the time the health carrier receives the notice pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

E. In addition to the documents and information provided or transmitted pursuant to Subsection D, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

F. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in Section 8 I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

G. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the expedited external review process with the health carrier and require that covered persons file requests for an expedited external review with the health carrier. This option also requires the health carrier to assign an approved independent review organization to conduct an expedited external review of the request if the request has satisfied specified requirements to be eligible for an expedited external review.

A. Except as provided in Subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the health carrier at the time the covered person receives:

(1) An adverse determination if:

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. (1) At the time the health carrier receives a request for an expedited external review, the health carrier immediately shall:

(a) Assign an independent review organization from the list compiled and maintained pursuant to Section 13 of this Act to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review if the request meets the reviewability requirements of Section 8B of this Act; and

(b) Send a copy of the request to the commissioner.

(2) In reaching a decision in accordance with Subsection E, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

C. At the time the health carrier assigns an independent review organization to conduct the expedited external review pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to Subsection C, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Section 8B of this Act, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in Section 8I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 10. External Review of Experimental or Investigational Treatment Adverse Determinations

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the external review process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. The commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan. After completion of the review, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review that meets the reviewability requirements of Subsection C, the commissioner immediately shall assign an independent review organization as set forth in Subsection E to conduct the review.

B. (1) Upon receipt of a request for external review pursuant to Subsection A, the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

(2) For an expedited external review request made pursuant to Subsection A(2), at the time the health carrier receives the notice pursuant to Paragraph (1), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.

C. Except for a request for an expedited external review made pursuant to Subsection A(2), within five (5) days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(a) Reasonably appears to be a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one of the following situations is applicable:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(b) Standard health care services or treatments are not medically appropriate for the covered person; or

(c) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in Paragraph (4);

(4) The covered person's treating physician:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(b) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

D. (1) Upon completion of the preliminary review pursuant to Subsection C, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the reasons for its nonacceptance.

E. (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D, the commissioner shall assign an independent review organization that has been approved pursuant to Section 13 of this Act that:

(a) Will be responsible for selecting one or more clinical peer reviewers, as it determines is appropriate, to conduct the external review; and

(b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, shall provide a recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.

(2) (a) Immediately upon assignment under Paragraph (1), the independent review organization shall select one or more clinical peer reviews to conduct the external review.

(b) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the independent review organization on whether the recommended or requested health care service or treatment should be covered.

(3) (a) In selecting clinical peer reviewers pursuant to Paragraph (2)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 14 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

F. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person, the covered person's authorized representative, if applicable, and the health carrier.

G. (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

H. (1) Upon receipt of the information required to be forwarded pursuant to Subsection G(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and

(d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(4)(a) or (b).

(3) (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.

(b) If the opinion provided in accordance with Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).

J. In addition to the documents and information provided pursuant to Subsection B(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:

(1) The covered person's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional; and

(4) Whether:

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or

(b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

K. (1) (a) Except as provided in Subparagraph (b), within ten (10) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a recommendation and provide written notice of the recommendation to the commissioner.

(b) (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a recommendation and provide notice of the recommendation orally or in writing to the commissioner.

(ii) If the recommendation provided under Item (i) was not in writing, within two (2) days after the date of providing the recommendation, the assigned independent review organization shall provide written confirmation of the recommendation to the commissioner and include the information set forth in Paragraph (3).

(2) (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall recommend to the commissioner that the health carrier's adverse determination or final adverse determination be reversed.

(b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall recommend to the commissioner that the health carrier's adverse determination or final adverse determination be upheld.

(c) (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a recommendation to the commissioner based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).

(ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.

(iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a recommendation to the commissioner based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).

(3) The independent review organization shall include in the recommendation provided pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(d) The date the external review was conducted;

(e) The date of its recommendation;

(f) The principal reason or reasons for its recommendation; and

(g) The rationale for its recommendation.

(4) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), the commissioner immediately shall review the recommendation to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the recommendation is experimental or investigational, the recommendation is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "experimental" or "investigational" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

L. (1) (a) Except as provided in Subparagraph (b), within ten (10) days after the date of receipt of the assigned independent review organization's recommendation provided pursuant to Subsection K, the commissioner shall complete the review and notify the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the decision.

(b) For an expedited external review, within two (2) days after the date of receipt of the assigned independent review organization's recommendation provided pursuant to Subsection K, the commissioner shall complete the review and orally or in writing notify the covered person, the covered person's authorized representative, if applicable, and the health carrier of the decision.

(2) The commissioner shall include in a written notice sent pursuant to Paragraph (1):

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided by the assigned independent review organization in regard to its recommendation pursuant to Subsection K; and

(b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.

(3) If the notice provided pursuant to Paragraph (1)(b) was not in writing, within two (2) days after the date of providing that notice, the commissioner shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier; and

(b) Include the information set forth in Paragraph (2).

(4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review that meets the reviewability requirements of Subsection C, the commissioner immediately shall assign an independent review organization as set forth in Subsection E to conduct the review.

B. (1) Upon receipt of a request for external review pursuant to Subsection A, the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

(2) For an expedited external review request made pursuant to Subsection A(2), at the time the health carrier receives the notice pursuant to Paragraph (1), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.

C. Except for a request for an expedited external review made pursuant to Subsection A(2), within five (5) days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(a) Reasonably appears to be a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one of the following situations is applicable:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(b) Standard health care services or treatments are not medically appropriate for the covered person; or

(c) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in Paragraph (4);

(4) The covered person's treating physician:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(b) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

D. (1) Upon completion of the preliminary review pursuant to Subsection C, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the reasons for its nonacceptance.

E. (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D, the commissioner shall assign an independent review organization that has been approved pursuant to Section 13 of this Act that:

(a) Will be responsible for selecting one or more clinical peer reviewers, as it determines is appropriate, to conduct the external review; and

(b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, shall make a decision to uphold or reverse the adverse determination or final adverse determination.

(2) (a) Immediately upon assignment under Paragraph (1), the independent review organization shall select one or more clinical peer reviewers to conduct the external review.

(b) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the independent review organization on whether the recommended or requested health care service or treatment should be covered.

(3) (a) In selecting clinical peer reviewers pursuant to Paragraph (2)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 14 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

F. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person, the covered person's authorized representative, if applicable, and the health carrier.

G. (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

H. (1) Upon receipt of the information required to be forwarded pursuant to Subsection G(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and

(d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(5)(a) or (b).

(3) (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.

(b) If the opinion provided in accordance with Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).

J. In addition to the documents and information provided pursuant to Subsection B(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:

(1) The covered person's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "experimental" or "investigational" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) Whether:

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or

(b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

K. (1) (a) Except as provided in Subparagraph (b), within twenty (20) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a decision and provide written notice of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a decision and provide notice of the decision orally or in writing to the persons listed in Subparagraph (a).

(ii) If the notice provided under Item (i) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in Subparagraph (a) and include the information set forth in Paragraph (3).

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to commissioner under Subsection K(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(c) (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).

(ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.

(iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).

(3) The independent review organization shall include in the notice provided pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(d) The date the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision; and

(g) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the external review process with the health carrier and require that covered persons file requests for external review with the health carrier. This option also requires the health carrier to assign an independent review organization from the list of approved independent review organizations compiled by the commissioner to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the health carrier.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review, the health carrier immediately shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 13 of this Act to determine whether the request meets the reviewability requirements of Subsection C and, if the request meets those requirements, conduct the review pursuant to Subsection E.

(c) At the time the health carrier assigns an independent review organization to review the request and, if appropriate, conduct the expedited external review pursuant to Subparagraph (b), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

B. Upon receipt of a request for external review under Subsection A, the health carrier shall send a copy of the request to the commissioner.

C. Except for a request for an expedited external review made pursuant to Subsection A(2), at the time the health carrier receives a request for an external review, the health carrier shall assign an independent review organization from the list of approved independent review organizations complied and maintained by the commissioner pursuant to Section 13 of this Act to conduct a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(a) Reasonably appears to be a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one of the following situations is applicable:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(b) Standard health care services or treatments are not medically appropriate for the covered person; or

(c) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in Paragraph (4);

(4) The covered person's treating physician:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(b) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

D. (1) Within five (5) days after receipt of the request for external review, the independent review organization assigned pursuant to Subsection C shall complete the preliminary review and immediately notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) The assigned independent review organization shall include in the notice provided pursuant to Paragraph (1) a statement that the covered person or, if applicable, the covered person's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review.

(3) If the request:

(a) Is not complete, the assigned independent review organization shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the assigned independent review organization shall inform the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner in writing of the reasons for its nonacceptance.

(4) Whenever a request for external review is accepted for external review, the assigned independent review organization shall notify the health carrier and the commissioner.

E. (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D(1), the assigned independent review organization shall:

(a) Immediately select one or more clinical peer reviewers, as it determines is appropriate, pursuant to Paragraph (2) to conduct the external review; and

(b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(2) (a) In selecting clinical peer reviewers pursuant to Paragraph (1)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 14 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(3) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

F. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(4), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

G. (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the assigned independent review organization immediately shall forward the information to the health carrier.

H. (1) Upon receipt of the information required to be forwarded pursuant to Subsection G(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and

(d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(5)(a) or (b).

(3) (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.

(b) If the opinion provided pursuant to Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).

J. In addition to the documents and information provided pursuant to Subsection A(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:

(1) The covered person's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "experimental" or "investigational" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) Whether:

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or

(b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

K. (1) (a) Except as provided in Subparagraph (b), within twenty (20) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization, in accordance with Paragraph (2), shall make a decision and provide written notice of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization, in accordance with Paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in Subparagraph (a).

(ii) If the notice provided under Item (i) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in Subparagraph (a) and include the information set forth in Paragraph (3).

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to commissioner under Subsection K(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(c) (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).

(ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.

(iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).

(3) The independent review organization shall include in the notice provided pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization received the assignment from the health carrier to conduct the preliminary review of the external review request;

(d) The date the external review was conducted, if appropriate;

(e) The date of its decision;

(f) The principal reason or reasons for its decision; and

(g) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

L. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 11. Binding Nature of External Review Decision

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to follow Option 1 for Sections 8 and 9 of this Act in establishing their external review processes where the commissioner makes the external review decision.

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

Drafting Note: States may wish to review their administrative procedure rules to see how they impact this section. In their review, states should pay particular attention to whether health carriers have a right to an automatic stay for any departmental decision, including an external review decision.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose to follow Option 2 or Option 3 for Sections 8 and 9 of this Act in establishing their external review processes where the independent review organization makes the external review decision.

A. An external review decision is binding on the health carrier.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Drafting Note: Regardless of whether a state uses Option 1 or Option 2 for this section of this Act, states may wish to add a provision that specifies whether an external review decision made in accordance with this Act is subject to the state's Administrative Procedure Act.

Section 12. Filing Fees (Optional)

A. Except in the case of a request for an expedited external review, at the time of filing a request for external review, the covered person or the covered person's authorized representative shall submit to the commissioner with the request a filing fee of [$25].

B. The commissioner may waive the filing fee upon a showing of undue financial hardship.

C. The filing fee shall be refunded to the person who paid the fee if the external review results in the reversal of the health carrier's adverse determination or final adverse determination that was the subject of the external review.

Drafting Note: This section is optional. Many states do not require filing fees for external reviews.

Section 13. Approval of Independent Review Organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act to ensure that an independent review organization satisfies the minimum qualifications established under Section 14 of this Act.

B. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

C. (1) Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 14 of this Act.

(2) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and reapproval.

D. (1) An approval is effective for two (2) years, unless the commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under Section 14 of this Act.

(2) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum requirements established under Section 14 of this Act, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to Subsection E.

E. The commissioner shall maintain and periodically update a list of approved independent review organizations.

F. The commissioner may promulgate regulations to carry out the provisions of this section.

Drafting Note: Instead of requiring the commissioner to approve independent review organizations, states may wish to consider accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established pursuant to Section 14 of this Act. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards for independent review organizations meet or exceed the minimum qualifications established pursuant to Section 14 of this Act. The private accrediting entity shall file or provide the state with documentation that an independent review organization has been accredited by the entity. An independent review organization accredited by the private accrediting entity then would be deemed to have met the requirements of this section and Section 14 of this Act except for the requirement that the independent review organization maintain the information required under Section 16 of this Act. States should periodically review an independent review organization's private accreditation and eligibility for deemed compliance. Also, states may wish to consider utilizing a mechanism for monitoring the performance of an independent review organization, such as a peer review organization.

Section 14. Minimum Qualifications for Independent Review Organizations

A. To be approved under Section 13 of this Act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in Sections 8 and 9 of this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Act;

(2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

Drafting Note: Paragraph (2) may not be necessary if the office of the commissioner is involved in the external review process. In such a case, the commissioner should maintain a toll-free telephone number for this purpose.

(3) Agree to maintain and provide to the commissioner the information set out in Section 16 of this Act.

B. All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in Subsection A, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

D. (1) In addition to the requirements set forth in Subsections A, B and C, to be approved pursuant to Section 13 of this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Paragraph (1), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in Paragraph (1), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

Drafting Note: In applying Subsection D, states should be aware that conflict of interest questions involving independent review organizations and clinical peer reviewers might arise in a variety of situations. For example, conflict of interest questions may arise when a health care provider, including a physician or other health care professional, who is a clinical peer reviewer for an independent review organization or an academic medical center, or other similar medical research center, which is seeking to be an approved independent review organization, has a contract to provide health care services to enrollees of the health carrier that is the subject of an external review or when a health care provider, including a physician or other health care professional, who is a clinical peer reviewer for an independent review organization, has staff privileges at the facility where the recommended health care service or treatment would be provided if the health carrier's adverse or final adverse determination is reversed. The question for states to consider is whether a relationship or connection with persons involved in an external review is a material conflict of interest such that the objectivity of the independent review organization to be assigned to conduct the external review or any clinical peer reviewer to be assigned by the independent review organization to conduct the external review may actually be or may perceived to be negatively impacted. Whether the relationship or connection is a material conflict of interest will depend on the characteristics of each state's market. Therefore, states should consider adding provisions to this section that provide additional guidelines or procedures to address this issue given their local market characteristics.

Section 15. Hold Harmless for Independent Review Organizations

No independent review organization or clinical peer reviewer working on behalf of an independent review organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this Act, unless the opinion was rendered in bad faith or involved gross negligence.

Section 16. External Review Reporting Requirements

A. (1) An independent review organization assigned pursuant to Section 8 or Section 9 of this Act to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the commissioner, as required under Paragraph (2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to Paragraph (1) for which it was assigned to conduct an external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate and for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(c) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(e) The number of external reviews pursuant to Section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(f) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. (1) Each health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier or that the health carrier receives notice of from the commissioner pursuant to this Act.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to Paragraph (1) shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate and by type of health benefit plan:

(a) The total number of requests for external review;

(b) From the number of requests for external review that are filed directly with the health carrier, the number of requests accepted for a full external review;

(c) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(d) The average length of time for resolution;

(e) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(f) The number of external reviews pursuant to Section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(g) Any other information the commissioner may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 17. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 18. Disclosure Requirements

A. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

B. The description required under Subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

Drafting Note: States that have not established an external review process in the office of the commissioner, such as those states that adopt Option 3 in Sections 8 and 9 of this Act, may wish to use the following provision in Subsection B: "The description required under Subsection A shall include a statement of the right of the covered person to contact the commissioner for assistance at any time. The statement shall include the telephone number and address of the commissioner."

C. In addition to Subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 19. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 20. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 21. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 3rd Quarter 8, 21, 856, 856-878, 954 (adopted).
2000 Proc. 2nd Quarter 21, 22, 163, 172, 175, 176-194 (amended).
2003 Proc. 4th Quarter 389, 527, 534-572 (amended, adopted by parent committee).
2004 Proc. 1st Quarter 52 (adopted by Plenary).

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.07.005 (2016).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-2537 to 20-2539 (1997/2013).
Arkansas	ARK. ADMIN. CODE §§ 054.00.76-1 to 054.00.76-19 (2012).		BULLETIN 10-2011 (2011).
California			CAL. HEALTH & SAFETY CODE § 1370.4 (1997/2001); CAL. INS. CODE § 10145.3 (1996/2001); CAL. INS. CODE §§ 10169 to 10169.5 (1999/2015); Notice 5-17-2011 (2011).
Colorado		3 COLO. CODE REGS. § 702-4:4-2-21 (2010).	COLO. REV. STAT. § 10-16-113.5 (2013); 3 COLO. CODE REGS. § 702-4:4-2-17 (1997/2013); BULLETIN B-4.20 (REVISED #4) (2017).

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut			CONN. GEN. STAT. §§ 38a-591a to 38a-591n (2011/2013); BULLETIN HC-74 (2009); BULLETIN HC-84 (2011); BULLETIN HC-93 (2013).
Delaware			DEL. CODE ANN. tit.18, § 332 (1996/2012).
District of Columbia			D.C. CODE §§ 44-301.01 to 44-301.11 (1998/2012).
Florida			FLA. STAT. § 641.312 (2012/2018); MEMORANDUM 2010-006 (2010); MEMORANDUM 2011-07M (2011).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAWAII REV. STAT. §§ 432E-31 to 432E-44 (2011).
Idaho	IDAHO CODE ANN. §§ 41-5901 to 41-5917 (2009/2011).		IDAHO ADMIN. CODE r. 18.04.01.000 to 18.04.01.024 (2019); BULLETIN 2009-8 (2009); BULLETIN 2011-4 (2011).
Illinois	215 ILL. COMP. STAT. 180/5 to 180/99 (2010) (portions of model).		215 ILL. COMP. STAT. 134/45 (2000); ILL. ADMIN. CODE tit. 50, §§ 4530.10 to 4530.90; Exs. A to D (2015); MEMORANDUM 5-27-2010 (2010); BULLETIN 2011-10 (2011).
Indiana			IND. CODE §§ 27-8-29-1 to 27-8-29-24 (2001/2003); §§ 27-13-10.1-1 to 27-13-10.1-12 (1999/2011) (HMOs); BULLETIN 193 (2012).
Iowa			IOWA CODE §§ 514J.101 to 514J.120 (2011/2014); IOWA ADMIN. CODE r. 191-76.1 to 191-76.11 (1999/2012).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kansas			KAN. STAT. ANN. §§ 40-22a13 to 40-22a16 (2000); KAN. ADMIN. REGS. §§ 40-4-42 to 40-4-42g (2000/2012).
Kentucky			KY. REV. STAT. ANN. §§ 304.17A-621 to 304.17A-633 (2000/2004); 806 KY. ADMIN. REGS. 17:290 (2001/2008); BULLETIN 2011-4 (2011).
Louisiana			LA. REV. STAT. ANN. §§ 22:2431 to 22:2445 (2013).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 4312 (2000/2013).
Maryland			MD. CODE ANN. INS. §§ 15-10A-01.1 to 15-10A-10 (1998/2001); MD. CODE REGS. 31.10.18.01 to 31.10.18.12 (1999/2005); BULLETIN 2010-30 (2010); BULLETIN 2012-3 (2012).
Massachusetts			MASS. GEN. LAWS ANN. ch. 176O, § 14 (2001/2013); 211 MASS. CODE REGS. 52.03 to 52.16 (2001/2005); 958 MASS. CODE REGS. 3.400 to 3.417 (2014).
Michigan		MICH. COMP. LAWS §§ 550.1901 to 550.1921 (2000/2016).	
Minnesota			MINN. STAT. § 62Q.73 (2000/2013).
Mississippi			19 MISS. CODE R. Pt. 3, §§ 15.01 to 15.24 (2012/2014).
Missouri			MO. REV. STAT. §§ 376.1350 to 376.1389 (1997); MO. CODE REGS. ANN. tit. 20, §§ 100-5.010 to 100-5.020 (1998/2012); BULLETIN 2011-08 (2011).

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. CODE ANN. §§ 33-32-401 to 33-32-423 (2015).		
Nebraska	NEB. REV. STAT. §§ 44-1301 to 44-1318 (2013/2016).		BULLETIN CB-123 (2011); BULLETIN CB-123 (Amended) (2011).
Nevada			NEV. REV. STAT. §§ 616C.360 to 616C.363 (2013); NEV. ADMIN. CODE §§ 683A.600 to 683A.670 (2004); BULLETIN 2011-013 (2011).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-J:5-a to 420-J:5-e (2000/2012); N.H. CODE R. INS. 2703.01 to 2703.09 (2001).	BULLETIN 2006-041-AB (2006); BULLETIN 11-019-AB (2011).
New Jersey			N.J. REV. STAT. §§ 26:2S-11 to 26:2S-12 (1997).
New Mexico			N.M. STAT. ANN. § 59A-57-4.1 (2003); N.M. CODE R. §§ 13.10.17.23 to 13.10.17.35 (2000/2004); BULLETIN 2011-012 (2011).
New York			N.Y. INS. LAW §§ 4910 to 4917 (1999/2014); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 410.1 to 410.13 (2001/2008) (Regulation 166).
North Carolina	N.C. GEN. STAT. §§ 58-50-75 to 58-50-95 (2002/2014) (portions of model).		MEMORANDUM 8-28-2009 (2009).
North Dakota			N.D. CENT. CODE § 26.1-36-44 (2005/2011); § 26.1-36-46 (2011).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3922.01 to 3922.23 (2011/2012).

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma			OKLA. STAT. tit. 63, §§ 6475.1 to 6475.17 (2011/2013); OKLA. ADMIN. CODE §§ 365:10-29-1 to 365:10-29-10 (2011/2012).
Oregon			OR. REV. STAT. §§ 743b.250 to 743b.258 (2002); OR. ADMIN. R. 836-053-1300 to 836-053-1365 (2002/2014).
Pennsylvania			28 PA. CODE § 9.707 (2001); NOTICE 12-31-2011 (2011).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 9501 to 9517 (2011).		
Rhode Island			R.I. GEN. LAWS §§ 27-18.9-1 to 27-18.9-15 (2017).
South Carolina		S.C. CODE ANN. §§ 38-71-1910 to 38-71-2060 (2002).	BULLETIN 4-2011 (2011).
South Dakota			S.D. ADMIN. R. 20:06:53 (2010/2011).
Tennessee			TENN. CODE ANN. §§ 56-61-101 to 56-61-125 (2010).
Texas			TEX. INS. CODE ANN. §§ 4201.401 to 4201.403 (2007/2009); 28 TEX. ADMIN. CODE §§ 19.1701 to 19.1719 (2013); BULLETIN B-0051-11 (2011).
Utah			UTAH ADMIN. CODE r. 590-203-1 to 590-203-10 (2002/2011).
Vermont			VT. STAT. ANN. tit. 8, § 4089f (1997/2011); VT. ADMIN. CODE §§ 4-5-4:1 to 4-5-4:13 (Rule H-2011-02) (2011).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE §§ 5-216-10 to 5-216-130 (2011/2012); VA. CODE ANN. §§ 32.1-137.7 to 32.1-137.17 (1998/2011).
Washington			WASH. REV. CODE § 48.43.535 (2011); WASH. ADMIN. CODE. § 284-43A-140 (2016); §§ 284-43-3000 to 284-43-3190 (2016); §§ 284-43-4000 to 4040 (2015).
West Virginia			W. VA. CODE R. §§ 114-97-1 to 114-97-15 (2014).
Wisconsin			WIS. STAT. § 632.835 (2000); WIS. ADMIN. CODE INS. §§ 18.10 to 18.18 (2001/2012).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2004

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (#75)

1. Description of the project, issues addressed, etc.

The revisions to this model clarify the scope of the model so that it is consistent with its original intent to permit external review only for adverse determinations involving an issue of medical necessity. These clarifying revisions were necessary in light of the recent revisions made to the Utilization Review and Health Carrier Grievance Procedure model acts.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair	
California	Nebraska
Delaware	New Hampshire
District of Columbia	New Mexico
Hawaii	North Carolina
Idaho	Oklahoma
Illinois	Oregon
Iowa	South Dakota
Kansas	Vermont
Louisiana	Virginia
Mississippi	West Virginia

3. Project authorized by what charge and date first given to the group:

The following charge given in January 2003:

Revise the External Review Model Act to account for the amendments made to the Utilization Review and Health Carrier Grievance Procedure model acts. Report by Winter 2003 National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the task force.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

The draft of the proposed revisions to the model were circulated to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments. The task force reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

The only controversial issue that was raised was whether certain definitions in this model that are also used in the Utilization Review and Grievance Procedure model acts, particularly the definition of "adverse determination," should be revised in the same manner as in those models. Industry expressed a concern that revising the definitions to conform would cause the scope of this model to be broadened beyond its original intent despite other revised language in this model that would narrow that scope. After discussion, the task force agreed to a compromise. It decided not to revise the definitions to mirror those same terms that are used in the Utilization Review and Grievance Procedure model acts. However, it would retain the revised language in the substantive provisions of this model to ensure that full external reviews are provided only for those requests that involve a question of medical necessity. This revision is consistent with the original intent of this model.

7. Any other important information (e.g., amending an accreditation standard).

None.

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Uniform Health Carrier External Review Act.

Drafting Note: In some States existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Act.

Section 3. Definitions

For purposes of this Act:

A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

D. "Best evidence" means evidence based on:

(1) Randomized clinical trials;

(2) If randomized clinical trials are not available, cohort studies or case-control studies;

(3) If paragraphs (1) and (2) are not available, case-series; or

(4) If paragraphs (1), (2)and (3) are not available, expert opinion.

E. "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

F. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

G. "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

H. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

I. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

J. "Cohort study" means a prospective evaluation of two (2) groups of patients with only one group of patients receiving a specific intervention(s).

K. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some State agency other than the insurance department, or if there is dual regulation, a State should add language referencing that agency to ensure the appropriate coordination of responsibilities.

L. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

M. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

N. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

O. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

P. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

Q. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

R. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

S. "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

T. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

U. "Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

V. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: States that do not require covered persons to exhaust a health carrier's internal grievance process procedures before filing a request for an external review should not adopt the definition of "final adverse determination" in subsection V and should not use the term in the rest of the law.

W. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

X. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

Y. "Health care provider" or "provider" means a health care professional or a facility.

Z. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

AA. "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

BB. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) The provision of health care services to an individual; or

(3) Payment for the provision of health care services to an individual.

CC. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

DD. "Medical or scientific evidence" means evidence found in the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) The following standard reference compendia:

(a) The American Hospital Formulary Service–Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia–Drug Information;

(5) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) The federal Agency for Healthcare Research and Quality;

(b) The National Institutes of Health;

(c) The National Cancer Institute;

(d) The National Academy of Sciences;

(e) The Centers for Medicare & Medicaid Services;

(f) The federal Food and Drug Administration; and

(g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

EE. "NAIC" means the National Association of Insurance Commissioners.

FF. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

GG. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

HH. "Protected health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

II. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

JJ. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

KK. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

LL. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

MM. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Section 4. Applicability and Scope

A. Except as provided in subsection B, this Act shall apply to all health carriers.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to State law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Notice of Right to External Review

A. (1) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 8, 9 or 10 of this Act and include the appropriate statements and information set forth in subsection B at the same time the health carrier sends written notice of:

(a) An adverse determination upon completion of the health carrier's utilization review process set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act]; and

Drafting Note: States that do not have a statutory utilization review process for health carriers similar to the NAIC Utilization Review and Benefit Determination Model Act may want to alter the reference to that model in subparagraph (a) above to take this into account. In addition, States may wish to include in their utilization review or grievance laws the requirement that the health carrier give timely notice of the right to request expedited external review prior to the conclusion of the utilization review or grievance process.

(b) A final adverse determination.

(2) As part of the written notice required under paragraph (1), a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]."

(3) The commissioner may prescribe by regulation the form and content of the notice required under this section.

Drafting Note: States are encouraged to use the model notice the NAIC Regulatory Framework Task Force plans to develop.

B. (1) The health carrier shall include in the notice required under subsection A:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 9 of this Act, or section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(ii) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to section 6 of this Act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 7 of this Act; and

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 9 of this Act; or

(ii) If the final adverse determination concerns:

(I) An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to section 9 of this Act; or

(II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 10 of this Act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under section 10 of this Act.

(2) In addition to the information to be provided pursuant to paragraph (1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 17 of this Act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(3) As part of any forms provided under paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in [insert reference to State law equivalent to section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

A. (1) Except for a request for an expedited external review as set forth in section 9 of this Act, all requests for external review shall be made in writing to the commissioner.

(2) The commissioner may prescribe by regulation the form and content of external review requests required to be submitted under this section.

Drafting Note: States are encouraged to use the model external review request form the NAIC Regulatory Framework Task Force plans to develop.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Section 7. Exhaustion of Internal Grievance Process

A. (1) Except as provided in subsection B, a request for an external review pursuant to section 8, 9 or 10 of this Act shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(a) Has filed a grievance involving an adverse determination pursuant to [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act]; and

(b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(3) Notwithstanding paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to [insert reference in State law equivalent to the Utilization Review and Benefit Determination Model Act] until the covered person has exhausted the health carrier's internal grievance process.

B. (1) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) Under section 9 of this Act if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) Under section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review under subparagraph (a) of this paragraph, the independent review organization conducting the external review in accordance with the provisions of section 9 or 10 of this Act shall determine whether the covered person shall be required to complete the expedited review process set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] before it conducts the expedited external review.

(c) Upon a determination made pursuant to subparagraph (b) of this paragraph that the covered person must first complete the expedited grievance review process set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in section 9 of this Act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the heath carrier's internal grievance procedures as set forth in [insert reference to State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act] whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection B(2), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 8 or 10 of this Act.

Drafting Note: States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this section.

Section 8. Standard External Review

A. (1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Within one (1) business day after the date of receipt of a request for external review pursuant to paragraph (1), the commissioner shall send a copy of the request to the health carrier.

B. Within five (5) business days following the date of receipt of the copy of the external review request from the commissioner under subsection A(2), the health carrier shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner and covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request is eligible for external review.

(2) If the request:

(a) Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(b) Is not eligible for external review, the health carrier shall inform the covered person, if applicable, the covered person's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under section 8B of this Act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

D. (1) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C, within one (1) business day after the date of receipt of the notice, the commissioner shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review Model and Benefit Determination Act] or the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

(3) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

E. (1) Within five (5) business days after the date of receipt of the notice provided pursuant to section D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within one (1) business day after making the decision under subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection D(3).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(3), the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

G. (1) Upon receipt of the information, if any, required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.

H. In addition to the documents and information provided pursuant to subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

I. (1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

(2) The independent review organization shall include in the notice sent pursuant to paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 9. Expedited External Review

A. Except as provided in subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. (1) Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

(2) Immediately upon receipt of the request pursuant to paragraph (1), the health carrier shall determine whether the request meets the reviewability requirements set forth in section 8B of this Act. The health carrier shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under section 8B of this Act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act. The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection E, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert State law equivalent to the Health Carrier Grievance Procedure Model Act].

C. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection B(5), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to subsection C, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 8B of this Act, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to paragraph (1) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in section 8I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 10. External Review of Experimental or Investigational Treatment Adverse Determinations

A. (1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review, the commissioner immediately shall notify the health carrier.

(c) (i) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection B. The health carrier shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(ii) The commissioner may specify the form for the health carrier's notice of initial determination under item (i) and any supporting information to be included in the notice.

(iii) The notice of initial determination under item (i) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(d) (i) The commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.

(ii) In making a determination under item (i), the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(e) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection B(2), the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act and notify the health carrier of the name of the assigned independent review organization.

(f) At the time the health carrier receives the notice of the assigned independent review organization pursuant to subparagraph (e) of this paragraph, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

B. (1) Except for a request for an expedited external review made pursuant to subsection A(2), within one (1) business day after the date of receipt of the request, the commissioner receives a request for an external review, the commissioner shall notify the health carrier.

(2) Within five (5) business days following the date of receipt of the notice sent pursuant to paragraph (1), the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(b) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(i) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(c) The covered person's treating physician has certified that one of the following situations is applicable:

(i) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) Standard health care services or treatments are not medically appropriate for the covered person; or

(iii) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph (d) of this paragraph;

(d) The covered person's treating physician:

(i) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(ii) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(e) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(f) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request is eligible for external review.

(2) If the request:

(a) Is not complete, the health carrier shall inform in writing the commissioner and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or

(b) Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its ineligibility.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under paragraph (2) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under paragraph (2) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(5) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative.

D. (1) Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection A(2)(d) or subsection C(5), the commissioner shall:

(a) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

(3) Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph (1), the assigned independent review organization shall:

(a) Select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph (4) to conduct the external review; and

(b) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4) (a) In selecting clinical reviewers pursuant to paragraph (3)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 13 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(5) In accordance with subsection H, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(6) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within five (5) business days after the date of receipt of the notice provided pursuant to subsection D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under subparagraph (a) of this paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

F. (1) Each clinical reviewer selected pursuant to subsection D shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subsection D(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(2), within one (1) business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.

(3) The external review may terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.

H. (1) Except as provided in paragraph (3), within twenty (20) days after being selected in accordance with subsection D to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection I on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to paragraph (3), each clinical reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence, as that term is defined in section 3DD of this Act, considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard, as that term is defined in section 3S of this Act; and

(e) Information on whether the reviewer's rationale for the opinion is based on subsection I(5)(a) or (b).

(3) (a) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five (5) calendar days after being selected in accordance with subsection D.

(b) If the opinion provided pursuant to subparagraph (a) of this paragraph was not in writing, within forty-eight (48) hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under paragraph (2).

I. In addition to the documents and information provided pursuant to subsection A(2) or subsection E, each clinical reviewer selected pursuant to subsection D, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection H:

(1) The covered person's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) Whether:

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

J. (1) (a) Except as provided in subparagraph (b) of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide written notice of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph (a) of this paragraph.

(ii) If the notice provided under item (i) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph (a) of this paragraph and include the information set forth in paragraph (3).

(2) (a) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(b) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(c) (i) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subparagraph (a) or (b) of this paragraph.

(ii) The additional clinical reviewer selected under item (i) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection I.

(iii) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection D pursuant to paragraph (1).

(3) The independent review organization shall include in the notice provided pursuant to paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization was assigned by the commissioner to conduct the external review;

(d) The date the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision; and

(g) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

L. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 11. Binding Nature of External Review Decision

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable State law.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Section 12. Approval of Independent Review Organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act.

B. In order to be eligible for approval by the commissioner under this section to conduct external reviews under this Act an independent review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 13 of this Act; and

(2) Shall submit an application for approval in accordance with subsection D.

C. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

D. (1) Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 13 of this Act.

(2) (a) Subject to subparagraph (b) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under section 13 of this Act.

(b) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(3) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and re-approval.

E. (1) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 13 of this Act.

(2) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 13 of this Act, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to subsection F.

F. The commissioner shall maintain and periodically update a list of approved independent review organizations.

G. The commissioner may promulgate regulations to carry out the provisions of this section.

Section 13. Minimum Qualifications for Independent Review Organizations

A. To be approved under section 12 of this Act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Act;

(2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agree to maintain and provide to the commissioner the information set out in section 15 of this Act.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a State of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State or local trade association of health benefit plans, or a national, State or local trade association of health care providers.

D. (1) In addition to the requirements set forth in subsections A, B and C, to be approved pursuant to section 12 of this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (1), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (1), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

Drafting Note: In applying subsection D, States should be aware that conflict of interest questions involving independent review organizations and clinical reviewers might arise in a variety of situations. For example, conflict of interest questions may arise when a health care provider, including a physician or other health care professional, who is a clinical reviewer for an independent review organization or an academic medical center, or other similar medical research center, which is seeking to be an approved independent review organization, has a contract to provide health care services to enrollees of the health carrier that is the subject of an external review or when a health care provider, including a physician or other health care professional, who is a clinical reviewer for an independent review organization, has staff privileges at the facility where the recommended health care service or treatment would be provided if the health carrier's adverse or final adverse determination is reversed. The question for States to consider is whether a relationship or connection with persons involved in an external review is a material conflict of interest such that the objectivity of the independent review organization to be assigned to conduct the external review or any clinical reviewer to be assigned by the independent review organization to conduct the external review may actually be or may perceived to be negatively impacted. Whether the relationship or connection is a material conflict of interest will depend on the characteristics of each State's market. Therefore, States should consider adding provisions to this section that provide additional guidelines or procedures to address this issue given their local market characteristics.

E. (1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 12 of this Act.

(2) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Section 14. Hold Harmless for Independent Review Organizations

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 15. External Review Reporting Requirements

A. (1) An independent review organization assigned pursuant to section 8, section 9 or section 10 of this Act to conduct an external review shall maintain written records in the aggregate by State and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under paragraph (2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (1) for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate by State, and for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(c) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(e) The number of external reviews pursuant to section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(f) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. (1) Each health carrier shall maintain written records in the aggregate, by State and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this Act.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to paragraph (1) shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

Drafting Note: States are encouraged to use the model report format form the NAIC Regulatory Framework Task Force plans to develop.

(3) The report shall include in the aggregate, by State, and by type of health benefit plan:

(a) The total number of requests for external review;

(b) From the total number of requests for external review reported under subparagraph (a) of this paragraph, the number of requests determined eligible for a full external review; and

(c) Any other information the commissioner may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 16. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 17. Disclosure Requirements

A. (1) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

(2) The disclosure required by paragraph (1) shall be in a format prescribed by the commissioner.

Drafting Note: States are encouraged to use the model disclosure form the NAIC Regulatory Framework Task Force plans to develop.

B. The description required under subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

C. In addition to subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 18. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 19. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2008 Proc. 2nd Quarter 3-22 to 3-53(adopted).
2010 Proc. 1st Quarter (adopted Guideline amendments)

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

The NAIC amended this model during the 2010 Spring National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2010 1st Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Uniform Health Carrier External Review Act.

Drafting Note: In some States existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Act.

Section 3. Definitions

For purposes of this Act:

A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

D. "Best evidence" means evidence based on:

(1) Randomized clinical trials;

(2) If randomized clinical trials are not available, cohort studies or case-control studies;

(3) If paragraphs (1) and (2) are not available, case-series; or

(4) If paragraphs (1), (2)and (3) are not available, expert opinion.

E. "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

F. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

G. "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

H. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

I. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

J. "Cohort study" means a prospective evaluation of two (2) groups of patients with only one group of patients receiving a specific intervention(s).

K. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some State agency other than the insurance department, or if there is dual regulation, a State should add language referencing that agency to ensure the appropriate coordination of responsibilities.

L. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

M. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

N. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

O. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

P. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

Q. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

R. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

S. "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

T. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

U. "Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

V. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: States that do not require covered persons to exhaust a health carrier's internal grievance process procedures before filing a request for an external review should not adopt the definition of "final adverse determination" in subsection V and should not use the term in the rest of the law.

W. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

X. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

Y. "Health care provider" or "provider" means a health care professional or a facility.

Z. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

AA. "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

BB. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) The provision of health care services to an individual; or

(3) Payment for the provision of health care services to an individual.

CC. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

DD. "Medical or scientific evidence" means evidence found in the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) The following standard reference compendia:

(a) The American Hospital Formulary Service–Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia–Drug Information;

(5) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) The federal Agency for Healthcare Research and Quality;

(b) The National Institutes of Health;

(c) The National Cancer Institute;

(d) The National Academy of Sciences;

(e) The Centers for Medicare & Medicaid Services;

(f) The federal Food and Drug Administration; and

(g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

EE. "NAIC" means the National Association of Insurance Commissioners.

FF. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

GG. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

HH. "Protected health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

II. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

JJ. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

KK. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

LL. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

MM. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Section 4. Applicability and Scope

A. Except as provided in subsection B, this Act shall apply to all health carriers.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to State law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Notice of Right to External Review

A. (1) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 8, 9 or 10 of this Act and include the appropriate statements and information set forth in subsection B at the same time the health carrier sends written notice of:

(a) An adverse determination upon completion of the health carrier's utilization review process set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act]; and

Drafting Note: States that do not have a statutory utilization review process for health carriers similar to the NAIC Utilization Review and Benefit Determination Model Act may want to alter the reference to that model in subparagraph (a) above to take this into account. In addition, States may wish to include in their utilization review or grievance laws the requirement that the health carrier give timely notice of the right to request expedited external review prior to the conclusion of the utilization review or grievance process.

(b) A final adverse determination.

(2) As part of the written notice required under paragraph (1), a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]."

(3) The commissioner may prescribe by regulation the form and content of the notice required under this section.

Drafting Note: States are encouraged to use the model notice the NAIC Regulatory Framework Task Force plans to develop.

B. (1) The health carrier shall include in the notice required under subsection A:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 9 of this Act, or section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(ii) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to section 6 of this Act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 7 of this Act; and

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 9 of this Act; or

(ii) If the final adverse determination concerns:

(I) An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to section 9 of this Act; or

(II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 10 of this Act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under section 10 of this Act.

(2) In addition to the information to be provided pursuant to paragraph (1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 17 of this Act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(3) As part of any forms provided under paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in [insert reference to State law equivalent to section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

A. (1) Except for a request for an expedited external review as set forth in section 9 of this Act, all requests for external review shall be made in writing to the commissioner.

(2) The commissioner may prescribe by regulation the form and content of external review requests required to be submitted under this section.

Drafting Note: States are encouraged to use the model external review request form the NAIC Regulatory Framework Task Force plans to develop.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Section 7. Exhaustion of Internal Grievance Process

A. (1) Except as provided in subsection B, a request for an external review pursuant to section 8, 9 or 10 of this Act shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(a) Has filed a grievance involving an adverse determination pursuant to [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act]; and

(b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(3) Notwithstanding paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to [insert reference in State law equivalent to the Utilization Review and Benefit Determination Model Act] until the covered person has exhausted the health carrier's internal grievance process.

B. (1) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) Under section 9 of this Act if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) Under section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review under subparagraph (a) of this paragraph, the independent review organization conducting the external review in accordance with the provisions of section 9 or 10 of this Act shall determine whether the covered person shall be required to complete the expedited review process set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] before it conducts the expedited external review.

(c) Upon a determination made pursuant to subparagraph (b) of this paragraph that the covered person must first complete the expedited grievance review process set forth in [insert reference to State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in section 9 of this Act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the heath carrier's internal grievance procedures as set forth in [insert reference to State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act] whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection B(2), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 8 or 10 of this Act.

Drafting Note: States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this section.

Section 8. Standard External Review

A. (1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Within one (1) business day after the date of receipt of a request for external review pursuant to paragraph (1), the commissioner shall send a copy of the request to the health carrier.

B. Within five (5) business days following the date of receipt of the copy of the external review request from the commissioner under subsection A(2), the health carrier shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner and covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request is eligible for external review.

(2) If the request:

(a) Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(b) Is not eligible for external review, the health carrier shall inform the covered person, if applicable, the covered person's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under section 8B of this Act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

D. (1) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C, within one (1) business day after the date of receipt of the notice, the commissioner shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review Model and Benefit Determination Act] or the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

(4) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

E. (1) Within five (5) business days after the date of receipt of the notice provided pursuant to section D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within one (1) business day after making the decision under subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection D(3).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(3), the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

G. (1) Upon receipt of the information, if any, required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.

H. In addition to the documents and information provided pursuant to subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

I. (1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

(2) The independent review organization shall include in the notice sent pursuant to paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 9. Expedited External Review

A. Except as provided in subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. (1) Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

(2) Immediately upon receipt of the request pursuant to paragraph (1), the health carrier shall determine whether the request meets the reviewability requirements set forth in section 8B of this Act. The health carrier shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under section 8B of this Act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act. The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection E, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert State law equivalent to the Health Carrier Grievance Procedure Model Act].

C. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection B(5), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

. In addition to the documents and information provided or transmitted pursuant to subsection C, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

(6) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 8B of this Act, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to paragraph (1) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in section 8I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 10. External Review of Experimental or Investigational Treatment Adverse Determinations

A. (1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review, the commissioner immediately shall notify the health carrier.

(c) (i) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection B. The health carrier shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(ii) The commissioner may specify the form for the health carrier's notice of initial determination under item (i) and any supporting information to be included in the notice.

(iii) The notice of initial determination under item (i) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(d) (i) The commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.

(ii) In making a determination under item (i), the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(e) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection B(2), the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act and notify the health carrier of the name of the assigned independent review organization.

(f) At the time the health carrier receives the notice of the assigned independent review organization pursuant to subparagraph (e) of this paragraph, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

B. (1) Except for a request for an expedited external review made pursuant to subsection A(2), within one (1) business day after the date of receipt of the request, the commissioner receives a request for an external review, the commissioner shall notify the health carrier.

(2) Within five (5) business days following the date of receipt of the notice sent pursuant to paragraph (1), the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(b) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(i) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(c) The covered person's treating physician has certified that one of the following situations is applicable:

(i) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) Standard health care services or treatments are not medically appropriate for the covered person; or

(iii) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph (d) of this paragraph;

(d) The covered person's treating physician:

(i) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(ii) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(e) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(f) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request is eligible for external review.

(2) If the request:

(a) Is not complete, the health carrier shall inform in writing the commissioner and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or

(b) Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its ineligibility.

(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under paragraph (2) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under paragraph (2) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(5) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative.

D. (1) Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection A(2)(d) or subsection C(5), the commissioner shall:

(a) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this Act and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

(3) Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph (1), the assigned independent review organization shall:

(a) Select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph (4) to conduct the external review; and

(b) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4) (a) In selecting clinical reviewers pursuant to paragraph (3)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 13 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(5) In accordance with subsection H, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(6) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within five (5) business days after the date of receipt of the notice provided pursuant to subsection D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under subparagraph (a) of this paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

F. (1) Each clinical reviewer selected pursuant to subsection D shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subsection D(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(2), within one (1) business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.

(3) The external review may terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.

H. (1) Except as provided in paragraph (3), within twenty (20) days after being selected in accordance with subsection D to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection I on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to paragraph (3), each clinical reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence, as that term is defined in section 3DD of this Act, considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard, as that term is defined in section 3S of this Act; and

(e) Information on whether the reviewer's rationale for the opinion is based on subsection I(5)(a) or (b).

(3) (a) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five (5) calendar days after being selected in accordance with subsection D.

(b) If the opinion provided pursuant to subparagraph (a) of this paragraph was not in writing, within forty-eight (48) hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under paragraph (2).

I. In addition to the documents and information provided pursuant to subsection A(2) or subsection E, each clinical reviewer selected pursuant to subsection D, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection H:

(1) The covered person's pertinent medical records;

(2) The attending physician or health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) Whether:

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

J. (1) (a) Except as provided in subparagraph (b) of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide written notice of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph (a) of this paragraph.

(ii) If the notice provided under item (i) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph (a) of this paragraph and include the information set forth in paragraph (3).

(2) (a) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(b) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(c) (i) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subparagraph (a) or (b) of this paragraph.

(ii) The additional clinical reviewer selected under item (i) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection I.

(iii) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection D pursuant to paragraph (1).

(3) The independent review organization shall include in the notice provided pursuant to paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization was assigned by the commissioner to conduct the external review;

(d) The date the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision; and

(g) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

L. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 13D of this Act.

Section 11. Binding Nature of External Review Decision

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable State law.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Section 12. Approval of Independent Review Organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act.

B. In order to be eligible for approval by the commissioner under this section to conduct external reviews under this Act an independent review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 13 of this Act; and

(2) Shall submit an application for approval in accordance with subsection D.

C. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

D. (1) Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 13 of this Act.

(2) (a) Subject to subparagraph (b) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under section 13 of this Act.

(b) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(3) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and re-approval.

E. (1) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 13 of this Act.

(2) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 13 of this Act, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to subsection F.

F. The commissioner shall maintain and periodically update a list of approved independent review organizations.

G. The commissioner may promulgate regulations to carry out the provisions of this section.

Section 13. Minimum Qualifications for Independent Review Organizations

A. To be approved under section 12 of this Act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Act;

(2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agree to maintain and provide to the commissioner the information set out in section 15 of this Act.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a State of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State or local trade association of health benefit plans, or a national, State or local trade association of health care providers.

D. (1) In addition to the requirements set forth in subsections A, B and C, to be approved pursuant to section 12 of this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (1), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (1), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

Drafting Note: In applying subsection D, States should be aware that conflict of interest questions involving independent review organizations and clinical reviewers might arise in a variety of situations. For example, conflict of interest questions may arise when a health care provider, including a physician or other health care professional, who is a clinical reviewer for an independent review organization or an academic medical center, or other similar medical research center, which is seeking to be an approved independent review organization, has a contract to provide health care services to enrollees of the health carrier that is the subject of an external review or when a health care provider, including a physician or other health care professional, who is a clinical reviewer for an independent review organization, has staff privileges at the facility where the recommended health care service or treatment would be provided if the health carrier's adverse or final adverse determination is reversed. The question for States to consider is whether a relationship or connection with persons involved in an external review is a material conflict of interest such that the objectivity of the independent review organization to be assigned to conduct the external review or any clinical reviewer to be assigned by the independent review organization to conduct the external review may actually be or may perceived to be negatively impacted. Whether the relationship or connection is a material conflict of interest will depend on the characteristics of each State's market. Therefore, States should consider adding provisions to this section that provide additional guidelines or procedures to address this issue given their local market characteristics.

E. (1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 12 of this Act.

(2) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Section 14. Hold Harmless for Independent Review Organizations

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 15. External Review Reporting Requirements

A. (1) An independent review organization assigned pursuant to section 8, section 9 or section 10 of this Act to conduct an external review shall maintain written records in the aggregate by State and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under paragraph (2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (1) for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate by State, and for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(b) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(e) The number of external reviews pursuant to section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(f) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. (1) Each health carrier shall maintain written records in the aggregate, by State and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this Act.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to paragraph (1) shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

Drafting Note: States are encouraged to use the model report format form the NAIC Regulatory Framework Task Force plans to develop.

(3) The report shall include in the aggregate, by State, and by type of health benefit plan:

(a) The total number of requests for external review;

(b) From the total number of requests for external review reported under subparagraph (a) of this paragraph, the number of requests determined eligible for a full external review; and

(c) Any other information the commissioner may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 16. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 17. Disclosure Requirements

A. (1) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

(2) The disclosure required by paragraph (1) shall be in a format prescribed by the commissioner.

Drafting Note: States are encouraged to use the model disclosure form the NAIC Regulatory Framework Task Force plans to develop.

B. The description required under subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

C. In addition to subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 18. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 19. Effective Date

This Act shall be effective [insert date].

Appendix A – Model Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact[1] us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.[1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of where appeals should be sent to the health carrier] within **180 days** of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **60 days** of receiving your appeal.[3] If you do not receive our decision within **60 days** of receiving your appeal[3], you may be entitled to file a request for external review.[4]

External Review[4]: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **4 months** after receipt of this notice to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.[1]

[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.
[2] Unless your plan or any applicable state law allows you additional time.
[3] Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's appeal process.
[4] See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

Appendix B – Model External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with [insert state insurance department] within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____ □Covered person/Patient □ Provider□ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Address:_____

_____

Covered Person Phone #: Home (_____)_____
Work (_____)_____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

_____

Insurer Telephone #: (_____)_____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (_____)_____

Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

_____

_____

Contact Person: _____ Phone: ( ) _____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

_____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the [insert state insurance department name]. I understand that the independent review organization and the [insert state insurance department name] will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

_____

Phone #: Daytime (_____) _____ Evening (_____) _____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. ☐ **YES**, I have included this completed application form signed and dated.

2. ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program].

4. ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Insurance Department at [insert appropriate telephone number(s)] if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to: [insert address where paperwork should be mailed].

If you are requesting an expedited external review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The [insert name of state insurance department] oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

Phone Number: (_____)_____ Fax Number: (_____)_____

Licensure and Area of Clinical Specialty: _____

_____

Name of Patient: _____

Patient's Insurer Member ID#: _____

CERTIFICATION

I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (**NOTE:** Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

☐ 1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

☐ 2) The covered person has a condition that qualifies under one or more of the following:
[please indicate which description(s) apply]:

☐ Standard health care services or treatments have not been effective in improving the covered person's condition;

☐ Standard health care services or treatments are not medically appropriate for the covered person; or

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.
Explain:_____

_____

☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.
Explain: _____

_____

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

_____

_____

_____ _____
Physician's Signature Date

Appendix C – Independent Review Organization External Review Annual Report Form

[Insert Name of State Insurance Department]

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20	_____.		
Due on [insert date] for previous calendar year.			
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in [insert name of state] only.			
1. IRO name:	_____	Filing date:	_____
2. IRO license/certification no:	_____		
3. IRO address:	_____		
City, State, ZIP:	_____		
4. IRO Web site:	_____		
5. Name, email address, phone and fax number of the person completing this form:			
_____			
_____			
6. Name and title of the person responsible for regulatory compliance and quality of external reviews:			
Name:	_____	Title:	_____
7. Total number of requests for external review received from [insert state insurance department name] during the reporting period:	_____		
8. Number of standard external reviews:	_____		
9. Average number of days IRO required to reach a final decision in standard reviews:	_____		
10. Number of expedited reviews completed to a final decision:	_____		
11. Average number of days IRO required to reach a final decision in expedited reviews:	_____		
12. Number of medical necessity reviews decided in favor of the health carrier:	_____		

Briefly list procedures denied:					
13. Number of medical necessity reviews decided in favor of the covered person:					
Briefly list procedures approved:					
14. Number of experimental/investigational reviews decided in favor of the health carrier:					
Briefly list procedures denied:					
15. Number of experimental/investigational reviews decided in favor of the covered person:					
Briefly list procedures approved:					
16. Number of reviews terminated as the result of a reconsideration by the health carrier:					
17. Number of reviews terminated by the covered person:					
18. Number of reviews declined due to possible conflict with:					
Health carrier		Covered person		Health care provider	
Describe possible conflicts(s) of interest:					
19. Number of reviews declined due to other reasons not reflected in #18 above:					

Appendix D – Model Health Carrier External Review Annual Report Form

[Insert Name of State Insurance Department]

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20	____.		
Due on [insert date] for previous calendar year.			
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.			
1. Health carrier name:	_____	Filing Date:	_____
2. Health carrier address:	_____		
City, State, ZIP:	_____		
3. Health carrier Web site:	_____		
4. Name, email address, phone and fax number of the person completing this form:			
_____			
_____			
5. Total number of external review requests received from [insert state insurance department name] during the reporting period:			_____
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:			_____

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2008 Proc. 2nd Quarter 3-22 to 3-53(adopted).
2010 Proc. 1st Quarter (adopted Guideline amendments)

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			BULLETIN 9-23-2010 (2010).
Alaska			ALASKA STAT. ANN. § 21.07.005 (2016); BULLETIN 2018-5 (2018).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-2537 to 20-2539 (1997/2013); BULLETIN 2011-7 (2011)
Arkansas	054.00.76 ARK. CODE R. §§ 1 to 19; Apps. A to D (2011/2012).		BULLETIN 10-2011 (2011).
California			CAL. HEALTH & SAFETY CODE § 1370.4 (1997/2001); CAL. INS. CODE § 10145.3 (1996/2001); CAL. INS. CODE §§ 10169 to 10169.5 (1999/2015); NOTICE 5-17-2011 (2011).
Colorado		3 COLO. CODE REGS. § 702-4:4-2-21 (2010).	COLO. REV. STAT. § 10-16-113.5 (2013); 3 COLO. CODE REGS. § 702-4:4-2-17 (1997/2013); BULLETIN B-4.20 (REVISED #4) (2017).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut			CONN. GEN. STAT. §§ 38a-591a to 38a-591n (2011/2013); BULLETIN HC-74 (2009); BULLETIN HC-84 (2011); BULLETIN HC-93 (2013).
Delaware			DEL. CODE ANN. tit.18, § 332 (1996/2012).
District of Columbia			D.C. CODE §§ 44-301.01 to 44-301.11 (1998/2012).
Florida			FLA. STAT. § 641.312 (2012/2018); MEMORANDUM 2010-006 (2010); MEMORANDUM 2011-07M (2011).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAWAII REV. STAT. §§ 432E-31 to 432E-44 (2011).
Idaho	IDAHO CODE ANN. §§ 41-5901 to 41-5917 (2009/2011).		IDAHO ADMIN. CODE r. 18.04.01.000 to 18.04.01.024 (2019); BULLETIN 2009-8 (2009); BULLETIN 2011-4 (2011).
Illinois	215 ILL. COMP. STAT. 180/5 to 180/99 (2010).		215 ILL. COMP. STAT. 134/45 (2000); ILL. ADMIN. CODE tit. 50, §§ 4530.10 to 4530.90; Exs. A to D (2015); MEMORANDUM 5-27-2010 (2010); BULLETIN 2011-10 (2011).
Indiana			IND. CODE §§ 27-8-29-1 to 27-8-29-24 (2001/2003); §§ 27-13-10.1 to 27-13-10.1-12 (1999/2011) (HMOs); BULLETIN 193 (2012).
Iowa	IOWA CODE §§ 514J.101 to 514J.120 (2011/2014).		IOWA ADMIN. CODE r. 191-76.1 to 191-76.119 (1999/2012).
Kansas		KAN. ADMIN. REGS. §§ 40-4-42 to 40-4-42g (2000/2012).	KAN. STAT. ANN. §§ 40-22a13 to 40-22a16 (2000);

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kentucky			KY. REV. STAT. ANN. §§ 304.17A-621 to 304.17A-633 (2000/2004); 806 KY. ADMIN. REGS. 17:290 (2000/2008); BULLETIN 2011-4 (2011).
Louisiana	LA. REV. STAT. ANN. §§ 22:2431 to 22:2445 (2013) (portions of model).		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 4312 (2000/2013).
Maryland			MD. CODE ANN., INS. §§ 15-10A-01 to 15-10A-10 (2000/2011); BULLETIN 2010-30 (2010); BULLETIN 2012-3 (2012).
Massachusetts			MASS. GEN. LAWS ANN. ch. 176O, § 14 (2001/2013); 211 MASS. CODE REGS. 52.03 to 52.16 (2001/2005); 958 MASS. CODE REGS. 3.400 to 3.417 (2014).
Michigan			MICH. COMP. LAWS §§ 550.1901 to 550.1921 (2000/2001).
Minnesota			MINN. STAT. § 62Q.73 (2000/2013).
Mississippi	19-1 MISS. CODE R. §§ 15.01 to 15.24 (2012/2014).		
Missouri			MO. CODE REGS. ANN. tit. 20, § 100-5.020 (1998/2012); MO. REV. STAT. § 376.1387 (1997); BULLETIN 2011-08 (2011).
Montana	MONT. CODE ANN. §§ 33-32-401 to 33-32-423 (2015).		
Nebraska	NEB. REV. STAT. §§ 44-1301 to 44-1318 (2013/2016).		BULLETIN CB-123 (2011); BULLETIN CB-123 (Amended) (2011).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NEV. REV. STAT. §§ 695G.241 to 695G.310 (2003/2011).		BULLETIN 2011-013 (2011).
New Hampshire		N.H. CODE R. INS. 2703.01 to 2703.09 (2001).	N.H. REV. STAT. ANN. 420-J:5-a to 420:J-5-e (2000/2012); BULLETIN 2006-041-AB (2006); BULLETIN 11-019-AB (2011).
New Jersey			N.J. REV. STAT. §§ 26:2S-11 to 26:2S-12 (1997).
New Mexico			N.M. STAT. ANN. § 59A-57-4.1 (2003); N.M. CODE R. §§ 13.10.17.23 to 13.10.17.32 (2000/2004); BULLETIN 2011-012 (2011).
New York			N.Y. INS. LAW §§ 4910 to 4917 (1999/2014); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 410.1 to 410.13 (2001/2008) (Regulation 166).
North Carolina	N.C. GEN. STAT. §§ 58-50-75 to 58-50-95 (2002/2014) (portions of model).		MEMORANDUM 8-28-2009 (2009).
North Dakota			N.D. CENT. CODE § 26.1-36-44 (2005/2011); § 26.1-36-46 (2011).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3922.01 to 3922.23 (2011/2012).		
Oklahoma	OKLA. STAT. tit. 63, §§ 6475.1 to 6475.17 (2011/2013) (portions of model).		OKLA. ADMIN. CODE §§ 365:10-29-1 to 365:10-29-10 (2011/2012).
Oregon			OR. REV. STAT. §§ 743b.250 to 743b.258 (2002); OR. ADMIN. R. 836-053-1300 to 836-053-1365 (2002/2014).
Pennsylvania			28 PA. CODE § 9.707 (2001); NOTICE 12-31-2011 (2011).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 9501 to 9517 (2011).		
Rhode Island			R.I. GEN. LAWS §§ 27-18.9-1 to 27-18.9-15 (2017).
South Carolina		S.C. CODE ANN. §§ 38-71-1910 to 38-71-2060 (2002).	BULLETIN 4-2011 (2011).
South Dakota			S.D. ADMIN. R. 20:06:53 (2010/2012).
Tennessee			TENN. CODE ANN. §§ 56-61-101 to 56-61-125 (2010).
Texas			TEX. INS. CODE ANN. §§ 4201.401 to 4201.403 (2007/2009); 28 TEX. ADMIN. CODE §§ 19.1701 to 19.1719 (2013); BULLETIN B-0051-11 (2011).
Utah			UTAH ADMIN. CODE r. 590-203-1 to 590-203-10 (2002/2011).
Vermont			VT. STAT. ANN. tit. 8, § 4089f (1997/2011); VT. ADMIN. CODE §§ 4-5-4:1 to 4-5-4:13 (Rule H-2011-02) (2011).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE §§ 5-216-10 to 5-216-130 (2011/2012); VA. CODE ANN. §§ 32.1-137.7 to 32.1-137.17 (1998/2011).
Washington			WASH. REV. CODE § 48.43.535 (2011); WASH. ADMIN. CODE. § 284-43A-140 (2016); §§ 284-43-3000 to 284-43-3190 (2016); §§ 284-43-4000 to 4040 (2015).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE R. §§ 114-97-1 to 114-97-15 (2014).		
Wisconsin			WIS. STAT. § 632.835 (2000); WIS. ADMIN. CODE INS. §§ 18.10 to 18.18 (2001/2012).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2010

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (#76)

1. Description of the Project, Issues Addressed, etc.

The revisions to the Uniform Health Carrier External Review Model Act add four new appendices:

- ***Appendix A Model Notice of Appeal Rights***
- ***Appendix B Model External Review Request Form***
- ***Appendix C Model Independent Review Organization External Review Annual Report Form***
- ***Appendix D Model Health Carrier External Review Annual Report Form***

This model law was adopted by the full NAIC membership in 2008. The purpose of the model was to establish a national standard and uniform approach for processing, conducting, and making external review determinations. Although approximately 47 states have adopted external review laws, there is no uniformity among the states regarding external review processes. This model provides for a single-option approach for external review. The model included a requirement that the Regulatory Framework (B) Task Force develop these appendices in an effort to promote uniformity among the states for these forms.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force of the Health Insurance and Managed Care (B) Committee drafted the model.

States Participating:

Nevada, Chair	Montana
Alabama	Nebraska
California	New Hampshire
Delaware	Ohio
Florida	Oregon
Idaho	Pennsylvania
Illinois	South Dakota
Indiana	Tennessee
Maine	Utah
Maryland	Vermont
Minnesota	Virginia
Mississippi	West Virginia
Missouri	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2005 by the following charge: Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. It was delegated to the Regulatory Framework Task Force in 2006. The model was adopted by the full NAIC membership in 2008. These model notices are to be considered guidelines to this model act.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Task Force. Numerous interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); and other interested parties, such as the National Association of Independent Review Organizations (NAIRO); Families USA; and the Council for Affordable Health Insurance (CAHI).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Drafts of the proposed model notices were distributed for comment prior to the 2008 Fall National Meeting. At the 2008 Fall National Meeting, the Task Force discussed the comments received on those drafts. Immediately following the 2009 Spring National Meeting, revised drafts of the proposed model notices were distributed for comment. At the 2009 Summer National Meeting, the Task Force discussed the comments received on these drafts. Following the 2009 Summer National Meeting, a third set of revised drafts were distributed for comment. The Task Force discussed the comments and adopted the model notices during a conference call on Oct. 13, 2009.

Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC Web site. The comments were also posted on the NAIC Web site.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

There were no significant issues or items of controversy raised during the drafting process. All of the comments received were of a technical nature.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2008

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT #76)

1. Description of the Project, Issues Addressed, etc.

This model law was drafted to achieve a national standard and uniform approach for processing, conducting, and making external review determinations. Although over 45 states have adopted external review laws, there is no uniformity among the states regarding external review processes. This model provides for a single-option approach for external review.

In 2006, the full NAIC membership adopted the Health Policy Rate and Form Filing Model Act. That model was the result of one of two charges that the Committee had concerning regulatory modernization. The Committee's second charge was to review issues surrounding internal appeals and external review and make a determination on whether national standards for these processes were appropriate. This model completes part of this second charge. It will ensure uniformity among the states with respect to external review processes and procedures and, as a result, consumers will have the same or substantively similar regulatory protections available to them no matter where they reside.

Specifically, the model establishes a standard external review process that includes the following major provisions:

- All requests for external review must be filed with the commissioner within 4 months following the date of receipt of an adverse determination or final adverse determination.
- Upon receipt of the external review request, the commissioner notifies and forwards the request to the health carrier.
- The health carrier conducts a preliminary review of the request to determine if it is eligible for a full external review. Among the conditions that must be satisfied is whether the individual making the request is or was a covered person at the time the health care service in dispute was provided. The health carrier will also determine whether the health care service in dispute is a covered service.
- The commissioner has the authority to review and ultimately overturn a health carrier's determination that an external review request is ineligible for external review and require that it be referred to full external review.
- If the external review request is determined eligible for external review, the commissioner randomly assigns an independent review organization (IRO) to review the request. Specifically, the commissioner randomly assigns an approved IRO from those approved IROs qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including any conflict of interest concerns.
- The assigned IRO has 45 days after the date of receipt of the external review request to reach a standard external review decision.
- In reaching a decision, the IRO can review any information and documents it considers appropriate to the extent the information or documents are available. The IRO must also consider the opinion of the its clinical reviewer or reviewers after the reviewer or reviewers consider specified information and documents related to the external review request to the extent the information and documents are available and the reviewer or reviewers consider appropriate.
- In its written decision notice, the IRO must provide the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision, the rationale for its decision and references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

The model also includes provisions for an expedited external review and a standard and expedited external review of experimental or investigational treatment of adverse determinations or final adverse determinations.

In addition, the model also provides a streamlined method of approving IROs eligible to conduct external reviews. An IRO is eligible to conduct external reviews if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has IRO accreditation standards that are equivalent to or exceed the minimum requirements in the model act. Any IRO that has such accreditation is presumed in compliance with the model act's minimum requirements to be eligible to conduct external reviews. The commissioner must initially review and periodically review the IRO accreditation standards to ensure that those standards are and continue to be equivalent or exceed the model act's minimum requirements. The commissioner may, however, rely on a review conducted by the NAIC. The model also requires IROs to be unbiased. IROs must establish and maintain written procedures to ensure that they are unbiased.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force of the Health Insurance and Managed Care (B) Committee drafted the model.

States Participating:

Wisconsin, Chair	Missouri
California	Montana
Colorado	Nebraska
Delaware	Nevada
Florida	Ohio
Idaho	Oregon
Illinois	Rhode Island
Indiana	South Dakota
Iowa	Utah
Kansas	Vermont
Kentucky	Virginia
Maine	West Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2005 by the following charge: Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. It was delegated to the Regulatory Framework Task Force in 2006. At the 2007 Summer National Meeting, Executive/Plenary approved the Health Insurance and Managed Care (B) Committee's model law development request related to this charge.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Task Force. Numerous interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); accrediting body representatives, such as URAC and the National Committee on Quality Assurance (NCQA); the National Association of Independent Review Organizations (NAIRO); provider representatives, such as the American Medical Association (AMA) and the American Psychiatric Association (APA); and other interested parties, such as the Council for Affordable Health Insurance (CAHI).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning with the NAIC 2006 Winter National Meeting, drafts of the proposed revisions were reviewed and discussed at each National Meeting. The Task Force also held an informational hearing on the several issues related to the proposed model at the NAIC 2007 Spring National Meeting. Those issues included the use of evidence-based medicine in making external review decisions, the accreditation of independent review organizations (IROs) to conduct external review and the appropriate external review regulatory structure to be used to conduct external reviews. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC Web site. The comments were also posted on the NAIC Web site.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The Task Force discussed and resolved a few significant issues during the drafting process.

The existing NAIC Health Carrier External Review Model Act includes three options that states can choose from in establishing an external review process. The options range from an approach that provides for extensive commissioner involvement under which the commissioner receives all external review requests, conducts the preliminary review to determine if the request is eligible for external review and, after considering the IRO's recommendation, makes the final external review determination to an approach that provides for very limited commissioner involvement under which the health carrier receives all external review requests and the IRO conducts the preliminary review for eligibility and makes the

final external review determination. As such, one general issue discussed at the beginning of the drafting process concerned the degree of involvement of the commissioner in the external review process. In considering this issue, the Task Force also considered two related issues: (1) whether the commissioner or the consumer should select the IRO to conduct the external review; and (2) whether the health carrier, the IRO or the commissioner should conduct the preliminary review to determine whether an external request is eligible for a full external review.

After extensive discussion and debate during several meetings, the Task Force settled on something in between. It decided that the commissioner should receive all external review requests. The Task Force also decided that the health carrier should conduct the preliminary review of each external request for eligibility but gave the commissioner the authority to overturn a health carrier's ineligibility determination. In reaching this decision, the Task Force reasoned that the health carrier has the information necessary to decide whether: (1) the person is or was covered under the health benefit plan at the time the health care service in dispute was provided; (2) the health care service that is the subject of the adverse determination or final adverse determination is a covered service; (3) the covered person has exhausted the health carrier's internal review process, if applicable; and (4) all of the necessary forms have been provided. Also, IROs have medical expertise, not coverage expertise. The Task Force also reasoned that it was not efficient for the commissioner to conduct the preliminary review. For some states, there could be staffing and financial resource issues if the commissioner was required to conduct the preliminary review.

The Task Force also decided that it would be in the best interest of consumers if the commissioner selected the IRO. At the request of interested parties, however, the Task Force added language requiring the commissioner to select the IRO on a random basis among approved IROs qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination, including any conflict of interest considerations.

The Task Force also had extensive discussions on the appropriate use and consideration of evidence-based standards in reaching an external review decision. The AMA and the APA both raised concerns about requiring IROs to consider evidence-based standards in reaching an external review decision. They also raised concerns about the definition of "best evidence" and how this definition ranks "expert opinion" last in the list of what would be considered "best evidence." The Task Force decided to leave the definition of "best evidence" unchanged and the provisions in the proposed model concerning what information the IRO must consider in reaching an external review decision. This provision requires the IRO to consider evidence-based standards in reaching a decision but does not limit the IRO to basing a decision on these standards. The IRO can consider other standards, as it deems appropriate, and even base its decision on these other standards. However, the Task Force did decide to include specific language requiring the IRO to consider the opinion of its clinical reviewers in reaching an external review decision.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING MODEL LAW

Table of Contents

Drafting Introductory Note: This model law pertains to the collection of data necessary to accomplish the purpose stated in Section 1. It is not intended to discourage states from collecting additional data for other purposes.

Section 1. Statement of Purpose

This Act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.

Section 2. Definitions

As used in this Act:

A. "Claim" means:

(1) A demand for monetary damages for injury or death caused by medical malpractice; or

(2) A voluntary indemnity payment for injury or death caused by medical malpractice.

B. "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.

C. "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility or provider. A claim may be closed with or without an indemnity payment to a claimant.

D. "Commissioner" means the commissioner of insurance.

E. "Companion claims" means separate claims involving the same incident of medical malpractice made against other providers or facilities.

F. "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services and loss of business or employment opportunities.

G. "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility or similar place where a health care provider provides health care to patients.

H. "Health care provider" or "provider" means:

(1) A person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, a nurse practitioner or a physician's trained mobile intensive care paramedic. If the person is deceased, this includes his or her estate or personal representative; or

(2) An employee or agent of a person described in paragraph (1) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative.

I. "Insuring entity" means:

(1) An authorized insurer;

(2) A captive insurer;

(3) A joint underwriting association;

(4) A patient compensation fund;

(5) A risk retention group; or

(6) An unauthorized insurer that provides surplus lines coverage.

J. "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services.

K. "Noneconomic damages" means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship.

L. "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

Drafting Note: If some of these terms are already defined elsewhere in this State's statutes, references to those statutes may be substituted for the definitions above. If some types of insuring entities are defined elsewhere in this State's statutes, those definitions may be cited.

Section 3. Applicability and Scope

This Act shall apply to all medical professional liability claims in this State, regardless of whether or how they are covered by medical professional liability insurance.

Section 4. Reporting Requirements

A. For claims closed on or after January 1, [insert year]:

(1) Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this State must report each medical professional liability closed claim to the commissioner.

(2) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

(3) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

(a) The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(b) The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(c) The annual aggregate coverage limits had been exhausted by other claim payments.

(4) If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the commissioner, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

(a) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this Act on behalf of the risk retention group.

(b) If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the unauthorized insurer.

(c) If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the captive insurer.

Drafting Note: When subsection A(4) applies, the State needs to consider inserting wording regarding who is responsible for notification to facilities and providers. Notification by either the domiciliary state regulator or the insurer must be provided in advance to insureds that they must produce all data required by this act upon behalf of the insurer.

B. Beginning in [insert year], reports required under subsection A of this section must be filed by March 1. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

C. The commissioner may adopt rules that require insuring entities, self-insurers, facilities and providers to submit all required closed claim data electronically.

Drafting Note: Many State insurance codes specify penalties for failure to timely file statutorily required reports or for submitting materially incorrect data. Each State should determine the applicability of such penalties to this Act. If it is determined that the State does not possess an adequate means to enforce this Act, the State may wish to consider inserting additional enforcement wording in this section.

Drafting Note: The year inserted in subsection B should be the year following the year inserted in subsection A.

Section 5. Required Data Elements

Reports required under section 4 of this Act must contain the following information in a format and coding protocol prescribed by the commissioner. To the greatest extent possible while still fulfilling the purposes of this Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

A. Claim and incident identifiers, including:

(1) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and

(2) An incident identifier if companion claims have been made by a claimant;

B. The policy limits of the medical professional liability insurance policy covering the claim;

C. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;

D. The type of health care facility where the medical malpractice incident occurred;

E. The primary location within a facility where the medical malpractice incident occurred;

F. The geographic location, by city and county, where the medical malpractice incident occurred;

G. The injured person's sex and age on the incident date;

H. The severity of malpractice injury using the National Practitioner Data Bank severity scale;

I. The dates of:

(1) The earliest act or omission by the defendant that was the proximate cause of the claim;

(2) Notice to the insuring entity, self-insurer, facility or provider;

(3) Suit, if a suit was filed;

(4) Final indemnity payment, if any; and

(5) Final action by the insuring entity, self-insurer, facility or provider to close the claim;

J. Settlement information that identifies the timing and final method of claim disposition, including:

(1) Claims settled by the parties;

(2) Claims disposed of by a court, including the date disposed;

(3) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and

(4) Whether the settlement occurred before or after trial, if a trial occurred;

K. Specific information about the indemnity payments and defense and cost containment expenses, including:

(1) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(a) The indemnity payment made on behalf of the defendant;

(b) Economic damages;

(c) Non-economic damages;

(d) Punitive damages, if applicable; and

(e) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and

(2) For claims that do not result in a verdict or judgment that itemizes damages:

(a) The total amount of the settlement on behalf of the defendant;

(b) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;

(c) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and

(d) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;

L. The reason for the medical professional liability claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and

M. Any other closed claim data the commissioner determines to be necessary to accomplish the purpose of this Act and requires by adopting a rule.

Section 6. Confidentiality of Data

Drafting Note: Each state should determine the extent to which the data collected may be made available to other parties and insert wording consistent with that determination. Options include:

- All data are available to the public.
- All data are subject to release under certain restricted conditions, such as to applicants submitting a research proposal and signing a confidentiality agreement.
- Only individual records that have been "anonymized" may be released. For example, the data can be anonymized to varying degrees by removing elements that may permit identification of the parties to a case, by removing place references such as counties, and by limiting the representation of dates to the corresponding year.
- All data are confidential except data released in summary or aggregate form. Data would be aggregated to a high enough level that readers would not be able to deduce information on any particular provider, facility, claimant, or claim.

Section 7. Authority to Adopt Rules

The commissioner shall adopt any rules needed for implementing the provisions of this Act.

Section 8. Effective Date

This Act shall take effect on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2008 Proc. 3rd Quarter 3-323 to 3-330 (adopted). (Comment Letters-8-144 to 8-169).

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1742 (1982/2002); § 12-570 (1986/2005).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado			COLO. REV. STAT. § 10-1-120 (2003); BULLETIN B-5.14 (2007).
Connecticut			CONN. GEN. STAT. § 38a-395 (1958/2007); INS. ORDER 7-27-2006 (2006).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.912 (1974/2009); FLA. ADMIN. CODE ANN. r. 69O-171.003 (1983/1999); BULLETIN 84-255 (1984); BULLETIN 87-213 (1987); MEMORANDUM 97-007 (1997); MEMORANDUM 99-105 (1999).

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. § 33-3-27 (1983/2019).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 50, §§ 4203.200 to 4203.230 (2007/2013); §§ 928.10 to 928.Exhibit E (2012); BULLETIN 2006-1 (2006).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE ANN. § 505.27 (2006/2019).
Kansas			KAN. STAT. ANN. § 40-1126 (1975/1996).
Kentucky			KY. REV. STAT. ANN. § 304.310 (1976/2010).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24, §§ 2601 to 2608 (1977/1997); BULLETIN 283 (1998).
Maryland			MD. CODE ANN., INS. § 4-401 (2014); § 4-405 (2009); MD. CODE REGS. 31.08.10.01 to 31.08.10.05; BULLETIN 9-2009 (2009).
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. COMP. LAWS § 600.2912H (1994).
Minnesota			MINN. STAT. ANN. § 144.693 (1986).
Mississippi	NO CURRENT ACTIVITY		

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri			MO. ANN. STAT. §§ 383.105 to 383.106 (1976/2006); § 383.110 (1976/2006).
Montana	NO CURRENT ACTIVITY		
Nebraska			172 NEB. ADMIN. CODE § 5-003 (1995/2006).
Nevada			NEV. REV. STAT. § 690B.360 (2003); BULLETIN 2012-006 (2012).
New Hampshire			N.H. CODE ADMIN. R. INS. 3801.01 to 3801.07 (2006/2014).
New Jersey			N.J. STAT. ANN. § 17:30D-17 (1983/2006); N.J. ADMIN. CODE §§ 11:1-7.1 to 11:1-7.5 (2005/2009); §§ 11:27-11.1 to 11:27-11.6 (2009).
New Mexico			N.M. CODE R. § 16.10.10.8 (2018).
New York			N.Y. INS. LAW § 315 (1984/2000); CIRCULAR LETTER 2010-6 (2010).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3929.302 (2004); OHIO ADMIN. CODE § 3901-1-64 (2005/2014).
Oklahoma	OKLA. STAT. tit. 36, §§ 6810 to 6820 (2009) (portions of model).		OKLA. STAT. tit. 76, § 17 (1976/1979); BULLETIN 2005-02 (2005).
Oregon			OR. REV. STAT. § 742.400 (2007/2013).

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			BULLETIN 2009-4 (2009).
Tennessee	TENN. COMP. R. REGS. 0780-1-84-.01 to 0780-01-84-.10 (2008/2009) (portions of model).		TENN. CODE ANN. § 56-3-111 (1979/2004); §§ 56-54-101 to 56-54-111 (2008).
Texas			BULLETIN B-0041-09 (2009).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, § 3561 (2009) (authority to adopt model).
Virgin Islands			V.I. CODE ANN. tit. 27, § 166g (1975).
Virginia			VA. CODE ANN. § 38.2-2228.2 (2005).
Washington			WASH. REV. CODE § 7.70.140 (2006); §§ 48.140.020 to 48.140.080 (2006/2007); WASH. ADMIN. CODE 284-24C-020 to 284-24C-060 (2006/2013); 284-24D-040 (2007).
West Virginia			W. VA. CODE ANN. §§ 33-20B-6 to 33-20B-8 (1986/2001); W. VA. CODE R. §§ 114-22-1 to 114-22-6(1988).
Wisconsin			WIS. STAT. § 655.45 (1985/2009); WIS. ADMIN. CODE § INS. 7.06 (1992).
Wyoming	NO CURRENT ACTIVITY		

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

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Purpose and Intent

This Act shall be known as the Single Health Care Voluntary Purchasing Alliance Model Act.

The purpose of this Act is to improve the fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than [insert number] employees. It does so by allowing for the establishment by the state of a centralized purchasing entity (purchasing alliance) through which eligible small employers, and self-employed individuals can purchase health coverage. Another goal is to avoid jurisdictional confusion and unnecessary and expensive bureaucracy within the purchasing alliance and state government by clarifying the respective roles and jurisdiction of existing regulatory agencies and the purchasing alliance. This Act provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws. In addition, the intent of the Act is to avoid creating an undue burden on small employers when purchasing health care coverage through the purchasing alliance.

The Act is also intended to provide a meaningful choice of high quality, fairly priced health care plans and health care coverage for member small employers, employees and individuals of the purchasing alliance through a system that is fair, efficient and accountable to its members and includes procedural and substantive protections.

The purchasing alliance, through an open and fair competitive procurement process, shall contract with qualified group carriers to provide a meaningful choice of carriers providing health benefit plans to purchasing alliance enrollees.

Drafting Note: In order that states might choose which approach would best accommodate their needs, the National Association of Insurance Commissioners (NAIC) has developed several purchasing alliance model acts to address the problems of providing health care coverage to small employers and their employees. In doing this, the NAIC is not expressing a preference for one model over another. This Act assumes that a state has already adopted substantially the most recent version of the NAIC's Small Employer Health Insurance Availability Model Act to ensure that the purchasing alliance operates properly. For example, it is imperative that both the purchasing alliance and existing markets operate under the same rating, underwriting, enrollment and participation requirements. Absent strong market reforms, such as guaranteed issue of all products sold in the small group market, a voluntary purchasing alliance will become a high risk pool. The Single Health Care Voluntary Purchasing Alliance Model Act is intended to be a portion of a larger program of underwriting reforms in the general small group market and would necessarily use the same terms and definitions.

Drafting Note: This Act establishes the purchasing alliance as a state agency. However, states may wish to establish the purchasing alliance as a state-chartered, nonprofit organization. States may also consider establishment under an existing state agency such as the office of the commissioner. States may consider expanding alliance eligibility to include individuals, state employees, and other designated population groupings that are eligible to purchase health insurance coverage through a purchasing alliance. However, in expanding eligibility prior to universal coverage, states should be careful to avoid burdening the purchasing alliance with high-risk individuals or groups. If population groupings other than small employers are eligible to purchase coverage through the alliance, underwriting and rating parity should be required inside and outside the alliance.

Section 1. Definitions

A. "Adjusted community rating" has the same meaning as in Section [cite reference to small employer health insurance availability law].

B. "Antitrust laws" means state laws intended to protect commerce from unlawful restraints, monopolies and unfair business practices.

C. "Board" means the state purchasing alliance board authorized pursuant to this Act.

D. "Carrier" has the same meaning as in Section [insert reference to small employer health insurance availability law] and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-along basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 6A(1) of this Act.

Drafting Note: Most states provide for the licensing of dental-only carriers authorized to offer dental benefits. Inclusion of dental-only carriers in the definitions of "small group carrier" and "participating carrier" is designed to enable these carriers to offer dental-only benefits through an alliance without requiring them to be "small group carriers" pursuant to a state's small employer health insurance availability law. These dental-only carriers are required to comply with all of the Act's provisions except those which would otherwise require qualified carriers to offer health benefits other than dental benefits.

E. "Commissioner" has the same meaning as in Section [insert reference to the chief insurance regulatory official of the state].

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears. Where jurisdiction of managed care organizations lies with some other state agency, or dual state regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

F. "Dependent" has the same meaning as in Section [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the following definition:

"Dependent" means a spouse; an unmarried child under the age of [nineteen (19)] years; an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the enrollee; and an unmarried child of any age who is medically certified as disabled and dependent upon the enrollee.

When using this definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the enrollee.

G. "Eligible employee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

H. "Enrollee" means an eligible employee, self-employed individual or a dependent of an eligible employee who is enrolled in a health benefit plan offered through the purchasing alliance by a participating carrier.

Drafting Note: The Act assumes that a small employer group includes self-employed individuals. This term should be deleted from the definition of "enrollee" if the minimum size of a small employer group is two or more.

I. "Fund" means the state purchasing alliance fund established under Section 11.

J. "Health benefit plan" has the same meaning as in Section [insert reference to small employer health insurance availability law].

K. "Late enrollee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

L. "Limited benefit health insurance" has the same meaning as in Section [insert reference to small employer health insurance availability law].

M. "Member small employer" means a small employer who enrolls in the purchasing alliance.

N. "Participating carrier" means a carrier that contracts with the purchasing alliance to provide coverage to enrollees under a health benefit plan and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-alone basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 6A(1) of this Act.

O. "Purchasing alliance" means the state agency established by this Act to provide health insurance through multiple unaffiliated participating carriers to member small employers and their employees throughout the state.

P. "Regional service areas" means clearly defined, non-overlapping and exclusive geographical regions encompassing the entire state as determined by the board.

Q. "Small employer" has the same meaning as in Section [insert reference to small employer health insurance availability law].

Drafting Note: Definitions that reference the small employer health insurance availability law may be deleted if placement of this Act is within the availability law.

Section 2. Jurisdiction of the Commissioner; Penalties

A. Except as authorized by this Act, no person or entity may market, sell, offer or arrange for a package of one or more health benefit plans underwritten by two (2) or more carriers to two (2) or more small employers or their eligible employees.

B. A person or entity not established under this Act as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance or health insurance purchasing cooperative, or otherwise use a confusing similar name.

C. Nothing in this Act shall be deemed to be in conflict with or in limitation of the duties and powers granted to the commissioner under the laws of this state.

D. The board shall report to the commissioner suspected or alleged law violations.

E. Violations of this Act shall be subject to the penalties contained in Sections [insert sections of state law penalty provisions].

Drafting Note: The range of regulatory actions, processes, remedies and penalties to be specified here should be at least as broad as those available to the commissioner when he or she investigates or sanctions entities under the insurance laws.

Section 3. Establishment of the Board; Membership; Terms; Conflicts of Interest

A. A state purchasing alliance, which shall be operated by the board, is established as a state agency.

Drafting Note: It is the intent of this Act to keep the roles of the board and commissioner clearly delineated. The role of the board is to oversee the operations of the purchasing alliance. Simply put, the commissioner continues as the "regulator" of all insurance activities within the state. The board operates the purchasing alliance for the benefit of its enrollees.

B. The initial board shall consist of nine (9) members, as follows:

(1) Three (3) appointed by the governor, including: two (2) who expect to be owners or managers of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(2) Two (2) appointed by the legislature upon the recommendation of the speaker of the house, including: one who expects to be an owner or manager of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(3) Two (2) appointed by the legislature upon recommendation of the president (pro tempore) of the senate, including: one who expects to be an owner or manager of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(4) The commissioner shall appoint one member; and

(5) The state's chief health officer shall appoint one member.

C. In reference to small employer and employee representatives appointed to the board pursuant to Subsection B, subsequent appointments shall be made using small employers and employees who are participating in the purchasing alliance.

D. Members of the board shall receive reimbursement for travel and subsistence at the rates specified in [insert reference to state rules regarding reimbursements].

E. The term for members appointed to serve on the board is four (4) years, except that the initial terms of one employee and one employer appointed by the governor, one employee appointed by the Senate and one employer appointed by the House shall expire two (2) years after the effective date of this Act. The initial term of the board shall commence on the effective date of this Act.

F. At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed.

G. The board shall elect officers biennially.

H. The board shall meet at least quarterly at the times and places it determines. The meeting and procedures shall be governed by the procedures and policies set forth in [insert citation to open meetings law]. A majority of the fully authorized membership of the board is a quorum.

I. No board members or members of their households nor the executive director may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of a carrier or other insurer, a health care provider or agent or broker. This provision shall not preclude a board member from purchasing coverage through the alliance.

J. The executive director and board members shall be subject to the provisions of [insert section of state law which controls the ethics of public officials].

Drafting Note: States should review their ethics laws to ensure prohibition or limitation on the amount of stock that the executive director and board members can own in the entities described in Section 3J. If no prohibition or limitation exists, a state should consider drafting language to do so.

K. No cause of action or liability of any nature or kind shall arise against a member of the board, or its employees or agents, for any action taken in good faith by them in the performance of their powers and duties as defined in Sections 4 and 5.

Section 4. Powers of the Board

A. The board may do the following:

(1) Enter into contracts with participating carriers to provide health benefits to eligible employees and their dependents. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments. The board may establish performance standards for specific contractual elements and penalties for failure to fulfill contractual obligations;

Drafting Note: This does not address the board's inherent power to cancel a contract in response to a participating carrier's breach of contract.

(2) Contract with qualified, independent third parties for services necessary to carry out the powers and duties of the purchasing alliance. Unless permission is specifically granted by the board, a third party hired by the purchasing alliance may not release, publish or otherwise use information to which the third party has access under its contract. Except with the express written approval of the board, an entity may not act, directly or through an affiliated company, in the same regional service area both as a participating carrier and a third party under contract to the purchasing alliance;

(3) Enter into all other contracts as are necessary to carry out the powers and duties of this Act;

(4) Sue or be sued, including taking action necessary for securing legal remedies on behalf of, or against the purchasing alliance, member small employers, enrollees, a board member or other parties subject to this Act;

(5) Employ staff necessary to carry out the powers and duties of this Act;

(6) Appoint advisory committees that may include persons with expertise in health benefits management and marketing and representatives of participating carriers, consumer groups, health care providers, and others as may be deemed necessary to carry out the purposes of this Act.

(7) Appoint local beneficiary advisory councils to evaluate purchasing alliance functions and the performance of participating carriers in order to assess the efficacy of the operations for member small employers and enrollees;

(8) Receive and accept grants, funds or anything of value from a public or private agency; and receive and accept contributions from a legitimate source of money, property, labor or any other thing of value. However, the board shall not accept anything of value from a person or entity that might have a vested interest in the decisions of the board except with the express permission of the commissioner;

(9) Define and offer other health benefit plans in addition to the standard and basic health benefit plans promulgated pursuant to [insert reference to small employer health insurance availability law]. The alliance may also incidentally offer optional group vision and dental benefit plans and, with the prior approval of the commissioner, other limited benefit health insurance to enrollees;

Drafting Note: Under the guaranteed issue provision of the small employers health insurance availability model act, carriers offering a particular health benefit plan designed through the purchasing alliance will also have to offer and issue that plan to small employers outside of the purchasing alliance.

Drafting Note: States may wish to exempt the alliance from having to purchase the basic and standard health benefit plans that carriers are obligated to offer under state laws. It may be desirable to do this if it is the view that the alliance is the ultimate consumer on behalf of its members and should, accordingly, be able to make the decision whether to accept or reject, on behalf of its members, the health benefit plans that are required to be offered by all carriers who sell in the small employer marketplace.

This approach would allow small employers who desire not to purchase the basic or standard plans to join the alliance and would provide the most flexible system for the board to then actively negotiate a more favorable benefit structure for its members. It would also be necessary to allow for this exemption in Section 5A(8).

(10) Assess member small employers a reasonable fee for costs incurred or anticipated in connection with the operation of the purchasing alliance;

(11) Undertake activities necessary to administer the purchasing alliance, including marketing and publicizing the purchasing alliance, and assuring participating carrier, small employer, and enrollee compliance with purchasing alliance requirements;

(12) Establish conditions and procedures for participation of:

(a) Small employers and eligible employees;

(b) Participating carriers; and

(c) Agents or brokers;

(13) Negotiate with participating carriers the administrative expense component of the premium rates charged for coverage offered through the alliance consistent with Section 6D;

(14) Apportion the state into regional service areas in which multiple unaffiliated participating carriers will provide coverage to enrollees; and

(15) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this Act.

Drafting Note: States may wish to allow the purchasing alliance to keep certain contract terms with participating carriers and third party administrators confidential. Accordingly, states may need to review and change existing statutes that may prohibit this.

B. Any contract entered into pursuant to this Act shall be exempt from the provisions of Section [insert law relating to competitive bidding].

Section 5. Operation of the Purchasing Alliance

A. The board shall:

(1) Establish and operate the purchasing alliance, which shall be a statewide entity offering health benefit plans to all small employers in the state;

(2) Employ an executive director to oversee and direct the administrative functions of the purchasing alliance;

Drafting Note: States should consider whether the executive director and other staff should be exempt from civil service requirements.

(3) Develop model contracts which detail for potential contractors the requirements of the purchasing alliance;

(4) Provide a copy of the model contract to interested carriers, detailing the contractual terms for participation in the purchasing alliance;

(5) Develop and make available a list of objective criteria that must be met by participating carriers in order to be eligible to participate in the purchasing alliance;

(6) Specify in contracts with participating carriers how all premiums will be transmitted together with inclusion of appropriate language for penalties and grace periods on late payments of premiums;

(7) Contract with at least three (3) unaffiliated carriers in each regional service area to ensure that enrollees have a choice from among a reasonable number of differing types of competing carriers and health benefit plans that include the basic and standard health benefits plans required by [cite small employer health insurance availability law]. The commissioner may, upon a showing of good cause, waive the requirement to have at least three (3) unaffiliated participating carriers throughout all portions of the regional service areas;

Drafting Note: Coverage through the purchasing alliance of employees who work and reside outside of the state can create administrative problems due to the application of other states' extraterritorial mandated benefit laws. Moreover, many participating carriers, notably local HMOs, will not be able to provide coverage for out-of-state residents in any event. The purchasing alliance may wish to address this by issuing a separate request for proposal for the purpose of contracting with carriers to provide out-of-state coverage.

(8) Develop standard enrollment procedures to be used by the purchasing alliance;

(9) Publish educational materials, plan descriptions and comparison sheets describing participating carriers and the health benefit plans available through the purchasing alliance for use in enrolling small employers and their eligible employees;

Drafting Note: The NAIC is in the process of evaluating standards and reporting measures that might be used in comparison guides. A number of accrediting organizations and other groups are also developing report cards that might be considered for inclusion under this Act.

(10) Establish conditions for participation of small employers that conform to the requirements of this Act and Section [insert reference to small employer health insurance availability law] and that include, but are not limited to, assurances that the small employer is a bona fide employer group. The board shall specify in contracts with member small employers that the purchasing alliance will be the master contract holder of the health benefit plan policy on behalf of member small employers and enrollees. These contracts shall also provide that all eligible employees of the small employer who obtain coverage under the health benefit plan offered by the small employer must obtain coverage through the purchasing alliance;

(11) In enrolling member small employers, the purchasing alliance shall provide that each eligible employee is permitted to enroll in any health benefit plan offered by any participating carrier so long as the health benefit plan provides coverage where he or she works or lives;

(12) Request from the commissioner certification that all participating carriers are in good standing and licensed as small group carriers as set forth in Section [insert reference to small employer health insurance availability law], and that the carriers satisfy the financial requirements established under Section [insert reference to capital and surplus law];

(13) Receive, review and act, as appropriate, on grievances by member small employers or enrollees;

(14) Review information and recommendations from consumers, employers, participating carriers or health care providers and other sources. After the review, the board may issue reports or otherwise make recommendations to improve the delivery or purchase of health care benefits;

(15) Establish administrative and accounting procedures for operating the purchasing alliance and for providing services to member small employers and enrollees;

(16) Prepare an annual report on the operations of the purchasing alliance for the commissioner, legislature and the governor, which shall include, but not be limited to, an accounting of all outside revenues received by the board and all internal and independent audits;

(17) Establish procedures and mechanisms for billing and collection of premiums from member small employers (including any share of the premium paid by enrollees);

(18) Establish procedures for annual or rolling open enrollment periods during which:

(a) An enrollee may elect to enroll in any other health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works; and

(b) Any late enrollees may elect to enroll in any health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works;

(19) Place into its contracts between the purchasing alliance and member small employers the following:

(1) For administrative purposes, the purchasing alliance will be the policyholder or contract holder of the health benefit plan on behalf of member small employers, their eligible employees and dependents;

(2) Provide that the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of the health benefit plan's coverage to each enrolled eligible employee; and

(3) Provide that all eligible employees of the small employer who obtains coverage under the health benefit plan offered by the small employer must obtain coverage through the purchasing alliance;

(20) Provide that in the event a member small employer terminates coverage purchased through the purchasing alliance, the former member small employer shall be ineligible to purchase a health benefit plan through the purchasing alliance for a period of twelve (12) months; and

(21) Publicly disclose grants, funds or anything of value received pursuant to Section 4A(8).

B. The board may develop uniform standards for data to be provided by participating carriers and providers. The purchasing alliance may collect and disseminate data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the state. In formulating data collection standards, the board may use standards based on, and consistent with, existing state, National Association of Insurance Commissioners (NAIC) and national health care data collection initiatives and shall take into account their feasibility and cost-effectiveness.

C. The board may not:

(1) Purchase health care services, assume risk for the cost or provision of health service, or otherwise contract with health care providers for the provision of health care services to enrollees;

(2) Exclude a small employer or eligible employee or dependent of an eligible employee from membership in the purchasing alliance who agrees to pay fees for membership and the premium for coverage through the purchasing alliance and who abides by the bylaws and rules of the purchasing alliance;

(3) Prohibit the participation of small employers, or differentiate classes of membership, based on industry type, experience, age, gender, family status, education, health status, income or other means in conflict with the rating methodology specified in Section [insert reference to small employers health insurance availability law];

(4) Commit an act constituting a rebate prohibited pursuant to Section [insert applicable section of state law];

(5) Charge a fee not directly related to the operation of the purchasing alliance or for non-health care related activities;

(6) As a condition of membership, require a small employer, eligible employee or dependent to subscribe to limited health benefit insurance or non-health care related products or services;

(7) Operate the purchasing alliance or market the purchasing alliance in a county or primary metropolitan statistical area in a way which would cause the purchasing alliance to select a risk pool with actuarially projected health care utilization over a two-year period which is below the projected average for all individuals residing in that county or primary metropolitan statistical area. The measurement and composition of projected utilization by members of the purchasing alliance to all individuals shall be done on a county or primary metropolitan statistical area basis and not across all members of the purchasing alliance;

(8) Engage in any competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors specified in this subsection or small employer size; or

(9) Require or take any action inconsistent or in conflict with state laws or regulations of the commissioner.

Section 6. Requirements for Participating Carriers

A. In order to be eligible to be a participating carrier, a carrier must be able to satisfactorily demonstrate to the board the following operating characteristics:

(1) That they are licensed, approved as a small employer carrier, and in good standing with the commissioner;

(2) The ability to administer a health benefit plan, to provide adequate service and to comply with all contractual requirements of the purchasing alliance;

(3) The ability to provide enrollees with reasonable access to covered services;

(4) The ability to arrange and pay for the appropriate quality, level and type of health care services;

(5) The ability to provide data required by the board, including information on enrollee satisfaction, including standard surveys as may be prescribed by the board and to meet reasonable satisfaction measures as may be established by the board;

(6) The ability to provide standard data elements in a manner prescribed by the board;

(7) The ability to meet quality of care standards established by the commissioner and other relevant regulators;

(8) Strong financial condition;

(9) Adequate administrative management;

(10) A procedure to address enrollee grievances and appeals;

(11) The ability to achieve satisfactory enrollment levels within the service area in which the carrier is licensed; and

(12) All other criteria established by the board.

B. In evaluating which carriers may participate in the purchasing alliance, the board shall consider, among other factors:

(1) Minimum regional service area and participation requirements, maximum thresholds for premium rates, and standards for determining whether a carrier operates efficiently;

(2) The ability of a carrier to provide services within a regional service area;

(3) Pricing and the competitiveness of each bid from a carrier; and

(4) The effect of contracting with additional carriers on the administrative costs of the purchasing alliance and member small employers, the efficiency of the purchasing alliance, and the competitiveness of the premiums that will be paid to participating carriers.

C. Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board, in consultation with the carrier's licensing agency:

(1) Review the quality of care covered;

(2) Review the appropriateness of care covered; and

(3) Provide accessible health care services.

D. Every participating carrier shall:

(1) Meet the standards established by the board pursuant to this Act;

(2) Provide data required by the board;

(3) Comply with all rules and regulations regarding underwriting, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices, the provisions of this Act and other applicable state statutes;

(4) Comply with all rules and regulations regarding adjusted community rating as specified in Section [cite applicable section of small employer health insurance availability law], except that the purchasing alliance and a participating carrier may negotiate only the administrative expense component of the premium rates charged for coverage offered through the alliance where the carrier can demonstrate net administrative cost savings for its alliance business. For the purposes of this paragraph, administrative expenses are limited to marketing expenses, acquisition expenses, the cost of paying claims, commissions and maintenance expenses;

Drafting Note: Participating carriers must be required to use the same rating methodology inside and outside the alliance. Alliances should be permitted to negotiate with carriers only on administrative costs. Claim costs must be uniform across a carrier's entire small employer group market and not be subject to negotiation.

(5) Enroll and dis-enroll individuals in the manner specified by the board or its designee; and

(6) Comply with other requirements established by the board pursuant to this Act.

E. Nothing in this Act shall prohibit participating carriers from contracting with particular health care providers or types, classes or categories of health care providers or setting reimbursement methodology.

F. Notwithstanding anything to the contrary in Section [cite guaranteed renewability section of the small employer health insurance availability law], in the event the participating carrier elects to terminate its contract with the purchasing alliance, the participating carrier shall:

(1) Provide advance notice of its decision to the board; and

(2) Provide notice of the decision at least 180 days prior to the nonrenewal of a health benefit plan to the member small employers and enrollees. A participating carrier that elects not to renew a health benefit plan with the purchasing alliance shall be prohibited from writing new business through the alliance for a period of three (3) years from the date of the notice to the purchasing alliance or until the purchasing alliance, with the concurrence of the commissioner, invites the former participating carrier to renew participation, whichever is sooner.

Section 7. Marketing Health Benefit Plans

A. The board shall establish marketing standards for use by participating carriers.

B. Any marketing, advertisement or educational material for health benefit plans sold through the purchasing alliance shall be approved by the board prior to its use. The board shall review all materials submitted to it and the materials shall be deemed approved if not disapproved within [insert number] days. The purchasing alliance may, through its contracts with participating carriers, deem certain classes of materials to be approved.

C. This section shall not be construed to prohibit or to compel the purchasing alliance or a participating carrier from using the services of an agent or broker.

Drafting Note: States are reminded that this section is not intended to modify existing statutes that require the licensing of individuals who provide advice on insurance coverage or who solicit sales of insurance.

D. A participating carrier, agent, broker, contractor or producer of a participating carrier, or independent insurance agent, broker, contractor or producer may not engage, directly or indirectly, in an activity or marketing practice that would encourage member small employers or eligible employees to:

(1) Refrain from enrolling in a health benefit plan offered through the purchasing alliance because of their health status or claims experience;

(2) Seek coverage from other participating carriers because of their health status or claim experience; or

(3) Enroll or fail to enroll in the purchasing alliance because of their health status or claims experience.

Section 8. Risk Adjustment Mechanism

The commissioner may establish a payment mechanism to adjust for the amount of risk covered by each participating carrier. The commissioner may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

Drafting Note: Some states may prefer to develop a risk adjustment mechanism that applies to the entire small group market and not simply to business written by participating carriers through the purchasing alliance. A risk adjustment mechanism that operates across the entire small group market would preserve the principle of uniform rating and underwriting rules both inside and outside of the alliance and would minimize incentives for carriers to either steer high-risk business to the alliance or avoid participating in the alliance altogether.

Section 9. Antitrust Protection

The purchasing alliance, its employees and agents, and participating carriers are exempt from state antitrust law for an act or omission that is permitted or required by this Act or authorized or required by the board in accordance with this Act.

Section 10. State Health Care Purchasing Alliance Fund

A. There is established in the office of the State Treasurer the State Health Care Purchasing Alliance Fund. All moneys received by the fund shall be placed in an interest-bearing account and interest or other income derived thereon shall be credited to the fund. Moneys in the fund shall be continuously appropriated to the board, without regard to fiscal year, for the purposes specified in this Act.

B. The account and all funds shall be wholly and completely the property of the state and at all times available for audit by the state. Funds in the account may be derived from the following sources:

(1) Employer premiums;

(2) Employer participation fees;

(3) Employer late fees;

(4) Employer reinstatement fees;

(5) Agent and broker fees paid by the employer;

(6) Developmental costs paid by the state;

(7) Interest earned on the account;

(8) Funds paid by the participating carriers for a pooled marketing effort; or

(9) Other lawful sources.

C. Funds from the account may be withdrawn by the board to pay:

(1) Participating carriers under their contracts;

(2) Third parties for their services provided under contract;

(3) Employer billing adjustments;

(4) Agent and broker fees;

(5) Funds owed the state for its administrative costs; and

(6) All other expenditures duly authorized by the board.

Drafting Note: This section should be changed if a state chooses to establish the purchasing alliance as a state-chartered nonprofit organization. Under those circumstances, the purchasing alliance fund should be set up in a bank trust fund subject to audit by the appropriate state agency.

Section 11. Purchasing Alliance Evaluation

The board shall make a report not later than [insert date] to the governor, commissioner and the legislature of at least the following:

A. The progress achieved in assuring affordable health care coverage to employees of member small employers;

B. The need, if any, for financial incentives or other mechanisms to increase participation in the purchasing alliance;

C. The benefits, if any, of exclusive purchasing of health insurance through the purchasing alliance for all small employers who choose to purchase health coverage; and

D. Other changes in the law or procedure that would improve the overall efficiency, further reduce costs and improve fairness.

Section 12. Rulemaking Authority

The board may promulgate regulations consistent with the powers and duties set forth in this Act as necessary to implement and administer the purchasing alliance. Any rules and regulations issued pursuant to this Act may be adopted as emergency regulations in accordance with [insert reference to applicable state law] and with the Administrative Procedures Act.

Section 13. Effective Date

This Act shall be effective [insert date].

Drafting Note: Each state should draft to be consistent with that state's procedures for establishing an effective date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 36, 555, 589, 620-629, 639 (adopted).
1996 Proc. 2nd Quarter 10, 30, 732, 678, 779-781 (amended).

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. §§ 23-86-501 to 23-86-512 (2001/2005); ARK. CODE R. §§ 054.00.78-1 to 054.00.78-7 (2003).
California			CAL. INS. CODE §§ 10730 to 10750 (1992); CAL. CODE REGS. tit. 10, §§ 2699.610 to 2699.6463.5 (1994/1999); CAL INS. CODE §§ 10800 to 10887 (1997).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. §§ 33-30A-1 to 33-30A-11 (1997); GA. COMP. R. & REGS. 120-2-79 (2000).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 123/1 to 123/75 (1997).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. §§ 191-73.1 to 191-73.24 (1994).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1951 to 1957 (1996/2003).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. ANN. §§ 62T.01 to 62T.12 (1997).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. §§ 33-22-1801 to 33-22-1822 (1995/2017).
Nebraska	NO CURRENT ACTIVITY		

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. ANN. §§ 689C.360 to 689C.600 (1995).
New Hampshire			N.H. REV. STAT. ANN. § 420-G:10a (2001) (authority to adopt regulations); N.H. CODE ADMIN. R. INS. §§ 3401.01 to 3401.11 (2001).
New Jersey			N.J. STAT. ANN. §§ 17B:27A-25.1 to 17B:27A-25.9 (2003).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE § 26.1-01-07.4 (1993/2005) (authority to adopt rules).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, §§ 4521 to 4529 (2002).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-71-730 (1987/1994).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		28 TEX. ADMIN. CODE §§ 26.401 to 26.442 (2004).

THE SINGLE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

Table of Contents

Purpose and Intent

This Act shall be known as the Regional Health Care Voluntary Purchasing Alliance Act.

The purpose of this Act is to improve the fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than [insert number] employees. It does so by allowing for the establishment by the state of regional purchasing entities that are referred to as purchasing alliances through which eligible small employers, and self-employed individuals can purchase health coverage. Another goal is to avoid jurisdictional confusion and unnecessary and expensive bureaucracy within the purchasing alliances and state government by clarifying the respective roles and jurisdiction of existing regulatory agencies and the purchasing alliances. This Act provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws. In addition, the intent of the Act is to avoid creating an undue burden on small employers when purchasing health care coverage through a purchasing alliance.

This Act is also intended to provide a meaningful choice of high quality, fairly priced health care plans and health care coverage for member small employers, employees and individuals of purchasing alliances through a system that is fair, efficient and accountable to its members and includes procedural and substantive protections.

The purchasing alliances, through an open and fair competitive procurement process, shall contract with qualified group carriers to provide a meaningful choice of carriers providing health benefit plans to purchasing alliance enrollees.

Drafting Note: In order that states might choose which approach would best accommodate their needs, the National Association of Insurance Commissioners (NAIC) has developed several purchasing alliance model acts to address the problems of providing health care coverage to small employers and their employees. In doing this, the NAIC is not expressing a preference for one model over another. This Act assumes that a state has already adopted substantially the most recent version of the NAIC's Small Employer Health Insurance Availability Model Act to ensure that the purchasing alliance operates properly. For example, it is imperative that the qualified health benefit plans issued to the purchasing alliances and the policies issued directly to small employers who are not members of a purchasing alliance operate under the same rating, underwriting, enrollment and participation requirements.

Absent strong market reforms, such as guaranteed issue of all products sold in the small group market, a voluntary purchasing alliance will become a high risk pool. The Regional Health Care Voluntary Purchasing Alliance Model Act is intended to be a portion of a larger program of underwriting reforms in the general small group market and would necessarily use the same terms and definitions.

Drafting Note: States may consider expanding alliance eligibility to include individuals, state employees, and other designated population groupings that are eligible to purchase health insurance coverage through a purchasing alliance. However, in expanding eligibility prior to universal coverage, states should be careful to avoid burdening the purchasing alliances with high-risk individuals or groups. If population groupings other than small employers are eligible to purchase coverage through an alliance, underwriting and rating parity should be required for inside and outside the alliance.

Section 1. Definitions

A. "Adjusted community rating" has the same meaning as in Section [insert reference to small employer health insurance availability law].

B. "Alliance service area" means a clearly defined, non-overlapping and exclusive geographical area determined by the state board for the purpose of defining the regions in which the purchasing alliances will operate.

C. "Antitrust laws" means state laws intended to protect commerce from unlawful restraints, monopolies and unfair business practices.

D. "Carrier" or "small group carrier" has the same meaning as in Section [insert reference to small employer health insurance availability law] and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-alone basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 4A(3)(a) and (c)(i) of this Act.

Drafting Note: Most states provide for the licensing of dental-only carriers authorized to offer dental benefits. Inclusion of dental-only carriers in the definitions of "small group carrier" and "participating carrier" is designed to enable these carriers to offer dental-only benefits through an alliance without requiring them to be "small group carriers" pursuant to a state's small employer health insurance availability law. These dental-only carriers are required to comply with all of the Act's provisions except those that would otherwise require qualified carriers to offer health benefits other than dental benefits.

E. "Carrier service area" or "participating carrier service area" means a geographic region in which a carrier is licensed to operate.

F. "Commissioner" has the same meaning as in Section [insert reference to the chief insurance regulatory official of the state].

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears. Where jurisdiction of managed care organizations lies with some other state agency, or dual state regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

G. "Dependent" means the same as defined in Section [insert reference to state insurance laws defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the following definition:

"Dependent" means a spouse; an unmarried child under the age of [nineteen (19)] years; an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the enrollee; and an unmarried child of any age who is medically certified as disabled and dependent upon the enrollee.

If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the enrollee.

H. "Eligible employee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

I. "Enrollee" means an eligible employee, self-employed individual or a dependent of an eligible employee who is enrolled in a qualified health benefit plan offered through a purchasing alliance by a participating carrier.

Drafting Note: The Act assumes that a small employer group includes self-employed individuals. This term should be deleted from the definition of "enrollee" if the minimum size of a small employer group is two or more.

J. "Health benefit plan" has the same meaning as in Section [insert reference to small employer health insurance availability law].

K. "Late enrollee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

L. "Limited benefit health insurance" has the same meaning as in Section [insert reference to small employer health insurance availability law].

M. "Member small employer" means a small employer who enrolls in a purchasing alliance.

N. "Participating carrier" means a carrier that contracts with a purchasing alliance to provide coverage to enrollees under a qualified health benefit plan.

O. "Premium" has the same meaning as in Section [insert reference to small employer health insurance availability law].

P. "Purchasing alliance" or "alliance" means a non-risk-bearing nonprofit corporation established pursuant to this Act under Section [insert statutory reference to nonprofit corporation law] to provide health insurance through multiple unaffiliated participating carriers to member small employers, their eligible employees and dependents within an alliance service area.

Q. "Purchasing alliance board" or "alliance board" means the board of directors of a purchasing alliance.

R. "Qualified carrier" means a carrier designated by the state board to offer a qualified health benefit plan to purchasing alliances and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-alone basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 4A(3)(a) and (c)(i) of this Act.

S. "Qualified health benefit plan" means the standard, basic or other standardized guaranteed issue health benefit plan approved by the state board and offered by a purchasing alliance to member small employers, their eligible employees and dependents. The term shall also include optional group vision and dental benefit plans and, with the prior approval of the commissioner, other limited benefit health insurance.

Drafting Note: Under the guaranteed issue provision of the small employer health insurance availability model act, carriers offering a particular health benefit plan designed through a purchasing alliance will also have to offer and issue that plan to small employers outside of the purchasing alliance.

T. "Small employer" has the same meaning as in Section [insert reference to small employer health insurance availability law].

U. "State board" means the state purchasing alliance oversight board established by this Act to oversee the activities of the purchasing alliances.

Section 2. Jurisdiction of the Commissioner; Penalties

A. Except as authorized by this Act, no person or entity may market, sell, offer or arrange for a package of one or more health benefit plans underwritten by two (2) or more carriers to two (2) or more small employers or their eligible employees.

B. A person or entity not established under this Act as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance or health insurance purchasing cooperative, or otherwise use a confusing similar name.

C. Nothing in this Act shall be deemed to be in conflict with or in limitation of the duties and powers granted to the commissioner under the laws of this state.

D. The state board and alliance boards shall report to the commissioner suspected or alleged law violations.

E. Violations of this Act shall be subject to the penalties contained in [insert sections of state law containing penalty provisions].

Drafting Note: The range of regulatory actions, processes, remedies and penalties to be specified here should be at least as broad as those available to the commissioner when he or she investigates or sanctions entities under the insurance laws.

Section 3. Establishment of the State Purchasing Alliance Oversight Board; Membership; Terms; Conflicts of Interest

A. A state purchasing alliance oversight board is established within the office of the commissioner and shall provide oversight of the purchasing alliances.

Drafting Note: The state board is established within the office of the commissioner to capitalize on the existing expertise that is needed to establish purchasing alliance operations in each of the alliance service areas. It is anticipated that the commissioner's office will require additional funding in order to carry out these duties. However, it is the intent of this Act to keep the roles of the state board and the commissioner clearly delineated. The role of the state board is to oversee the operations of the purchasing alliances. Simply put, the commissioner continues as the regulator of all insurance activities within the state. The state board oversees the purchasing alliances for the benefit of their enrollees.

B. The initial state board shall consist of nine (9) members, as follows:

(1) Three (3) appointed by the governor, including: two (2) who expect to be owners or managers of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(2) Two (2) appointed by the legislature upon the recommendation of the speaker of the house, including: one who expects to be an owner or manager of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(3) Two (2) appointed by the legislature upon recommendation of the president (pro tempore) of the senate, including: one who expects to be an owner or manager of a member small employer of the purchasing alliance, and one who expects to be an employee enrollee of the purchasing alliance;

(4) The commissioner shall appoint one member; and

(5) The state's chief health officer shall appoint one member.

C. In reference to small employer and employee representatives appointed to the state board pursuant to Subsection B, subsequent appointments shall be made using small employers and employees who are participating in the purchasing alliance.

D. Members of the state board shall receive reimbursement for travel and subsistence at the rates specified in [insert reference to state rules regarding reimbursements].

E. The term for members appointed to serve on the state board is four (4) years, except that the initial terms of one employee and one employer appointed by the governor, one employee appointed by the Senate and one employer appointed by the House shall expire two (2) years after the effective date of this Act. The initial term of the board shall commence on the effective date of this Act.

F. At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed.

G. The state board shall elect officers biennially.

H. The state board shall meet at least quarterly at the times and places it determines. The meeting and procedures shall be governed by the procedures and policies set forth in [insert citation to state open meetings law]. A majority of the fully authorized membership of the board is a quorum.

I. No state board members or members of their households may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of a carrier or other insurer, a health care provider or agent or broker. This provision shall not preclude a state board member from purchasing coverage through a purchasing alliance.

J. The state board members shall be subject to the provisions of [insert section of state law which controls the ethics of public officials].

Drafting Note: States should review their ethics laws to ensure prohibition or limitation on the amount of stock that the state board members can own in the entities described in Section 3I. If no prohibition or limitation exists, a state should consider drafting language to do so.

K. No cause of action or liability of any nature or kind shall arise against a member of the state board, or its employees or agents, for an action taken in good faith by them in the performance of their powers and duties.

Section 4. Powers of the State Board

A. The state board shall:

(1) Establish no less than [insert number] and no more than [insert number] alliance service areas in this state no later than [insert date]. In establishing these areas, the state board shall assure that every location in the state is a part of an alliance service area.

The state board shall consider potential size of enrollment populations, geographic compactness, transportation patterns, metropolitan statistical areas, availability of health and medical resources (especially for disadvantaged populations or areas), unique regional health care problems, medical referral patterns, existing rating territories, health care cost variations, carrier service areas and availability of managed care arrangements. The state board may redefine alliance service areas when:

(a) Insufficient numbers of enrollees, managed care arrangements, health care providers or participating carriers are available to make the requirements feasible; or

(b) Other operational considerations occur that are deemed appropriate by the state board;

(2) Establish and contract, as required, with the purchasing alliance in each designated alliance service area to carry out the purpose of this Act;

(3) Coordinate the qualification of small group carriers eligible to respond to the request for proposals for participating carriers issued by the purchasing alliances. Each small group carrier must seek qualification from the state board in order to be eligible to respond to a request for proposal to participate in a particular purchasing alliance as a participating carrier. The state board shall administer the qualification of small group carriers in accordance with the following:

Drafting Note: The commissioner licenses and regulates small group carriers that are eligible to sell health insurance coverage to the small group marketplace. Carriers that comply with the state's small group reform measures and other regulatory requirements are referred to as "small group carriers." Small group carriers interested in offering coverage through a purchasing alliance must apply to and be qualified by the state board to do so, using the process described above. A small group carrier whose application is approved by the state board is called a "qualified carrier". A qualified carrier is eligible to respond to requests for proposals issued by the purchasing alliances for offering health insurance coverage to member small employers, their eligible employees and dependents. If a carrier's proposal is approved and it signs a contract with one or more of the purchasing alliances to provide health insurance coverage, it is referred to as a "participating carrier." It is important to note that the state board does not regulate in the insurance sense participating carriers, but merely decides which carriers are eligible to respond to the request for proposals for participating carriers issued by the purchasing alliances. Regulatory oversight remains the responsibility of the commissioner.

(a) The state board shall request from the commissioner a list of small group carriers that: (i) are licensed carriers as set forth in Section [insert reference to small employer health insurance availability law]; (ii) satisfy the financial requirements required under Section [insert section of state law on capital and surplus requirements]; (iii) have a demonstrated capacity to administer health benefit plans; and (iv) are otherwise in good standing. The commissioner shall update this list as requested, but not less than on a quarterly basis;

(b) The state board, in consultation with the commissioner, shall develop and make available a list of objective criteria that must be met by small group carriers in order to become qualified carriers eligible to respond to the request for proposals for participating carriers that are issued by the purchasing alliances;

(c) In order to be eligible to be designated as a qualified carrier, a carrier must be able to demonstrate the following minimum qualifying and operating characteristics:

(i) That it is licensed and approved as a small employer carrier and in good standing with the commissioner;

(ii) That it has the demonstrated ability or capacity to administer health benefit plans;

(iii) That it has the ability to provide enrollees reasonable access to covered services within the alliance service area;

(iv) That it has the ability to arrange and pay for the appropriate quality, level and type of health care or claims payment services;

(v) That it has the ability to provide information on enrollee satisfaction based on standard surveys as may be prescribed by the state board, and to meet reasonable satisfaction and other minimum service measures as may be established;

(vi) That it has the ability to provide standard data elements in a manner prescribed by the commissioner; and

Drafting Note: States may want to base the data requirements, at least in part, on the data reporting standards under development for all health carriers by the NAIC standards in common use by recognized national accreditation entities or by national health care data collection initiatives.

(vii) That it has the ability to meet basic quality of care standards established by the commissioner.

Drafting Note: Commissioners may want to allow qualified carriers to meet the requirements for quality assurance standards established by the commissioner by receiving and maintaining accreditation from recognized private accreditation entities. Under this approach the commissioner would periodically affirm that the standards in use by the private accreditation entity meets or exceeds the standards he or she establishes for use in the state. Once affirmed, qualified carriers holding accreditation by the private entities can be deemed as having met the desired standards until such time as the private accreditation entity is again reviewed by the commissioner.

(d) Each small group carrier wishing to become a qualified carrier must submit a completed application to the state board. The state board shall evaluate, with the assistance of the commissioner and other professionals as may be required, each completed application to determine whether the objective criteria established by the state board have been satisfied. If the state board approves the response, the carrier shall be registered in the state as a qualified carrier;

(e) When a small group carrier does not qualify based upon the criteria set forth in Section 4A(3)(c), the state board may take into account unique services or needs not currently being met within an alliance service area for an identifiable segment of the community. In such cases, the state board may grant waivers on a limited basis allowing small employer carriers, who would not otherwise be qualified to provide coverage to an underserved population;

(4) Review and update the application and qualification process at least once every three (3) years. The review shall include input from the purchasing alliance boards. After the review is completed, the state board may issue a revised application setting forth new criteria;

(5) Conduct or arrange for periodic reviews of the performance of the purchasing alliances and participating carriers to assure compliance with this Act in consultation with the commissioner;

(6) Provide to the commissioner, governor and legislature a summary of these reviews at least biennially, which shall include, but not be limited to, an accounting of all outside revenues received by the state board and purchasing alliances and all internal and independent audits, and make the summary available to the public;

(7) Periodically review and consider comments by purchasing alliance boards relative to services, quality of care, cost, grievance procedures, access and administrative efficiency;

(8) Develop standard enrollment procedures to be used within each purchasing alliance;

Drafting Note: To assure efficient and cost effective interactions between a regional purchasing alliance and its member small employers, between a regional purchasing alliance and its participating carriers, and between one regional purchasing alliance and another, states may consider requiring that all regional purchasing alliances contract with a common administrator. At a minimum it is important that common procedures be adopted for addressing issues which impact more than one alliance, e.g., enrollment procedures for an employer whose employees work or reside in multiple regional purchasing alliance service areas.

(9) Publish educational materials, plan descriptions and comparison sheets describing participating carriers and the qualified health benefit plans being offered within the purchasing alliances for enrolling small employers and their eligible employees and make reasonable efforts to notify all small employers of their option to join a purchasing alliance;

Drafting Note: The NAIC is in the process of evaluating standards and reporting measures that might be used in developing comparison sheets. A number of accrediting organizations and other groups are also developing report cards that might be considered for inclusion under this Act.

(10) Establish conditions of participation for small employers that conform to the requirements of this Act and Section [insert reference to small employer health insurance availability law] and include, but are not limited to the following:

(a) Provide assurances that the small employers are bona fide employer groups;

(b) Assure that small employers that meet the requirements established by the state board and this Act may purchase health care coverage through a purchasing alliance from a participating carrier;

Drafting Note: Each state should insert one of the following alternatives for Subparagraph (c).

(c) [**Alternative A (pure employee choice):** Offer to all member small employer's eligible employees a choice of all participating carriers in the alliance service area; and]

[**Alternative B (modified employee choice):** Offer to all member small employer's eligible employees a choice of at least three (3) participating carriers in the alliance service area and chosen by the employer, one of which must provide out-of-network coverage if available, and at least one managed care plan if available; and]

(d) Establish procedures and mechanisms for billing and collection of premiums from member small employers (including any share of the premium paid by enrollees);

(11) Appoint advisory committees that include persons with expertise in health benefits management and marketing and representatives of participating carriers, consumers, small businesses or health care providers, as may be deemed necessary to carry out the purposes of this Act. In addition, the state board may appoint local beneficiary advisory councils to evaluate purchasing alliance functions and the performance of participating carriers in order to assess the efficacy of the operations for member small employees;

(12) Develop standard procedures for the resolution of grievances and disputes between the purchasing alliances and participating carriers, and between the purchasing alliances and member small employers; and

(13) Develop a standardized request for proposal form for use by the purchasing alliances when soliciting health insurance coverage from qualified carriers.

Drafting Note: In order to decrease the administrative costs associated with responding to multiple RFP's from all or most of the purchasing alliances, it is important that the same standardized request for proposal (RFP) form be used by all of the purchasing alliances. This will also enhance the ability of the state board to uniformly compare the effectiveness and performance of each of the purchasing alliances. While the terms, conditions and format of the RFP should be standardized, the form may allow for a section that recognizes unique contractual differences necessary in a particular purchasing alliance.

B. The state board may:

(1) Sue or be sued, including taking action necessary for securing legal remedies on behalf of or against the purchasing alliances, member small employers, enrollees, a state board member or other parties subject to this Act;

(2) Approve all assessments made upon member small employers by the purchasing alliances for costs incurred or anticipated in connection with the operation of the purchasing alliances;

(3) Review all matters of dispute between a purchasing alliance and a participating carrier;

(4) Review information and recommendations from consumers, small employers, purchasing alliances, participating carriers, or health care providers, and other sources. Upon review, the state board may issue reports or otherwise make recommendations to improve the delivery or purchase of health care;

(5) Establish administrative and accounting procedures for operating the purchasing alliances, providing services to member small employers and enrollees; and

(6) Issue model legal documents for the purchasing alliances which may include articles of incorporation, bylaws and purchasing alliance participation agreements with participating carriers.

C. If review by the state board reveals that a purchasing alliance is not carrying out its duties or acting in the best interests of its enrollees, the state board may relieve the purchasing alliance board of its duties and in the interim may assume, or appoint an entity that assumes, the duties of the purchasing alliance until a new purchasing alliance board is appointed.

Section 5. Purchasing Alliances Authorized

A. Each purchasing alliance shall operate under the supervision of a purchasing alliance board of directors, which shall consist of no more than nine (9) members. The majority of members on each purchasing alliance board shall be member employers.

(1) The state board shall initially appoint the members. In so doing, the state board shall consider, among other things, the alliance service area's geographical, ethnic, gender, and workforce diversity, as well as the expertise of consumer and business interests, needed to oversee purchasing alliance operations.

(2) Subsequent members of the purchasing alliance board of directors shall be elected pursuant to the purchasing alliance's bylaws.

(3) Of the initially appointed members of each purchasing alliance board, five (5) members shall be designated to serve two-year terms and the remaining four (4) members shall serve four-year terms. Thereafter, the term of an elected member shall be four (4) years.

(4) Vacancies on the purchasing alliance board shall be filled for the remaining period of the term by a majority vote of the remaining purchasing alliance board members. A member who was appointed after the beginning of a term may serve for the remainder of that term and until a qualified successor is elected for a new term.

(5) A member who serves two (2) consecutive full four-year terms may not be re-elected for four (4) years after completion of those terms.

(6) The purchasing alliance board shall elect officers from among its members every two (2) years. Officers may not serve more than two (2) consecutive terms in an office.

(7) Each purchasing alliance board shall adopt bylaws. The bylaws shall be subject to review and approval by the state board.

B. The purchasing alliance board shall meet at least quarterly at times and places as it determines necessary to operate in accordance with this Act. The meetings shall be governed by the procedures and policies set forth in Section [insert reference to existing state open meetings law].

C. A purchasing alliance board member or members of their households may not be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of a carrier or other insurer, a health care provider or agent or broker. This provision shall not preclude a purchasing alliance board member from purchasing coverage through an alliance.

D. The purchasing alliance board members shall be subject to the provisions of [insert section of state law which controls the ethics of public officials].

Drafting Note: States should review their ethics laws to ensure prohibition or limitation on the amount of stock that purchasing alliance board members can own in the entities described in Section 5.C. If no prohibition or limitation exists, a state should consider drafting language to do so.

E. No cause of action or liability of any nature or kind shall arise against a member of a purchasing alliance board, or its employees or agents, for any action taken in good faith by them in the performance of their duties.

F. The purchasing alliance board shall not employ or hire employees or agents that have conflicts of interest with the operations and activities of the purchasing alliance.

Section 6. Powers and Duties of and Restrictions on Purchasing Alliances

A. In addition to other powers granted to nonprofit corporations under state law, a purchasing alliance shall have the following powers and duties:

(1) Appoint an executive director to serve as the chief operating officer of the purchasing alliance who may employ other staff as needed to administer the purchasing alliance. The executive director shall serve at the pleasure of the purchasing alliance board;

(2) Establish advisory committees as necessary to assist with carrying out the duties established pursuant to this section. Consumer representatives shall serve on all such advisory committees;

(3) Coordinate its operations with other purchasing alliances, including those operations where the purchasing alliances are in the same or different states, when the state board and the commissioner in each state deem that interstate coordination is in the best interests of enrollees. Coordination may include adoption of joint operating rules, staff and activities;

(4) Make recommendations to the state board and provide other information that may be requested by the state board;

(5) Prepare annual reports on the operations of the purchasing alliance, including program and financial operations as required by the state board, and provide for annual internal and independent audits;

(6) Receive and accept grants, state funds or anything of value from a public or private agency; and receive and accept contributions from any legitimate source of money, property, labor or any other thing of value. However, the purchasing alliance board shall not accept anything of value from a person or entity that might have a vested interest in the decisions of the board except with the express permission of the commissioner;

(7) Contract with at least three (3) unaffiliated participating carriers to ensure that enrollees have a choice from among a reasonable number of competing carriers and types of health benefit plans which include the basic and standard health benefits plans required by Section [cite small employer health insurance availability law]. The commissioner may, upon a showing of good cause, waive the requirement to have at least three (3) unaffiliated participating carriers throughout all portions of the purchasing alliance's service area;

Drafting Note: Coverage through a purchasing alliance of employees who work and reside outside of the state can create administrative problems due to the application of such other states' extraterritorial mandated benefit laws. Moreover, many participating carriers, notably local HMOs, will not be able to provide coverage for out-of-state residents in any event. Purchasing alliances may wish to address this by issuing a separate request for proposal for the purpose of contracting with carriers to provide out-of-state coverage.

(8) Enter into contracts with member small employers;

(9) In instances where not already provided for by the state board:

(a) Establish procedures and mechanisms for billing and collection of premiums from member small employers (including any share of the premium paid by employee enrollees); and

(b) Establish procedures for annual open enrollment periods;

(10) Impose reasonable fees upon member small employers for necessary costs incurred in connection with the operation of the purchasing alliance;

(11) Provide that in the event a member small employer terminates coverage purchased through the purchasing alliance, the former member small employer shall be ineligible to purchase a health benefit plan through the purchasing alliance for a period of twelve (12) months, except as permitted by the state board for good cause;

(12) Contract, as authorized by the state board, with qualified, independent third parties for services necessary to carry out the powers and duties of the purchasing alliance, including contracts with agents and brokers to assist in contracting with participating carriers and member small employers and to assist the purchasing alliance in educational, marketing, service, grievance and administrative activities. Unless permission is specifically granted by the purchasing alliance board, a third party hired may not release, publish or otherwise use information to which the third party has access under its contract. Except with the express written approval of the state board, no entity may act, directly or through an affiliated company, in a purchasing alliance service area both as a participating carrier and a third party under contract to the purchasing alliance;

(13) Provide to member small employers comparison sheets, in accordance with state board rules, describing participating carriers and the qualified health benefit plans available through the purchasing alliance;

(14) Offer health insurance coverage through multiple unaffiliated participating carriers to all small employers, their eligible employees and dependents;

(15) Develop a marketing plan specifically designed for the purchasing alliance's service area using the marketing standards established by the state board; and

(16) Use the standardized request for proposal format for participating carriers to provide qualified health benefit plans to member small employers, their eligible employees and dependents as provided by the state board.

B. Purchasing alliances shall place premiums, operating funds and all other funds received by it in a trust account.

C. Purchasing alliances may not:

(1) Purchase health care services, assume risk for the cost or provision of health care services, or otherwise contract with health care providers for the provision of health care services to enrollees;

(2) Exclude a small employer or eligible employee or dependent of an eligible employee from membership in the purchasing alliance who agrees to pay fees for membership and the premium for coverage through the purchasing alliance and who abides by the bylaws and rules of the purchasing alliance;

(3) Prohibit the participation of small employers, or differentiate classes of membership, based on industry type, experience, age, gender, family status, education, health status, income or other means in conflict with the rating methodology specified in Section [insert reference to small employers health insurance availability law];

(4) Commit an act constituting a rebate prohibited pursuant to Section [insert applicable section of state law];

(5) Charge a fee not directly related to the operation of the purchasing alliance or for non-health care related activities;

(6) As a condition of membership, require a small employer, eligible employee or dependent to subscribe to limited health benefit insurance or non-health care related products or services;

(7) Operate the purchasing alliance or market the purchasing alliance in a county or primary metropolitan statistical area in a way which would cause the purchasing alliance to select a risk pool with actuarially projected health care utilization over a two-year period which is below the projected average for all individuals residing in that county or primary metropolitan statistical area.

The measurement and composition of projected utilization by members of the purchasing alliance to all individuals shall be done on a county or primary metropolitan statistical area basis and not across all members of the purchasing alliance;

(8) Engage in a competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors specified in Paragraph (3) of this subsection or small employer size;

(9) Require or take an action inconsistent or in conflict with state laws or regulations of the commissioner; or

(10) Provide products or services other than those specifically authorized in this Act.

Section 7. Requirements of Participating Carriers

A. In every purchasing alliance in which it participates, a participating carrier shall:

(1) Offer only qualified health benefit plans;

(2) Provide for the collection and reporting to the state board and to the appropriate purchasing alliance of information on the performance of the participating carrier regarding the effectiveness and outcomes in providing selected services. The data reporting requirements adopted by the state board shall be based on and consistent with national or state standards and should not impose an unreasonable cost for compliance;

(3) Establish premium rates for each qualified health benefit plan in accordance with the rating method described in Section [insert reference to small employer health insurance availability law];

(4) Comply with all rules and regulations regarding underwriting, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices, the provisions of this Act and other applicable state statutes;

(5) Comply with all rules and regulations regarding adjusted community rating as specified in [cite applicable section of small employer health insurance availability law], except that the purchasing alliance and a participating carrier may negotiate only the administrative expense component of the premium rates charged for coverage offered through the alliance where the carrier can demonstrate net administrative cost savings for its alliance business. For the purposes of this paragraph, administrative expenses are limited to marketing expenses, acquisition expenses, the cost of paying claims, commissions, and maintenance expenses;

Drafting Note: Participating carriers must be required to use the same rating methodology inside and outside the alliance. Alliances should be permitted to negotiate with carriers only on administrative costs. Claim costs must be uniform across a carrier's entire small employer group market and not be subject to negotiation.

(6) Issue coverage under a health benefit plan to an enrollee who elects to be covered in the manner required under this Act and the provisions of Section [insert reference to small employer health insurance availability law].

B. After notice and hearing, the state board may place a participating carrier on probation, or suspend or revoke its designation as a qualifying carrier if it fails to maintain compliance with the requirements listed in this Act. In cases of noncompliance, participating carriers shall be afforded reasonable time to correct the areas of deficiency. If the participating carrier fails to comply after that time period, the state board shall revoke the qualification status as a qualified carrier. Carriers subject to revocation shall be afforded the opportunity to appeal the decision of the state board in accordance with the state administrative procedures act or other applicable state law.

C. Notwithstanding anything to the contrary in Section [cite guaranteed renewability section of the small employer health insurance availability law], in the event the participating carrier elects to terminate its contract with a purchasing alliance, the participating carrier shall:

(1) Provide advance notice of its decision to the purchasing alliance board, and;

(2) Provide notice of the decision at least 180 days prior to the nonrenewal of a qualified health benefit plan to the member small employers and enrollees. A participating carrier that elects not to renew a health benefit plan with a purchasing alliance shall be prohibited from writing new business through the purchasing alliance for a period of three (3) years from the date of the notice to the purchasing alliance or until the purchasing alliance, with the concurrence of the commissioner, invites the former participating carrier to renew participation, whichever is sooner.

D. In the event that renewal or the acceptance of additional applications for coverage would place the participating carrier in a financially impaired condition, the state board, upon the counsel of the purchasing alliance board and upon the approval by the commissioner, may recommend that the participating carrier be excused from issuing coverage in accordance with this Act until the impairment is remedied.

Section 8. Purchasing Alliance Contracts

A. A contract between the purchasing alliance and a participating carrier shall specify how all premiums will be transmitted, on what basis, and the penalties and grace periods for payments.

B. A contract between the purchasing alliance and a member small employer shall provide:

(1) For administrative purposes, the purchasing alliance will be the policyholder or contract holder of the qualified health benefit plan on behalf of member small employers, their eligible employees and dependents;

(2) Provide that the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of the qualified health benefit plan's coverage to each enrolled eligible employee; and

(3) Provide that all eligible employees of the small employer who obtains coverage under the qualified health benefit plan offered by the small employer must obtain coverage through the purchasing alliance.

Section 9. Marketing Qualified Health Benefit Plans

A. The state board shall establish marketing standards for use by purchasing alliance boards and participating carriers.

B. Any marketing, advertisement or educational material for qualified health benefit plans sold through purchasing alliances shall be approved by the state board prior to its use. The state board shall review all materials submitted to it and the materials shall be deemed approved if not disapproved within [insert number] days. The purchasing alliance may, through its contracts with participating carriers, deem certain classes of materials to be approved.

C. This section shall not be construed to prohibit or to compel the purchasing alliance or a participating carrier from using the services of an agent or broker.

D. A participating carrier, agent, broker, contractor or producer of a participating carrier, or independent insurance agent, broker, contractor or producer may not engage, directly or indirectly, in an activity or marketing practice that would encourage member small employers or eligible employees to:

(1) Refrain from enrolling in a qualified health benefit plan offered through the purchasing alliance because of their health status or claims experience;

(2) Seek coverage from other participating carriers because of their health status or claim experience; or

(3) Enroll or fail to enroll in the purchasing alliance because of their health status or claims experience.

Section 10. Risk Adjustment Mechanism

The commissioner may establish a payment mechanism to adjust for the amount of risk covered by each participating carrier. The commissioner may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

Drafting Note: Some states may prefer to develop a risk adjustment mechanism that applies to the entire small group market and not simply to business written by participating carriers through the purchasing alliance. A risk adjustment mechanism that operates across the entire small group market would preserve the principle of uniform rating and underwriting rules both inside and outside of the alliance and would minimize incentives for carriers to either steer high-risk business to the alliance or avoid participating in the alliance altogether.

Section 11. Antitrust Protection

A. If a purchasing alliance develops standards that have the potential to exclude a participating carrier from offering a qualified health benefit plan or requires a participating carrier to engage in a practice or course of conduct that restricts competition, the state board shall approve the standards prior to their use.

B. The state board shall prescribe the form and procedure for application for approval under this section. The state board may permit a purchasing alliance to file an operating plan on an annual basis to obtain approval or may require a separate application for each exclusion or requirement.

C. The state board may approve an application under this section only if it finds that:

(1) The exclusion will not significantly affect the competitiveness of the affected market; or

(2) The effect on the competitiveness of the affected market is justified because the exclusion or requirement is reasonably necessary to accomplish a purpose which is expected to benefit consumers by improving the quality or efficiency of the provision of health care coverage or health care delivery.

D. The state board shall actively supervise the purchasing alliances and participating carriers to ensure that actions taken affecting market competition are not for private interest, but to accomplish the legislative intent of this Act.

E. A purchasing alliance, its employees and agents, and participating carriers are exempt from state antitrust law for an act or omission which is permitted or required in accordance with this Act.

Section 12. Program Evaluation

The state board shall make a report not later than [insert date] to the governor, commissioner and the legislature of at least the following:

A. The progress achieved in assuring affordable health care coverage to employees of member small employers;

B. The possible need, if any, for financial incentives or other mechanisms to increase participation in the purchasing alliance;

C. The benefits, if any, of exclusive purchasing of health insurance through the purchasing alliance for all small employers who choose to purchase health coverage; and

D. The need to provide choices of additional or supplemental benefit designs beyond the basic and standard benefit plans; and

E. Other changes in the law or procedure that would approve the overall efficiency, further reduce costs and improve fairness.

Section 13. Effective Date

This Act shall be effective [insert date].

Drafting Note: Each state should draft to be consistent with that state's procedures for establishing an effective date.

Chronological Sumary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 36, 555, 588, 609-619, 639 (adopted).
1996 Proc. 2nd Quarter 10, 30, 732, 768, 777-779 (amended).

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. §§ 23-86-501 to 23-86-512 (2001/2005); ARK. CODE R. §§ 054.00.78-1 to 054.00.78-7 (2003).
California			CAL. INS. CODE §§ 10730 to 10750 (1992); CAL. CODE REGS. tit. 10, §§ 2699.610 to 2699.6463.5 (1994/1999); CAL INS. CODE §§ 10800 to 10887 (1997).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. §§ 33-30A-1 to 33-30A-11 (1997); GA. COMP. R. & REGS. 120-2-79 (2000).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. §§ 191-73.1 to 191-73.24 (1994).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1951 to 1957 (1996/2003).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 62T.01 to 62T.12 (1997/2000).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. § 33-22-501 (1994) (purchasing alliances authorized); MONT. CODE ANN. §§ 33-22-1801 to 33-22-1822 (1995/2017).
Nebraska	NO CURRENT ACTIVITY		

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. §§ 689C.360 to 689C.600 (1995/2013); NEV. ADMIN. CODE §§ 689C.300 to 689C.450 (1996).
New Hampshire			N.H. REV. STAT. ANN. § 420-G:10a (2001) (authority to adopt regulations); N.H. CODE ADMIN. R. INS. 3401.01 to 3401.11 (2001).
New Jersey			N.J. REV. STAT. §§ 17B:27A-25.1 to 17B:27A-25.9 (2003).
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAW §§ 4701 to 4714 (1994) (municipal, school district and other public employees).
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE § 26.1-01-07.4 (1993/2005) (authority to adopt rules); N.D. ADMIN. CODE § 45-06-09 (1994).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3924.01 to 3924.42 (1993).
Oklahoma			OKLA. STAT. tit. 36, §§ 4521 to 4529 (2002); OKLA. ADMIN. CODE §§ 365:10-19-1 to 365:10-19-8 (2002/2003).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-71-730 (1987/1994); BULLETIN 5-94 (1994).

THE REGIONAL HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota			S.D. CODIFIED LAWS §§ 58-18-52 to 58-18-62 (1994).
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 26.401 to 26.442 (2004).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

Table of Contents

Purpose and Intent

This Act shall be known as the Private Health Care Voluntary Purchasing Alliance Model Act.

The purpose of this Act is to improve the fairness, efficiency and competition in the pricing and delivering of health care coverage for employers with no more than [insert number] employees. It does so by allowing for the establishment of private competing purchasing entities (purchasing alliances) through which eligible small employers, and self-employed individuals can purchase health coverage. Another goal is to avoid jurisdictional confusion and unnecessary and expensive bureaucracy within a purchasing alliance and state government by clarifying the respective roles and jurisdiction of existing regulatory agencies and a purchasing alliance. This Act provides a mechanism for small employers to join together solely for the purpose of procuring health insurance and operates as an exception to existing false group or fictitious group laws. In addition, the intent of the Act is to avoid creating an undue burden on small employers when purchasing health care coverage through a purchasing alliance.

This Act is also intended to provide a meaningful choice of high quality, fairly priced health care providers and health care coverage for member small employers, employees and individuals of a purchasing alliance through a system that is fair, efficient and accountable to its members and includes procedural and substantive protections.

It is envisioned that a purchasing alliance, through an open and fair competitive procurement process, will contract with qualified group carriers to provide a meaningful choice of carriers providing health benefit plans to purchasing alliance members.

Drafting Note: In order that states might choose which approach would best accommodate their needs, the National Association of Insurance Commissioners (NAIC) has developed several purchasing alliance model acts to address the problems of providing health care coverage to small employers and their employees. In doing this, the NAIC is not expressing a preference for one model over another. This Act assumes that a state has already adopted substantially the most recent version of the NAIC's Small Employer Health Insurance Availability Model Act to ensure that a purchasing alliance formed under this Act operates properly.

For example, it is imperative that health benefit plans issued to purchasing alliances and policies issued directly to small employers who are not members of a purchasing alliance operate under the same rating, underwriting, enrollment and participation requirements. Absent strong market reforms, such as guaranteed issue of all products sold in the small group market, a voluntary purchasing alliance will become a high risk pool. The Private Health Care Voluntary Purchasing Alliance Model Act is intended to be a portion of a larger program of underwriting reforms in the general small group market and would necessarily use the same terms and definitions.

Drafting Note: States may consider expanding alliance eligibility to include individuals, state employees, and other designated population groupings that are eligible to purchase health insurance coverage through a purchasing alliance. However, in expanding eligibility prior to universal coverage, states should be careful to avoid burdening a purchasing alliance with high-risk individuals or groups. If population groupings other than small employers are eligible to purchase coverage through an alliance, underwriting and rating parity should be required inside and outside the alliance.

Section 1. Definitions

A. "Adjusted community rating" has the same meaning as in Section [insert reference to small employer health insurance availability law].

B. "Board" means a purchasing alliance board.

C. "Business plan" means the plan of operation of the health care purchasing alliance.

D. "Carrier" has the same meaning as in Section [insert reference to small employer health insurance availability law] and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-alone basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 8A(1) of this Act.

Drafting Note: Most states provide for the licensing of dental-only carriers authorized to offer dental benefits. Inclusion of dental-only carriers in the definitions of "small group carrier" and "participating carrier" is designed to enable these carriers to offer dental-only benefits through an alliance without requiring them to be "small group carriers" pursuant to a state's small employer health insurance availability law. These dental-only carriers are required to comply with all of the Act's provisions except those which would otherwise require qualified carriers to offer health benefits other than dental benefits.

E. "Commissioner" has the same meaning as in Section [insert reference to the chief insurance regulatory official of the state].

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears. Where jurisdiction of managed care organizations lies with some other state agency, or dual state regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

F. "Dependent" has the same meaning as in Section [insert reference to small employer health insurance availability law].

Drafting Note: States without a statutory definition of dependent may wish to use the following definition:

"Dependent" means a spouse; an unmarried child under the age of [nineteen (19)] years; an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the enrollee; and an unmarried child of any age who is medically certified as disabled and dependent upon the enrollee.

When using this definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the enrollee.

G. "Eligible employee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

H. "Enrollee" means an eligible employee, self-employed individual or a dependent of an eligible employee who is enrolled in a health benefit plan offered through the purchasing alliance by a participating carrier.

Drafting Note: The Act assumes that a small employer group includes self-employed individuals. This term should be deleted from the definition of "enrollee" if the minimum size of a small employer group is two or more.

I. "Health benefit plan" has the same meaning as in Section [insert reference to small employer health insurance availability law].

J. "Late enrollee" has the same meaning as in Section [insert reference to small employer health insurance availability law].

K. "Limited benefit health insurance" has the same meaning as in Section [insert reference to small employer health insurance availability law].

L. "Member small employer" means a small employer who enrolls in a purchasing alliance.

M. "Participating carrier" means a carrier that contracts with a purchasing alliance to provide coverage to enrollees under a health benefit plan and for the purposes of this Act shall include carriers that are authorized to offer dental benefits pursuant to [insert reference to applicable state statutes dealing with dental-only carriers] for the limited purpose of enabling dental-only carriers to offer dental benefits through an alliance, either in conjunction with a small group carrier or on a stand-alone basis. These carriers shall be subject to the terms of this Act relating to participating carriers but shall not be required to qualify as small group carriers pursuant to Section 8A(1) of this Act.

N. "Purchasing alliance" or "alliance" means a non-risk bearing nonprofit corporation licensed pursuant to this Act established under [insert statutory reference to nonprofit corporation act] to provide health insurance through multiple unaffiliated participating carriers to member small employers and their employees within a defined service area authorized by the commissioner.

O. "Small employer" has the same meaning as in Section [insert reference to small employer health insurance availability law].

Drafting Note: Definitions that reference small employer health insurance availability statutes may be deleted if a state places this Act within the same statutory chapter.

Section 2. Jurisdiction of the Commissioner; Penalties

A. The commissioner shall have the authority to regulate the establishment and conduct of purchasing alliances as set forth in this Act.

B. No person or entity may market, sell, offer, or arrange for a package of one or more health benefit plans underwritten by two (2) or more carriers to two (2) or more small employers or their eligible employees without first being licensed by the commissioner pursuant to this Act.

C. A person or entity not licensed by the commissioner as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance, health insurance purchasing cooperative or purchasing cooperative, or otherwise use a confusingly similar name.

D. Nothing in this Act shall be deemed to be in conflict with or limit the duties and powers granted to the commissioner under the laws of this state.

E. Purchasing alliances shall report to the commissioner any suspected or alleged law violations.

F. Violations of this Act shall be subject to the penalties contained in [insert reference to state law penalty provisions].

Drafting Note: The range of regulatory actions, processes, remedies and penalties to be specified here should be least as broad as those available to the commissioner when he or she sanctions entities under the insurance laws.

Section 3. Purchasing Alliance Application and Licensing Process

A. An application in a form designated by the commissioner shall be completed and filed with the commissioner by an authorized representative of the board of the nonprofit corporation established as a precursor to being granted a purchasing alliance license. An application will not be deemed filed until all information necessary to properly process the application has been received by the commissioner.

Upon filing, the commissioner will make a determination concerning the application and will provide notice of the determination to the applicant. If approved, a copy of a license, in a form designed by the commissioner, shall be provided to the purchasing alliance. The license shall serve as authorization to operate pursuant to this Act.

B. Each applicant and duly licensed purchasing alliance shall file with the commissioner the following information or documents:

(1) A business plan for approval by the commissioner. The business plan is a detailed, written plan of operations explaining how the applicant intends to meet the public policy objectives of reduced cost, increased access and improved quality within the small employer marketplace. The business plan is a written commitment by the alliance. Material changes in policy or operations of the business plan are subject to the prior approval of the commissioner on the same basis as the original business plan. The business plan shall include, but not be limited to, the following information:

(a) The specific steps planned to advance cost control and quality improvement, and to improve access to health insurance or health care services. The business plan shall affirmatively demonstrate that the alliance will have the technical expertise and physical capacity to serve a significant group of small employers and their eligible employees not currently being served by a purchasing alliance. Significant means at least ten percent (10%) of the population within the proposed service area. The business plan shall affirmatively demonstrate that the alliance will reduce cost, improve quality and improve access to health insurance or health care services; and

(b) The scope of services to be offered in the proposed service area and the resources and expertise to be used to implement and administer those services. An alliance shall demonstrate the technical and physical capacity to serve a significant group of small employers and their eligible employees over a wide territory. An alliance shall demonstrate the technical and physical capacity to provide service quality throughout the entire alliance service area;

(2) The applicant's nonprofit articles of incorporation, bylaws and other formation and business operation documents. An alliance shall demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of small employers and their eligible employees' interests within the proposed service area. An alliance shall demonstrate that it is more than a marketing or distribution channel for a single product or the products of a single carrier. An alliance shall organize and facilitate competition between multiple unaffiliated carriers;

(3) A list of officers and directors of the applicant and the contract administrator, if one is employed, and personal biographical information or firm descriptions for each. The officers, directors and contract administrator shall not have a prior record of administrative, civil or criminal violations within any financial service industry.

The personal biographical information and firm descriptions shall demonstrate by clear and convincing evidence that those involved in the operation of the alliance have the expertise, experience and character to effectively and professionally represent small employers and their eligible employees in a fiduciary capacity;

(4) Evidence of adequate security and prudence in the accounting, deposit, collection, handling and transfer of moneys. An alliance shall affirmatively demonstrate adequate financial controls to the satisfaction of the commissioner as a condition of licensure;

(5) The small employers and their eligible employees to which the alliance will be marketing. An alliance shall demonstrate to the satisfaction of the commissioner that it will extend alliance coverages to a significant group of small employers and their eligible employees not currently served by an alliance;

(6) Disclosure of any preexisting oral or written agreements;

Drafting Note: Preexisting agreements may raise questions of conflict or demonstrate the intention to create a marketing channel for a single product or single carrier. Conversely, pre-existing agreements may assist in affirmatively demonstrating technical or physical capacity to serve a service area or to extend alliance services to a significant group of small employers and their eligible employees not currently served by an alliance.

(7) Quarterly financial statements and annual reports on forms approved by the commissioner. The financial statements and annual reports shall be designed to ensure the operation of the alliance in a sound financial fashion, to ensure the alliance is not a risk-bearing entity, to ensure sound financial controls and money management, and to prevent mismanagement or misappropriation of funds either through neglect or malfeasance;

(8) Reports of material changes in the policy or operations of the business plan. The changes are subject to approval by the commissioner prior to implementation by the alliance; and

(9) Any other information required by the commissioner deemed pertinent to the policies and operation of the alliance.

C. Financial and performance audits or examinations of the alliance shall be conducted on a regular basis by the commissioner. The commissioner may require audited financial statements from an alliance. Reasonable costs of examinations or audits are to be paid by the alliance. The commissioner may impose conditions on licensure, or continued licensure, for example, the removal and replacement of managerial, marketing staff or third party contractors to remedy compliance or performance problems.

Section 4. Grounds for Denial, Nonrenewal, Suspension or Revocation of License

In addition to any other grounds specified in this Act, the following constitute grounds for denial, nonrenewal, suspension or revocation of an application or existing license, following notice and an opportunity for hearing:

A. Failure to comply with the provisions of this Act;

B. Failure to disclose a preexisting oral or written agreement during the alliance application process;

C. Failure to comply with and carry out the purchasing alliance business plan filed with the commissioner;

D. Failure to have adequate controls or failure to follow approved procedures;

E. Failure to meet minimum standards in a financial or performance audit or examination;

F. Failure to extend alliance health benefit plan coverages to a significant group of small employers and their eligible employees not currently served by an alliance;

G. Failure to comply with a lawful order of the commissioner;

H. Committing an unfair or deceptive act or practice as defined in [insert reference to unfair trade practices act];

I. Filing any necessary form with the commissioner that contains fraudulent information or omission;

J. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or participating carrier otherwise not entitled to the alliance and that have been entrusted to the alliance in its fiduciary capacity;

K. Failure to demonstrate through clear and convincing evidence that it will extend alliance services to a significant group of buyers not currently being served by an alliance; or

L. Failure to demonstrate through clear and convincing evidence that it will reduce the cost, improve the quality, and improve access to or choice of affordable health insurance or health care services.

Section 5. Conflicts of Interest

No board members or members of their household nor any management personnel of the alliance may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any carrier or other insurer, a health care provider, agent or broker. This provision shall not preclude a board member from purchasing coverage through an alliance.

Drafting Note: States should review their ethics laws to ensure prohibition or limitation on the amount of stock that a board members can own in the entities described in Section 5. If no prohibition or limitation exists, a state should consider drafting language to do so.

Section 6. Additional Powers of and Restrictions on Purchasing Alliances

In addition to the powers granted to it in Section [insert reference to nonprofit corporation act]:

A. A purchasing alliance may do any of the following:

(1) Set reasonable fees for membership, which may vary by employer size, in the purchasing alliance that will finance reasonable and necessary costs incurred in administering the purchasing alliance;

(2) Define and offer other health benefit plans in addition to the standard and basic health benefit plans promulgated pursuant to [insert reference to small employer health insurance availability law]. The alliance may also incidentally offer optional group vision and dental benefit plans and, with the prior approval of the commissioner, other limited benefit health insurance to enrollees;

Drafting Note: Under the guaranteed issue provision of the small employer health insurance availability model act, carriers offering a particular health benefit plan designed through a purchasing alliance will also have to offer and issue that plan to any small employer outside of the purchasing alliance.

(3) Require as a condition of membership that all employers include all their employees or a minimum percentage of employees in coverage purchased through the purchasing alliance. The purchasing alliance may require an employer making membership application to the purchasing alliance that would entail entering fewer than 100 percent of the employer's eligible employees or dependents to demonstrate that the resultant membership will not result in an adverse selection group being brought into the purchasing alliance or that the action would otherwise act as a form of risk selection or risk avoidance;

(4) Provide premium collection services for health benefit plans offered through the purchasing alliance;

(5) Reject or allow a carrier to reject an employer from membership or drop or allow a carrier to drop a member small employer if the member employer or any of its eligible employees fail to pay premiums or engage in fraud or material misrepresentation in connection with a health benefit plan purchased through the purchasing alliance. If a member small employer or enrollee is dropped from coverage, the enrollee shall be entitled to continuation and conversion coverage to the extent provided for under applicable state or federal continuation laws and the state conversion law;

(6) Contract with qualified independent third parties for any service necessary to carry out the powers and duties authorized or required by this Act;

(7) Contract with licensed insurance agents or brokers to market and service coverage made available through the purchasing alliance to its members. Compensation for agents and brokers may not vary based on the actual or expected health status or medical utilization of the group to which coverage is sold;

(8) Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access or information reporting standards of the purchasing alliance;

(9) Require that member employers and their eligible employees continue to pay administrative fees that are part of the contract with the purchasing alliance if a member employer or enrollee cancels prior to completion of a contract period;

(10) Have the authority to develop uniform standards for data to be provided by participating carriers and providers. The purchasing alliance may collect data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the commissioner. In formulating data collection standards, the board may use standards based on, and consistent with, existing state, National Association of Insurance Commissioners (NAIC), and national health care data collection initiatives and shall take into account their feasibility and cost-effectiveness; and

(11) Negotiate with participating carriers the administrative expense component of the premium rates charged for coverage offered through the alliance consistent with Section 8D.

B. A purchasing alliance shall not:

(1) Purchase health care services, assume risk for the cost or provision of health services, or otherwise contract with health care providers for the provision of health care services to enrollees;

(2) Exclude a small employer or eligible employee or dependent of an eligible employee from membership in the purchasing alliance who agrees to pay fees for membership and the premium for coverage through the purchasing alliance and who abides by the bylaws and rules of the purchasing alliance;

(3) Prohibit the participation of small employers, or differentiate classes of membership, based on industry type, experience, age, gender, family status, education, health status, income or other means in conflict with the rating methodology specified in Section [insert reference to small employers health insurance availability law];

(4) Commit an act constituting a rebate prohibited pursuant to [insert applicable section of state law];

(5) Charge a fee not directly related to the operation of the purchasing alliance or for non-health care related activities;

(6) As a condition of membership, require a small employer, eligible employee or dependent to subscribe to limited benefit health insurance or non-health care related products or services;

(7) Operate the purchasing alliance or market the purchasing alliance in a county or primary metropolitan statistical area in a way which would cause the purchasing alliance to select a risk pool with actuarially projected health care utilization over a two-year period which is below the projected average for all individuals residing in that county or primary metropolitan statistical area. The measurement and composition of projected utilization by members of the purchasing alliance to all individuals shall be done on a county or primary metropolitan statistical area basis and not across all members of the purchasing alliance;

(8) Engage in any competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors specified in Paragraph (3) of this subsection or small employer size; or

(9) Require or take any action inconsistent or in conflict with state laws or regulations.

Section 7. Operation of Purchasing Alliances

The board shall:

A. Operate the purchasing alliance;

B. Develop and make available a list of objective criteria that participating carriers must meet in order to be eligible to participate in the purchasing alliance;

C. Contract with at least three (3) unaffiliated participating carriers to ensure that enrollees have a choice from among a reasonable number of competing carriers and types of health benefit plans that include the basic and standard health benefits plans required by Section [cite small employer health insurance availability law]. The commissioner may, upon a showing of good cause, waive the requirement to have at least three (3) unaffiliated participating carriers throughout all portions of the purchasing alliance's service area.;

Drafting Note: Coverage through a purchasing alliance of employees who work and reside outside of the state can create administrative problems due to the application of other states' extraterritorial mandated benefit laws. Moreover, many participating carriers, notably local HMOs, will not be able to provide coverage for out-of-state residents in any event. Purchasing alliances may wish to address this by issuing a separate request for proposal for the purpose of contracting with carriers to provide out-of-state coverage.

D. Develop standard enrollment procedures;

E. Publish educational materials, plan descriptions and comparison sheets describing participating carriers and the health benefit plans available through the purchasing alliance for use in enrolling small employers and their eligible employees. The information may include an assessment of utilization management procedures and the level of quality and cost effective care;

Drafting Note: A number of accrediting organizations and other groups are developing report cards that might be considered for inclusion under this Act. In addition, the NAIC is in the process of evaluating standards and reporting measures that might be used in a comparison sheet.

F. Establish conditions for participation of small employers that conform to the requirements of this act and Section [insert reference to small employer health insurance availability law] and that include, but are not limited to, assurances that the small employer is a bona fide employer group and provision for prepayment of premiums or other mechanisms to assure that payment will be made for coverage;

G. In enrolling member small employers, provide that each eligible employee is permitted to enroll in any health benefit plan offered by any participating carrier so long as the health plan provides coverage where he or she works or lives;

H. Request from the commissioner certification that all participating carriers are licensed small group carriers as set forth in Section [insert reference to small group law], and that the carriers satisfy the financial requirements established under Section [insert section] of the laws of the state;

I. Receive, review and act, as appropriate, on grievances by member small employers or enrollees;

J. Review information and recommendations from consumers, employers, participating carriers or health care providers and other sources. After the review, the board may issue reports or otherwise make recommendations to improve the delivery or purchase of health care;

K. Establish administrative and accounting procedures for operating the purchasing alliance and for providing services to member small employers and employee enrollees;

L. Prepare an annual report on the operations of the purchasing alliance to the commissioner, which shall include an accounting of all outside revenues received by the board and internal and independent audits and any other information the commissioner may require;

M. Establish procedures for billing and collection of premiums from member small employers (including any share of the premium paid by employee enrollees);

N. Establish procedures for annual or rolling open enrollment periods during which an employee enrolled in a health benefit plan through the purchasing alliance may elect to enroll in any health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works and during which late enrollees may elect to enroll in any health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works;

O. Provide that in the event a member small employer terminates coverage purchased through the purchasing alliance, the former member small employer shall be ineligible to purchase a health benefit plan through the purchasing alliance for a period of twelve (12) months;

P. Maintain a trust account or accounts for deposit of all moneys received and collected or the operation of the purchasing alliance. A purchasing alliance, its board members, employees and agents shall have a fiduciary duty with respect to all moneys received or owed to it to assure payments of its obligations and a full accounting to its members and the commissioner;

Q. Assure the offering of the same premiums and prices on negotiated health care services to all member classes equally; and

R. Treat all members within a class equally with regard to membership and administrative fees and benefits of membership.

Section 8. Participating Carriers

A. In order to be eligible to be a participating carrier, a carrier must be able to demonstrate the following operating characteristics satisfactory to the board:

(1) Be licensed and approved as a small employer carrier, and in good standing with the commissioner;

(2) The ability to administer health benefit plans, to provide adequate service, and to comply with all contractual requirements of the purchasing alliance;

(3) The ability to provide enrollees with reasonable access to covered services;

(4) The ability to provide coverage for enrollees in any service area in which the carrier plans to participate through the purchasing alliance;

(5) The ability to arrange and pay for the appropriate quality, level and type of health care services;

(6) The ability to provide data required by the board, including information on enrollee satisfaction based on standard surveys as may be prescribed and to meet reasonable satisfaction measures as may be established;

(7) The ability to provide standard data elements in a manner prescribed by the board;

(8) The ability to meet basic quality of care standards established by the commissioner and other relevant regulators;

(9) Strong financial condition;

(10) Adequate administrative management;

(11) A procedure to address enrollee grievances and appeals;

(12) The ability to achieve satisfactory enrollment levels within the service area in which the carrier is licensed; and

(13) All other criteria established by the board.

B. Carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following in a manner satisfactory to the board, in consultation with the carrier's licensing agency:

(1) Review the quality of care covered;

(2) Review the appropriateness of care covered; and

(3) Provide accessible health care services.

C. In evaluating which carriers may participate in the purchasing alliance, the board shall consider:

(1) Minimum geographic service and participation requirements, maximum thresholds for premium rates, and standards for determining whether a carrier operates efficiently;

(2) The ability of a carrier to provide services within the purchasing alliance service area;

(3) Pricing and the competitiveness of each bid from a carrier; and

(4) The effect of contracting with additional carriers on the administrative costs of the purchasing alliance and member small employers, the efficiency of the purchasing alliance, and the competitiveness of the premiums that will be paid to participating carriers.

D. Every participating carrier shall:

(1) Meet the standards established by the board pursuant to this Act;

(2) Provide data required by the board;

(3) Comply with all rules and regulations regarding underwriting, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices, the provisions of this Act and other applicable state statutes;

(4) Comply with all rules and regulations regarding adjusted community rating as specified in Section [cite applicable section of small employer health insurance availability law], except that the purchasing alliance and a participating carrier may negotiate only the administrative expense component of the premium rates charged for coverage offered through the alliance where the carrier can demonstrate net administrative cost savings for its alliance business. For the purposes of this paragraph, administrative expenses are limited to marketing expenses, acquisition expenses, the cost of paying claims, commissions and maintenance expenses;

Drafting Note: Participating carriers should be required to use the same rating methodology inside and outside the alliance. Alliances should be permitted to negotiate with carriers only on administrative costs. Claim costs must be uniform across a carrier's entire small employer group market and not be subject to negotiation.

(5) Enroll and dis-enroll individuals as directed by the purchasing alliance or its designee; and

(6) Comply with any other requirement established by the board pursuant to this Act.

E. In contracts with participating carriers, the board may establish performance standards for specific contractual elements and penalties for failure to fulfill specific contractual obligations.

Drafting Note: This section does not specifically address the board's inherent power to cancel a contract in response to a participating carrier's breach of contract.

F. Nothing in this Act shall prohibit a participating carrier from contracting with particular health care providers or types, classes or categories of health care providers or setting reimbursement methodology.

G. Notwithstanding anything to the contrary in Section [cite guaranteed renewability section of the small employer health insurance availability law], in the event the participating carrier elects to terminate its participating agreement with a purchasing alliance, the participating carrier shall:

(1) Provide advance notice of its decision to the board; and

(2) Provide notice of the decision at least 180 days prior to the nonrenewal of any health benefit plan to the member small employers and enrollees. A participating carrier that elects not to renew a health benefit plan with a purchasing alliance shall be prohibited from writing new business through the purchasing alliance for a period of three (3) years from the date of the notice to the purchasing alliance or until the purchasing alliance, with the concurrence of the commissioner, invites the former participating carrier to renew participation, whichever is sooner.

Section 9. Contracts with Member Small Employers and Participating Carriers

A. Contracts between the board and participating carriers shall specify how all premiums will be transmitted, and penalties and grace periods for payments.

B. Contracts between purchasing alliances and member small employers shall provide:

(1) For administrative purposes, the purchasing alliance will be the policyholder or contract holder of the health benefit plan on behalf of member small employers, their eligible employees and dependents;

(2) Provide that the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of the health benefit plan's coverage to each enrolled eligible employee; and

(3) Provide that all eligible employees of the small employer who obtains coverage under the health benefit plan offered by the small employer must obtain coverage through the purchasing alliance.

Section 10. Marketing Health Benefit Plans

A. The board shall establish marketing standards to be used by participating carriers.

B. Any marketing, advertisement or educational material for health benefit plans sold through the purchasing alliance shall be approved by the board prior to its use. The board shall review all materials submitted to it and the materials shall be deemed approved if not disapproved within [insert number days. The board may, through its contracts with participating carriers, deem certain classes of materials to be approved.

C. This section shall not be construed to prohibit or to compel the purchasing alliance or a participating carrier from using the services of an agent or broker.

Drafting Note: States are reminded that this section is not intended to modify any existing statutes that require the licensing of individuals who provide advice on insurance coverage or who solicit sales of insurance.

D. A participating carrier, agent, broker, contractor or producer of a participating carrier, or independent insurance agent, broker, contractor or producer may not engage, directly or indirectly, in an activity or marketing practice that would encourage member small employers or eligible enrollees to:

(1) Refrain from enrolling in a health benefit plan offered through the purchasing alliance because of their health status or claims experience;

(2) Seek coverage from other participating carriers because of their health status or claim experience; or

(3) Enroll or fail to enroll in the purchasing alliance because of their health status or claims experience.

Section 11. Solvency

In the event a purchasing alliance becomes insolvent, the commissioner shall maintain jurisdiction of the alliance for purposes of protection of the interests of the alliance enrollees.

Section 12. Purchasing Alliance Evaluation

The board shall make a report not later than [insert date] to the commissioner of at least the following:

A. The progress achieved in assuring affordable health care coverage to eligible employees of member small employers;

B. The need, if any, for financial incentives or other mechanisms to increase participation in the purchasing alliance;

C. The benefits, if any, of exclusive purchasing of health insurance through the purchasing alliance for all small employers who choose to purchase health coverage; and

D. Other changes in the law or procedure that would improve the overall efficiency, further reduce costs and improve fairness.

Section 13. Effective Date

This Act shall be effective [insert date].

Drafting Note: Each state should draft to be consistent with that state's procedures for establishing an effective date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 36, 555, 589, 629-638 (adopted).
1996 Proc. 2nd Quarter 10, 30, 732, 768, 781-783 (amended).

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. §§ 23-86-501 to 23-86-512 (2001/2005); ARK. CODE R. §§ 054.00.78-1 to 054.00.78-7 (2003).
California			CAL. INS. CODE §§ 10730 to 10750 (1992); CAL. CODE REGS. tit. 10, §§ 2699.610 to 2699.6463.5 (1994/1999); CAL INS. CODE §§ 10800 to 10887 (1997).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. §§ 33-30A-1 to 33-30A-11 (1997); GA. COMP. R. & REGS. 120-2-79 (2000).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 123/1 to 123/75 (1997).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. §§ 191-73.1 to 191-73.24 (1994).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1951 to 1957 (1996/2003).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 62T.01 to 62T.12 (1997/2000).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. § 33-22-501 (1994) (purchasing alliances authorized); MONT. CODE ANN. §§ 33-22-1801 to 33-22-1822 (1995/2017).
Nebraska	NO CURRENT ACTIVITY		

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. §§ 689C.360 to 689C.600 (1995); NEV. ADMIN. CODE §§ 689C.300 to 689C.450 (1996).
New Hampshire			N.H. REV. STAT. ANN. § 420-G:10a (2001) (authority to adopt regulations); N.H. CODE ADMIN. R. INS. 3401.01 to 3401.11 (2001).
New Jersey			N.J. REV. STAT. §§ 17B:27A-25.1 to 17B:27A-25.9 (2003).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE § 26.1-01-07.4 (1993/2005) (authority to adopt rules); N.D. ADMIN. CODE § 45-06-09 (1994).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3924.01 to 3924.42 (1993).
Oklahoma			OKLA. STAT. tit. 36, §§ 4521 to 4529 (2002); OKLA. ADMIN. CODE §§ 365:10-19-1 to 365:10-19-8 (2002/2003).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-71-730 (1987/1994); BULLETIN 5-94 (1994).

THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota			S.D. CODIFIED LAWS §§ 58-18-52 to 58-18-62 (1994).
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 26.401 to 26.442 (2004).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

Table of Contents

Statement of Principles

Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective.

Uninsurable plans may not be needed in every state, nor present the most effective answer to questions of availability of health insurance and health benefits coverage in every state. The establishment of such programs is costly and their cost effectiveness should be weighed in relation to whether there is a demonstrated need for a plan in a given state.

By definition, a plan consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial minimum rate of 125-150 percent of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience; however, in no event shall rates exceed 200 percent of standard risk rates. A minimum rate of 125-150 percent is admittedly inadequate for the risks insured, and the 200 percent maximum will prevent the rates from becoming prohibitive. Plan losses in excess of the 200 percent maximum rate must be financed through other sources of revenue. Section 7 of the Model Act contains several alternative methods for financing plan losses. It is important to note that if plan losses are financed by assessments against insurers, the plan's cost effectiveness can be substantially impaired unless contributions from both insured and self-funded health benefit plans can be secured. Without the inclusion of self-funded plans, the financial base necessary to support the pooling mechanism may be insufficient.

For the obvious cost containment reasons, the plan coverage is the coverage of "last resort" and may not necessarily duplicate coverages from any other source, private or public. The model contains two alternative methods for establishing plan benefits. The mechanics of the plan and its operations and functions must all be established under a plan of operation approved by the commissioner. The plan is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to provide health insurance coverage.

BE IT ENACTED BY THE STATE OF [insert state].
[adapt caption and formal portions to local requirements and statutes]

Section 1. Definitions

For the purposes of this act:

A. "Board" means the board of directors of the plan.

B. "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

C. "Commissioner" means the Insurance Commissioner.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

D. (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10, United States Code;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, United States Code;

(i) A public health plan as defined in federal regulations; or

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Act, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

E. "Department" means the Insurance Department.

F. "Dependent" means a resident spouse or resident unmarried child under the age of nineteen (19) years, a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

G. "Federally defined eligible individual" means an individual:

(1) For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection D, is eighteen (18) or more months;

(2) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

(3) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX of the Act (Medicaid) or any successor program, and who does not have other health insurance coverage;

(4) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

(6) Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in Paragraph (5).

H. "Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

I. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection N, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

J. (1) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(2) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

K. "Health maintenance organization" [reference applicable state laws].

L. "Hospital" [reference applicable state laws].

Drafting Note: Definitions of "physician" and "hospital" are needed only if the benefit package is specified in the Act.

M. "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this Act, insurer includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation.

N. "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

O. "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 USC 1395 *et seq*., as amended.

P. "Participating insurer" means any insurer providing health insurance coverage to residents of this state.

Q. "Physician" [reference applicable state laws].

R. "Plan" means the [State] Health Insurance Plan as created in Section 2 of the Act.

S. "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to Section 2 of this Act.

T. "Resident" means an individual who has been legally domiciled in this state for a period of at least thirty (30) days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement.

U. "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Section 2. Operation of the Plan

A. There is hereby created the [State] Health Insurance Plan.

B. The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner or his or her designated representative, who shall serve as an *ex officio* member of the board and shall be its chairperson, and [insert even number] members appointed by the Governor [or elected commissioner]. At least two (2) board members shall be individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan. At least two (2) board members shall be representatives of insurers. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers.

Drafting Note: A state may wish to establish the plan as a public entity. Establishment as a public entity is most appropriate if public funds are used to subsidize plan losses.

C. The initial board members shall be appointed as follows: one-third of the members to serve a term of two (2) years; one-third of the members to serve a term of four (4) years; and one-third of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

D. Vacancies in the board shall be filled by the Governor [or elected commissioner]. Board members may be removed by the Governor [or elected commissioner] for cause.

E. Board members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

F. The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this Act must be made available. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.

G. The plan of operation shall:

(1) Establish procedures for operation of the plan;

(2) Establish procedures for selecting an administrator in accordance with Section 6 of this Act;

(3) Establish procedures to create a fund, under management of the board, for administrative expenses;

(4) Establish procedures for the handling, accounting and auditing of assets, monies and claims of the plan and the plan administrator;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment; and to maintain public awareness of the plan;

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The rievances shall be reported to the board after completion of the review. The board shall retain all written complaints regarding the plan for at least three (3) years; and

(7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this Act.

H. The plan shall have the general powers and authority granted under the laws of this state to health insurers and in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the plan;

(3) Take such legal action as necessary:

(a) To avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(b) To recover any amounts erroneously or improperly paid by the plan;

(c) To recover any amounts paid by the plan as a result of mistake of fact or law; or

(d) To recover other amounts due the plan;

(4) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Issue policies of insurance in accordance with the requirements of this Act;

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the pool;

(7) Borrow money to effect the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;

(8) Establish rules, conditions and procedures for reinsuring risks of participating insurers desiring to issue plan coverages in their own name. Provision of reinsurance shall not subject the plan to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

Drafting Note: Optional Paragraph: A state may wish to utilize the existing distribution systems of insurers for the issuance of pool coverage. If so, such a provision should authorize the establishment of specific rules under which the pool would approve and serve as a reinsurer for coverage issued by participating insurers in their own names. Paragraph (8) is designed to allow states to implement this option.

(9) Employ and fix the compensation of employees. Such employees may be paid on a warrant issued by the state treasurer pursuant to a payroll voucher certified by the board and drawn by the comptroller against appropriations or trust funds held by the state treasurer;

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;

(11) Provide for reinsurance of risks incurred by the plan;

(12) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplemental insurance coverage;

Drafting Note: Due to the inability of some individuals to obtain Medicare supplement insurance, especially individuals who are eligible for Medicare by reason of disability, a state may wish to require the plan to offer Medicare supplement insurance coverage.

(13) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective;

(14) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements; and

(15) Adopt bylaws, policies and procedures as may be necessary or convenient for the implementation of this Act and the operation of the plan.

I. The board shall make an annual report to the Governor which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

J. Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Act, unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

Section 3. Establishment of Rules

The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement this Act.

Section 4. Eligibility

A. (1) An individual person, who is and continues to be a resident shall be eligible for plan coverage if evidence is provided:

(a) Of a notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

(b) Of a refusal by an insurer to issue insurance except at a rate exceeding the plan rate.

(2) A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for plan coverage.

(3) A rejection or refusal by an insurer offering only stop loss, excess of loss or reinsurance coverage with respect to an applicant under Paragraph (1) shall not be sufficient evidence under this subsection.

B. The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage pursuant to Subsection A(1). Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in Subsection A(1). The list shall be effective on the first day of the operation of the plan and may be amended from time to time as may be appropriate.

C. Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

D. A person shall not be eligible for coverage under the plan if:

(1) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it; except that:

(a) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy; and

(b) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

(2) The person is determined to be eligible for health care benefits under [reference state Medicaid law];

(3) The person has previously terminated plan coverage unless twelve (12) months have lapsed since such termination, except that this paragraph shall not apply with respect to an applicant who is a federally defined eligible individual;

(4) The plan has paid out $[insert number] in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this paragraph shall not apply with respect to an applicant who is a federally defined eligible individual; or

(6) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

E. Coverage shall cease:

(1) On the date a person is no longer a resident of this state;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date state law requires cancellation of the policy; or

(5) At the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

F. Except under the circumstance described in Subsection D, a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

Drafting Note: Plans may wish to consider establishing reciprocal agreements with plans for uninsurables in other states to provide coverage to covered persons who move between states with such plans. In such cases, the plan may wish to consider counting benefits provided to the person by another plan toward the person's lifetime maximum benefits.

Drafting Note: With regard to lifetime limits on benefits referred to in Subsection D(4) of this section, HIPAA requires generally that federally defined eligible individuals have a choice of coverage available to them and that one of those choices be comprehensive coverage. State high risk pools with low lifetime limits might not qualify as an acceptable alternative mechanism under HIPAA.

Section 5. Unfair Referral to Plan

It shall constitute an unfair trade practice for the purposes of [insert reference to state's unfair trade practices act] for an insurer, insurance producer or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

Drafting Note: This section generally prohibits insurers and agents from "carving out" the sickest members of an insured group and referring them to the plan. The intent is to reduce the plan's costs by keeping coverage for these employees in the private voluntary market.

Section 6. Plan Administrator

A. The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The plan administrator's proven ability to handle health insurance coverage to individuals;

(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

(3) An estimate of total charges for administering the plan;

(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and

(5) The financial condition and stability of the plan administrator.

B. (1) The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions and limitations of the contract between the plan and the plan administrator.

(2) At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six (6) months prior to the end of the current period.

C. The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:

(1) Determination of eligibility;

(2) Payment of claims;

(3) Establishment of a premium billing procedure for collection of premium from persons covered under the plan; and

(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan.

D. The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be specified in the contract between the board and the plan administrator.

E. Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Department on a form prescribed by the commissioner.

F. The plan administrator shall be paid as provided in the contract between the plan and the plan administrator.

Section 7. Funding of the Plan

A. Premiums

(1) The plan shall establish premium rates for plan coverage as provided in Paragraph (2). Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the commissioner for approval prior to use.

(2) The plan, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be less than [125-150] percent of rates established as applicable for individual standard risks. Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed 200 percent of rates applicable to individual standard risks.

B. Sources of Additional Revenue

Drafting Note: Health plans for uninsurables cannot be supported by premiums and must be subsidized by additional revenues. States may wish to consider one or more of the following sources for revenues to fund plan deficits. The order of the additional sources of revenue does not indicate any preference among the options. States that wish to use more than one source of additional revenue should include the bracketed language in the appropriate alternatives below and should include an additional paragraph specifying the percentage of revenue to come from each additional revenue source.

ALTERNATIVE ONE. Assessment of health insurers based upon their health insurance premiums written in the state.

(1) In addition to the powers enumerated in Section 2 of this Act, the plan shall have the authority to assess participating insurers in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.

(2) Following the close of each fiscal year, the plan administrator shall determine the net premiums (premiums less administrative expense allowances), the plan expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the plan shall be recouped by assessments apportioned by the board among participating insurers [and from other sources of revenue as provided by this section].

Drafting Note: In the case of plans that do not offer coverage to supplement Medicare benefits, for equity purposes the state may wish to consider exempting Medicare supplement coverage from the assessment under this section.

(3) Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in Paragraph (2) by a fraction, the numerator of which equals that participating insurer's premium and subscriber contract charges for health insurance coverage written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all participating insurers.

(4) If assessments exceed the plan's actual losses and administrative expenses the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(5) Each participating insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the participating insurer with the board.

(6) A participating insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, such assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the participating insurer to fulfill its contractual obligations. In the event an assessment against a participating insurer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred shall be assessed against the other participating insurers in a manner consistent with the basis for assessments set forth in this subsection. The participating insurer receiving such abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

Drafting Note: A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the participating insurers of the plan. If so, such a provision should allow appropriate reductions in assessments as to participating insurers not subject to the taxes against which offsets are allowed.

ALTERNATIVE TWO. Assessment of health insurers and reinsurers based upon the number of persons they cover through primary, excess and stop loss insurance in this state.

(1) For the purposes of this subsection, "participating insurer" includes all insurers providing health insurance coverage, including excess or stop loss coverage, to residents of this state.

(2) In addition to the powers enumerated in Section 2 of this Act, the plan shall have the authority to assess participating insurers in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.

(3) Following the close of each fiscal year, the administrator shall determine the net premiums (premiums less reasonable administrative expense allowances), the plan expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the plan shall be recouped by assessments apportioned under this section by the board among participating insurers [and from other sources of revenue as provided in this section].

(4) Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in Paragraph (3) by a fraction, the numerator of which equals the number of individuals in this state covered under health insurance policies (including by way of excess or stop loss coverage) by each participating insurer, and the denominator of which equals the total number of all individuals in this state covered under health insurance policies (including by way of excess or stop loss coverage) by all participating insurers, all determined as of the end of the prior calendar year.

(5) The board shall make reasonable efforts designed to ensure that each insured individual is counted only once with respect to any assessment. For that purpose, the board shall require each participating insurer that obtains excess or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured (including by way of excess or stop loss coverage) in whole or part. The board shall allow a participating insurer who is an excess or stop loss insurer to exclude from its number of insured individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection.

(6) Each participating insurer's assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board. The board may use any reasonable method of estimating the number of insureds of a participating insurer if the specific number is unknown. With respect to participating insurers that are reinsurers or excess or stop loss insurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stop loss insurer.

(7) A participating insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the participating insurer to fulfill its contractual obligations. In the event an assessment against a participating insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other participating insurers in a manner consistent with the basis for assessments set forth in this subsection. The participating insurer receiving such abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

Drafting Note: A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the participating insurers of the plan. If so, such a provision should allow appropriate reductions in assessments as to participating insurers not subject to the taxes against which offsets are allowed.

ALTERNATIVE THREE. Service Charge on Hospital and Surgical Centers

(1) The deficit incurred by the plan shall be subsidized by the state through the service charge provided for in this subsection [and from other sources of revenue as provided in this section]. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums and service charges provided for in this subsection [and from other sources of additional revenue as provided in this section]. After determining the amount of funds available to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(2) (a) Each patient, except a private pay patient, a patient covered by Medicare or a patient covered by any other public program that is directly subsidized by the federal government, who is admitted to a hospital for treatment shall be assessed a service charge of two (2) dollars for each day, or portion thereof, during which the patient is confined as an inpatient in that facility. For purposes of this section only, "hospital" does not include any hospital operated by the state or any hospital created or operated by the Department of Veteran Affairs or other agency of the United States of America. Each hospital in which a patient is confined shall calculate the total service charge due for that service charge in the bill for services rendered to the patient. The service charge shall be collected as provided in Subparagraph (c).

(b) Each patient, except a private pay patient, a patient covered by Medicare or a patient covered by any other public program that is directly subsidized by the federal government, who is admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of one dollar for each admission to that facility. The service charge shall be included in the bill for services or supplies, or both, rendered to the patient by the ambulatory surgical center or hospital.

(c) Each hospital and ambulatory surgical center shall collect the service charges assessed under this section. In the event that no payment is made by or on behalf of the patient for services rendered, the fee assessed under this section shall be waived. Each hospital and ambulatory surgical center shall remit to the plan for each reporting period, as established in the plan of operation, but no more frequently than [insert time period], charges collected during that reporting period in accordance with the reporting and remittance procedures established by the board. Failure to pay within sixty (60) days after the end of the reporting period shall cause the hospital or ambulatory surgical center to be liable to the plan for an amount determined by the board, not to exceed $500, plus interest. Any hospital or ambulatory surgical center found to have failed to pay according to this section on three (3) or more occasions during a six-month period shall be liable for an amount determined by the board, no less than $500 and not to exceed $1,500 per failure, together with attorney fees, interest and court costs.

(d) For the purposes of this subsection, "private pay patient" means a person whose admission to a hospital or ambulatory surgical center is not reimbursed through health or other insurance or any other health benefit plan or arrangement.

ALTERNATIVE FOUR. Appropriation of General Revenue

The deficit incurred by the plan shall be funded through amounts appropriated by the state legislature [and from other sources of revenue as provided in this section]. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the state legislature [and from other sources of additional revenue as provided in this section]. After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

Drafting Note: States may wish to consider using other sources of dedicated revenues to support state plans, including tobacco and alcohol taxes, per-person payroll taxes, income tax surcharges, or revenues from state lotteries.

Section 8. Benefits

Drafting Note: Two alternatives for Subsection A are offered for establishing covered services for the plan. Alternative One provides for the plan board to establish the covered services and exclusions, subject to the approval of the commissioner. The advantages of this alternative are that legislators can leave the benefit determinations to experts in plan design and that benefits can be easily modified from time to time to recognize changes in marketplace standards and medical technology.

Alternative Two contains a list of covered services and exclusions for states that wish to include the benefits and exclusions in the statute. The advantage of Alternative Two is that the list contains the benefits and exclusions found in some high risk plans in operation at the time the model was adopted. The list is intended to be inclusive and states may wish to add or delete benefits or exclusions to reflect the state's policy preferences. The list is an outline of the benefits and exclusions; it is not policy language.

Consideration should be given prior to enactment to the cost effectiveness of inclusion or deletion of benefit mandates or other minimum benefit standards. Consideration also should be given to providing sufficient flexibility in the plan to allow for the delivery of services through health maintenance organizations, preferred provider organizations and other managed care arrangements.

Drafting Note: HIPAA requires that federally defined eligible individuals have a choice of coverage available to them. This requirement is satisfied by the plan offering at least two different deductible options to such individuals.

ALTERNATIVE ONE

A. The plan shall offer health care coverage consistent with comprehensive coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and subject to the approval of the commissioner.

ALTERNATIVE TWO

A. (1) Outline of Benefits. Covered expenses shall be the usual, customary and reasonable charge in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services, subject to provisions of Subsection B:

(a) Hospital services;

(b) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;

(c) Drugs requiring a physician's prescription;

(d) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year;

(e) Services of a home health agency up to a maximum of 270 services per year;

(f) Use of radium or other radioactive materials;

(g) Oxygen;

(h) Anesthetics;

(i) Prostheses other than dental;

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;

(k) Diagnostic X-rays and laboratory tests;

(l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(m) Services of a physical therapist;

(n) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;

(o) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a fifty percent (50%) copayment, and that the plan's payment shall not exceed $[insert number].

(2) Exclusions. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(b) Care which is primarily for custodial or domiciliary purposes;

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is medically necessary;

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(f) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(g) Dental care except as provided in Subsection A(1)(l);

(h) Eyeglasses and hearing aids;

(i) Illness or injury due to acts of war;

(j) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to an eligible person each policy year;

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;

(l) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of additional premiums;

(m) Any expense or charge for services, drugs or supplies that are not provided in accord with generally accepted standards of current medical practice;

(n) Any expense or charge for routine physical examinations or tests;

(o) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(p) Any expense incurred for benefits provided under the laws of the United States and this state, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;

(q) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;

(r) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;

(s) Any expense or charge for sterilization or sterilization reversals;

(t) Any expense or charge for weight loss programs, exercise equipment or treatment of obesity, except when certified by a physician as morbid obesity (at least two (2) times normal body weight);

(u) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;

(v) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant; or

(w) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community.

B. In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in the state.

C. The board may adjust any deductibles and coinsurance factors annually according to the Medical Component of the Consumer Price Index.

D. Preexisting Conditions.

(1) Plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such conditions during the six-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

Drafting Note: In order to reduce the premiums and costs of the plan, states may wish to provide for a longer exclusion period for preexisting conditions; as noted above, however, no preexisting condition exclusion may be applied to a federally defined eligible individual. States will need to weigh the need to provide access to individuals with preexisting conditions with the increased costs associated with a shorter preexisting condition exclusion period.

(2) Subject to Paragraph (1), the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that

(a) Application for pool coverage is made not later than sixty-three (63) days following such involuntary termination and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated; and

(b) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

E. Nonduplication of Benefits.

(1) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this paragraph.

Section 9. **Collective Action**

Neither the participation in the plan as participating insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the plan or any participating insurer.

Section 10. **Taxation**

The plan established pursuant to this Act shall be exempt from any and all taxes.

Section 11. **Effective Date**

The provisions of this Act shall become effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 35, 644, 741-742, 755-762 (adopted).
1983 Proc. II 16, 22, 638, 693, 698-712 (amended and reprinted).
1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance Availability Act of 1983 as NAIC policy).
1992 Proc. II 8, 62, 672, 719, 726-740 (amended and reprinted).
2000 Proc. 3rd Quarter 13, 14, 163, 200, 311-323 (amended and reprinted).

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

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MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

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PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-52-1 to 27-52-6 (1997/2014).	ALA. ADMIN. CODE r. 482-1-115 (1997/2010).
Alaska			ALASKA STAT. §§ 21.55.010 to 21.55.500 (1992/2010).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE ANN. §§ 23-79-501 to 23-79-517 (1997/2013) (portions of model).		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut			CONN. GEN. STAT. § 38a-556 (1975/2003).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia		GA. CODE ANN. §§ 33-44-1 to 33-44-10 (1989/1990).	GA. COMP. R. & REGS. 111-4-1-.01 to 111-4-1-.13 (2005).

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. §§ 41-5501 to 41-5509 (2000/2005).
Illinois	215 ILL. COMP. STAT. 105/1 to 105/15 (1984/2005) (portions of model).		
Indiana			IND. CODE §§ 27-8-10-0.1 to 27-8-10-11.2 (1981/2013) (comprehensive health insurance).
Iowa		IOWA CODE §§ 514E.1 to 514E.11 (1986/2005).	
Kansas	KAN. STAT. ANN. §§ 40-2117 to 40-2131 (1992/2004) (portions of model).		
Kentucky			KY. REV. STAT. ANN. §§ 304.17B-001 to 304-17B-031 (2000/2019).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24A, §§ 6901 to 6981 (2009/2013).
Maryland			MD. CODE ANN., HEALTH GEN. §§ 15-1001 to 15-1006 (2002/2014) (senior drug); MD. CODE REGS. 31.17.01.01 to 31.17.03.19 (2003/2013).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 62E.01 to 62E.19 (1976/2013).
Mississippi			MISS. CODE ANN. §§ 83-9-201 to 83-9-222 (1991/2009).

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri		MO. REV. STAT. §§ 376.960 to 376.989 (1991/2013).	
Montana	NO CURRENT ACTIVITY		
Nebraska		NEB. REV. STAT. §§ 44-4201 to 44-4235 (1987/2004).	210 NEB. ADMIN. CODE ch. 44, §§ 001 to 012 (1987/2004).
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. REV. STAT. ANN. §§ 404-G:1 to 404-G:12 (2001/2010).
New Jersey	NO CURRENT ACTIVITY		
New Mexico		N.M. STAT. ANN. §§ 59A-54-1 to 59A-54-21 (1987/2005).	13 N.M. CODE R. §§ 10.10.1 to 10.10.24 (1998).
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE §§ 26.1-08-01 to 26.1-08-14 (1983/2005).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. ADMIN. CODE § 365:45-3-1 (2009).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. §§ 38-74-10 to 38-74-80 (1989/2003) (portions of model).		
South Dakota	NO CURRENT ACTIVITY		

MODEL HEALTH PLAN FOR UNINSURABLE INDIVIDUALS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. REV. CODE ANN. §§ 48.41.010 to 48.41.920 (1987/2013).
West Virginia	W. VA. CODE §§ 33-48-1 to 33-48-12 (2004/2009).		
Wisconsin			WIS. ADMIN. CODE INS. §§ 18.01 to 18.18 (1981/2001).
Wyoming			WYO. STAT. ANN. §§ 26-43-101 to 26-43-118 (1990/2013); WYO. CODE R. 044.0002.41 §§ 1 to 4 (1996/2016).

STOP LOSS INSURANCE MODEL ACT

Table of Contents

Section 1. Purpose and Intent

This law shall be known as the Stop Loss Insurance Act. The purpose of this Act is to establish criteria for the issuance of stop loss insurance policies. Nothing in this act shall be construed as imposing any requirement or duty on any person other than an insurer or as treating any stop-loss policy as a direct policy of health insurance.

Section 2. Definitions

A. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that an insurer is in compliance with the provisions of this Act, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop loss insurance coverage.

B. "Attachment point" means the claims amount incurred by an insured group beyond which the insurer incurs a liability for payment.

C. "Expected claims" means the amount of claims that, in the absence of a stop loss policy or other insurance, are projected to be incurred by an insured group through its health plan.

Drafting Note: This model act establishes criteria for the issuance of stop loss insurance policies. The criteria apply regardless of how the stop loss insurance carrier calculates when the aggregate attachment point has been met for the purposes of triggering payment under the policy. The model act only requires an insurer to calculate the numerical value of the aggregate attachment point pursuant to the definitions and parameters of the model; it does not preclude a stop loss carrier from using different contractual definitions of "expected claims" and other terms in order to determine how that numerical value is to be reached under the terms of its contract with the insured group.

Section 3. Stop Loss Insurance Coverage Standards

A. (1) An insurer shall not issue a stop loss insurance policy that :

(a) Has an annual attachment point for claims incurred per individual which is lower than $20,000;

(b) Has an annual aggregate attachment point, for groups of fifty (50) or fewer, that is lower than the greater of:

(i) $4,000 times the number of group members;

(ii) 120 percent of expected claims; or

(iii) $20,000;

(c) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than 110 percent of expected claims; or

(d) Provides direct coverage of health care expenses of an individual.

(2) An insurer shall determine the number of persons in a group, for the purposes of this subsection, on a consistent basis, at least annually.

(3) For the purposes of determining the dollar amounts set forth in Paragraph (1) above, and upon consideration of the medical components of the Consumer Price Index (CPI), the commissioner may amend these dollar amounts and shall publish any change in these dollar amounts at least six (6) months prior to their effective dates.

Drafting Note: States may wish to provide the commissioner with the authority to promulgate regulations relating to the establishment of the attachment points set forth in Paragraph (1) above. A state may wish to adjust the dollar amounts specified in Paragraph (1) to appropriately reflect medical costs in the particular state. Detailed discussions, including a statement of legislative intent, discussions concerning the actuarial assumptions underlying this model, and an actuarial study on issues relating to risk transference to stop loss insurance carriers, can be found in the minutes of the NAIC State and Federal Health Insurance Legislative Policy Task Force, and its ERISA Working Group in 1994 and 1995.

B. The commissioner may adopt rules that carry out the requirements of this act and prescribe additional standards for stop loss insurance policies.

Section 4. Actuarial Certification

An insurer shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the insurer is in compliance with this Act. The certification shall be in a form and manner, and shall contain information, specified by the commissioner. A copy of the certification shall be retained by the insurer at its principal place of business.

Section 5. Effective Date

This Act shall become effective with respect to stop loss insurance policies issued or renewed six (6) months after [insert effective date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 38, 553, 663, 671-672 (adopted).
1999 Proc 3rd Quarter 25, 26, 834, 838, 839-840 (amended and reprinted).

STOP LOSS INSURANCE MODEL ACT

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STOP LOSS INSURANCE MODEL ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	ALASKA STAT. § 21.42.145 (2002) (portions of model); BULLETIN 2006-4 (2006).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. § 23-62-111 (2007/2009) (employee benefit stop loss); BULLETIN 4-2007 (2007); BULLETIN 6-2008 (2008).
California			CAL. INS. CODE §§ 10752 to 10752.8 (2013).
Colorado			COLO. REV. STAT. § 10-16-119 (1994/2013).
Connecticut			CONN. GEN. STAT. § 38a-8b (2004).
Delaware			DEL. CODE ANN. tit. 18, § 7218 (2011).
District of Columbia			D.C. CODE ANN. §§ 31-3821 to 31-3822 (2015).
Florida			FLA. STAT. ANN. § 627.66997 (2015).

STOP LOSS INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			OPINION NO. 90–10–2 (1990).
Kansas			KAN. ADMIN. REGS. 40-1-49 (2002); BULLETIN 1993-12 (1993); BULLETIN 1993-12 (Addendum) (1993); BULLETIN 1997-7 (1997).
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. § 22:883 (2001/2011).
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. § 15-129 (2008).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. STAT. §§ 60A.235 to 60A.236 (1995/2009) (portions of model).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska			NEB. REV. STAT. ANN. § 44-7609 (2002).
Nevada	NEV. ADMIN. CODE § 689B.350 (2001).		

STOP LOSS INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire	N.H. REV. STAT. ANN. §§ 415-H:1 to 415-H:5 (2006).		
New Jersey			N.J. STAT. ANN. § 17B:27A-17 (1992/1997); BULLETIN 2011-20 (2011).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. ADMIN. CODE 45-06-14-13 (2017).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 1739.12 (2015).
Oklahoma			OKLA. STAT. ANN. tit. 36, § 7401 (2016); BULLETIN LH 2013-03 (2013).
Oregon			OR. REV. STAT. § 742.065 (1993/1995).
Pennsylvania			31 PA. CODE §§ 89.471 to 89.474 (1992).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R. I. GEN. LAWS §§ 27-8.2-1 to 27-8.2-5 (2013).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-18B-35 (1995/1998) (prohibits adoption of a rule affecting stop loss coverage for self-funded employee health programs); S.D. CODIFIED LAWS § 58-33-106 (2007).
Tennessee			BULLETIN 7-1-94 (1994).
Texas	NO CURRENT ACTIVITY		

STOP LOSS INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah			UTAH CODE ANN. §§ 31A-43-101 to 31A-43-304 (2013) (small employer); UTAH ADMIN. CODE r. 590-268 (2014).
Vermont			4-5 Vt. Code R. § 15 (2009/2018).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. REV. CODE ANN. § 48.21.015 (1992).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Discount Medical Plan Organization Model Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to change the short title of this Act to the "Discount Medical Plan and Prescription Drug Plan Organization Model Act."

Section 2. Purpose

The purpose of this Act is to promote the public interest by establishing standards for discount medical plan organizations to protect consumers from unfair or deceptive marketing, sales or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in this section.

Section 3. Definitions

For purposes of this Act:

A. "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. "Ancillary services" includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic and podiatry services.

C. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

D. "Control" or "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert reference in state law that is equivalent to Section 4K of the NAIC Insurance Holding Company System Regulatory Act] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

E. (1) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

(2) "Discount medical plan" does not include:

(a) A plan that does not charge a membership or other fee to use the plan's discount medical card; or

(b) Any product regulated under [insert reference to applicable state law].

F. (1) "Discount prescription drug plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration provides access for its plan members to providers of pharmacy services and the right to receive discounts on pharmacy services provided under the discount prescription drug plan from those providers.

(2) "Discount prescription drug plan" does not include:

(a) A plan that does not charge a membership or other fee to use the plan's discount prescription drug card;

(b) A patient access program; or

(c) A Medicare prescription drug plan or any product regulated under [insert reference to applicable state law].

Drafting Note: A state should adopt Subsection F only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided Section 16 of this Act.

G. "Discount medical plan organization" means an entity that, in exchange for fees, dues, charges or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members.

H. "Discount prescription drug plan organization" means an entity that, in exchange for fees, dues, charges or other consideration, provides access for discount prescription drug plan members to providers of pharmacy services and the right to receive pharmacy services from those providers at a discount. It is the organization that contracts with providers, pharmacy networks or other discount prescription drug plan organizations to offer access to pharmacy services at a discount and determines the charge to discount prescription drug plan members.

Drafting Note: A state should adopt Subsection H only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

I. (1) "Facility" means an institution providing medical or ancillary services or a health care setting.

(2) "Facility" includes, but is not limited to:

(a) A hospital or other licensed inpatient center;

(b) An ambulatory surgical or treatment center;

(c) A skilled nursing center;

(d) A residential treatment center;

(e) A rehabilitation center; and

(f) A diagnostic, laboratory or imaging center.

J. "Health care professional" means a physician, pharmacist or other health care practitioner who is licensed, accredited or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification or other appropriate authority and consistent with state law.

K. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or medical or ancillary services.

Drafting Note: States that license health maintenance organizations pursuant to other statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

L. "Marketer" means a person or entity that markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization.

M. (1) "Medical services" means any maintenance care of, or preventive care for, the human body or care, service or treatment of an illness or dysfunction of, or injury to, the human body.

(2) "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies.

(3) "Medical services" does not include pharmacy services or ancillary services.

N. "Medicare prescription drug plan" means a plan that provides a Medicare Part D prescription drug benefit in accordance with the requirements of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Drafting Note: A state should adopt Subsection N only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

O. (1) "Member" means any individual who pays fees, dues, charges or other consideration for the right to receive the benefits of a discount medical plan [or discount prescription drug plan].

(2) "Member" does not include any individual who enrolls in a patient access program.

Drafting Note: A state should include the reference to discount prescription drug plan in Subsection O (1) and the provisions of Section O (2) if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

P. "Patient access program" means a voluntary program sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers, that provides free or discounted health care products directly to low income or uninsured individuals either through a discount card or direct shipment.

Drafting Note: A state adopt Subsection P only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

Q. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

R. "Pharmacy services" includes pharmaceutical supplies and prescription drugs.

Drafting Note: A state should adopt Subsection R only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

S. "Provider" means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members.

T. "Provider network" means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

Section 4. Applicability and Scope

A. This Act applies to all discount medical plan organizations doing business in [or from] this state.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in Subsection A.

B. A discount medical plan organization that is a health carrier licensed pursuant to [insert reference to state insurance code or other applicable state statute]:

(1) Is not required to obtain a [license] [certificate of registration] under Section 5 of this Act, except that any of its affiliates that operate as a discount medical plan organization in this state shall obtain a [license] [certificate of registration] under Section 5 of this Act and comply with all other provisions of this Act; but

(2) Is required to comply with Sections 9, 10, 11, 12, and 13 of this Act and report, in the form and manner as the commissioner may require, any of the information described in Section 15B(2) (3) or (4) of this Act that is not otherwise already reported.

Section 5. [Licensing] [Registration] Requirements

Drafting Note: This section provides two options for a state to choose from when deciding what regulatory scheme to establish for those persons wishing to operate in [or from] the state as a discount medical plan organization. Option 1 sets out the requirements that must be satisfied to obtain and maintain a license to operate as a discount medical plan organization in [or from] the state. Option 2 sets out the requirements that must be satisfied to obtain and maintain a certificate of registration to operate as a discount medical plan organization in [or from] the state. Depending on which regulatory scheme is chosen a state should use the term "license" or "certificate of registration", as appropriate, wherever the term is referenced in other sections of this Act.

Option 1. Licensing Requirements

Drafting Note: This option is for those states that want to require persons wishing to operate in [or from] the state as a discount medical plan organization to obtain a license from the commissioner before doing so.

A. Before doing business in [or from] this state as a discount medical plan organization, a person other than an individual:

(1) Shall be authorized to transact business in this state under [insert reference to applicable state law]; and

(2) Shall obtain a license from the commissioner to operate as a discount medical plan organization.

B. Except as provided in Subsection C, each application for a license to operate as a discount medical plan organization:

(1) Shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant; and

(2) Shall demonstrate, set forth or be accompanied by the following, if applicable:

(a) The applicable fees required under [insert reference to appropriate section in state law];

(b) A copy of the organization documents of the applicant, such as the articles of incorporation, including all amendments;

(c) A copy of the applicant's bylaws or other enabling documents that establish organizational structure;

(d) The applicant's federal identification number, business address and mailing address;

(e) (i) A list of names, addresses, official positions and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the officers, contracted management company personnel and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant; and

(ii) A disclosure in the listing of the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest;

(f) A complete biographical statement, on forms prescribed by the commissioner, [an independent investigation report and a set of fingerprints, as provided in [insert reference to applicable section in state law],] with respect to each individual identified under Subparagraph (e) of this paragraph;

(g) A statement generally describing the applicant, its facilities and personnel and the medical or ancillary services for which a discount will be made available under the discount medical plan;

(h) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical or ancillary services to members;

(i) A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in Subparagraph (e) of this paragraph;

(j) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, [investment management] and subcontracting for the provision of medical or ancillary services to members;

(k) A copy of the applicant's most recent financial statements audited by an independent certified public accountant, except that, subject to the approval of the commissioner, an applicant that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under Section 6 of this Act will be met by the parent entity instead of the audited financial statement of the applicant;

Drafting Note: States should include Subparagraph (k) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

(l) A description of the proposed methods of marketing, including, but not limited to, describing the use of marketers, use of the Internet, sales by telephone, and use of salespersons to market the discount medical plan benefits;

(m) A description of the member complaint procedures to be established and maintained by the applicant;

(n) The name and address of the applicant's [insert state name] statutory agent for service of process, notice or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all law process in any legal action or proceeding against the discount medical plan organization on a cause of action arising in this state may be served; and

(o) Any other information the commissioner may reasonably require.

C. (1) Upon application to and approval by the commissioner and payment of the applicable fees under [insert reference to appropriate sections in state law], a discount medical plan organization that holds a current license or other form of authority from another state to operate as a discount medical plan organization, at the commissioner's discretion, may not be required to submit the information required under Subsection B in order to obtain a license under this section if the commissioner is satisfied that the other state's requirements, at a minimum, are equivalent to those required under Subsection B or the commissioner is satisfied that the other state's requirements are sufficient to protect the interests of the residents of this state.

(2) Whenever the discount medical plan organization loses its license or other form of authority in that other state to operate as a discount medical plan organization, or is the subject of any disciplinary administrative proceeding related to the organization's operating as a discount medical plan organization in that other state, the discount medical plan organization shall immediately notify the commissioner.

D. After the receipt of an application filed pursuant to Subsection B or Subsection C, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

E. Within ninety (90) days after the date of receipt of a completed application, the commissioner shall:

(1) Issue a license if the commissioner is satisfied that the applicant has met the following:

(a) The requirements of Subsection B or Subsection C have been met;

(b) The applicant has the required minimum capital in accordance with Section 6 of this Act; and

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

(c) The ownership, control and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount medical plan organization beneficial to discount medical plan members; or

Drafting Note: In making a determination under Subparagraph (c), the commissioner may want to consider, for example, whether the applicant or an officer or manager of the applicant: (1) is not financially responsible; (2) does not have adequate expertise or experience to operate a medical discount plan organization; or (3) is not of good character. Among the factors that the commissioner may consider in making the determination is whether the applicant or an affiliate or a business formerly owned or managed by the applicant or an officer or manager of the applicant has had a previous application for a license, or other authority, to operate as any entity regulated by the commissioner, denied, has had such license or other authority revoked, suspended or terminated for cause, or is under investigation for or has been found in violation of a statute or regulation in another jurisdiction within the previous 5 years.

(2) Disapprove the application and state the grounds for disapproval.

F. Prior to licensure by the commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of Section 11B of this Act.

G. (1) A license is effective for one (1) year, unless prior to its expiration the license is renewed in accordance with this subsection or suspended or revoked in accordance with Subsection H.

Drafting Note: The one-year licensure term is optional. States should determine on a case-by-case basis the length of any license that is issued under this section.

(2) At least ninety (90) days before a license expires, the discount medical plan organization shall submit:

(a) A renewal application form; and

(b) The renewal fee.

(3) The commissioner shall renew the license of each holder that meets the requirements of this Act and pays the appropriate renewal fee required by [insert reference to appropriate section in state law].

H. (1) The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's license if the commissioner finds that any of the following conditions exist:

(a) The discount medical plan organization is not operating in compliance with this Act;

(b) The discount medical plan organization does not have the minimum net worth as required under Section 6 of this Act;

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

(c) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;

(d) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(e) The continued operation of the discount medical plan organization would be hazardous to its members.

(2) If the commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a license exists, the commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of the [insert reference to state Administrative Procedure Act].

(3) When the license of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the license, to wind up its affairs transacted under the license. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.

(4) (a) The commissioner shall, in its order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its license to enroll members.

(b) The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

(c) The license of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The commissioner shall not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

I. In lieu of suspending or revoking a discount medical plan organization's license under Subsection H, whenever the discount medical plan organization has been found to have violated any provision of this Act, the commissioner may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

J. Each licensed discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's license, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.

K. A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a license under this Act as a discount medical plan organization.

Option 2. Registration Requirements

Drafting Note: This option is for those states that want to require persons wishing to operate in [or from] the state as a discount medical plan organization to obtain a certificate of registration from the commissioner before doing so.

A. Before doing business in [or from] this state as a discount medical plan organization, a person other than an individual:

(1) Shall be authorized to transact business in this state under [insert reference to applicable state law]; and

(2) Shall obtain a certificate of registration from the commissioner to operate as a discount medical plan organization.

B. Each application for a certificate of registration to operate as a discount medical plan organization:

(1) Shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant;

(2) Shall be accompanied by the applicable fees required under [insert reference to appropriate section in state law];

(3) Shall include information on whether:

(a) A previous application for a certificate of registration has been denied, revoked, suspended or terminated for cause; and

(b) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statue or regulation in any jurisdiction within the previous five (5) years; and

(4) Shall include information, as the commissioner may require, that permits the commissioner, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

(a) Is financially responsible;

(b) Has adequate expertise or experience to operate a discount medical plan organization; and

(c) Is of good character.

C. After the receipt of an application filed pursuant to Subsection B, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

D. Within ninety (90) days after the date of receipt of a completed application, the commissioner shall:

(1) Issue a certificate of registration if the commissioner is satisfied that the applicant has met the following:

(a) The requirements of Subsection B have been met; and

(b) The applicant has the required minimum capital in accordance with Section 6 of this Act; or

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of registration.

(2) Disapprove the application and state the grounds for disapproval.

E. Prior to issuance of a certificate of registration by the commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of Section 11B of this Act.

F. (1) A registration is effective for one (1) year, unless prior to its expiration it is renewed in accordance with this subsection or suspended or revoked in accordance with Subsection G.

Drafting Note: The one-year registration term is optional. States should determine on a case-by-case basis the length of any registration that is issued under this section.

(2) At least ninety (90) days before a certificate of registration expires, the discount medical plan organization shall submit:

(a) A renewal application form; and

(b) The renewal fee.

(3) The commissioner shall renew the certificate of registration of each holder that meets the requirements of this Act and pays the appropriate renewal fee required by [insert reference to appropriate section in state law].

G. (1) The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's certificate of registration if the commissioner finds that any of the following conditions exist:

(a) The discount medical plan organization is not operating in compliance with this Act;

(b) The discount medical plan organization does not have the minimum net worth as required under Section 6 of this Act;

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of registration.

(c) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;

(d) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(e) The continued operation of the discount medical plan organization would be hazardous to its members.

(2) If the commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a certificate of registration exists, the commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of the [insert reference to state Administrative Procedure Act].

(3) When the certificate of registration of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the certificate of registration, to wind up its affairs transacted under the certificate of registration. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.

(4) (a) The commissioner shall, in its order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members.

(b) The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

(c) The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The commissioner shall not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

H. In lieu of suspending or revoking a discount medical plan organization's certificate of registration under Subsection G, whenever the discount medical plan organization has been found to have violated any provision of this Act, the commissioner may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

I. Each registered discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's certificate of registration, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.

J. A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under this Act as a discount medical plan organization.

Section 6. Minimum Capital Requirements [Optional]

Drafting Note: This section is optional for those states that wish to require discount medical plan organizations to have and to maintain a minimum net worth as a condition of [licensure] [registration].

A. Before the commissioner issues a [license] [certificate of registration] to any person required to obtain a license under Section 5 of this Act, the person seeking to operate a discount medical plan organization shall have a net worth of at least $150,000.

B. Each discount medical plan organization shall at all times maintain a net worth of at least $150,000.

C. At the commissioner's discretion, the amounts in Subsections A and B may be adjusted annually for inflation.

Section 7. Surety Bond or Deposit Requirements

A. Each [licensed] [registered] discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than $35,000 to be used in the discretion of the commissioner to protect the financial interest of members. The bond shall be issued by an insurance company licensed to do business in this state.

B. In lieu of the bond specified in Subsection A, a [licensed] [registered] discount medical plan organization may deposit and maintain deposited with the commissioner, or at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the commissioner with at all times have a market value of not less than $35,000.

C. All income from a deposit made under Subsection B shall be an asset of the discount medical plan organization.

D. Except for the commissioner, the assets or securities held in this state as a deposit under Subsection A or B shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.

Section 8. Examinations and Investigations

A. The commissioner may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of this state based on the following reasons, including, but not limited to, complaint indices, recent complaints, information from other states, or as the commissioner deems necessary.

B. An examination or investigation conducted as provided in Subsection A shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC Model Law on Examinations].

C. The commissioner may:

(1) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials or other information; and

(2) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.

D. The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay the expenses is grounds for denial of a [license] [certificate of registration] to operate as a discount medical plan organization or revocation of a [license] [certificate of registration] to operate as a discount medical plan organization.

Section 9. Charges and Fees; Refund Requirements; Bundling of Services

A. A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

B. (1) (a) If a member cancels his or her membership in the discount medical plan organization within the first thirty (30) days after the date of receipt of the written document for the discount medical plan described in Section 13D of this Act, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds [$30] upon return of the discount medical plan card to the discount medical plan organization.

Drafting Note: The maximum one-time processing fee amount of $30 in Paragraph (1)(a) is a suggested amount.

(b) (i) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(ii) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount medical plan organization.

(c) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(2) If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

Drafting Note: Subsection C below has two options for states to choose from with respect to bundling of services (i.e. – when a marketer or discount medical plan organization sells the discount medical plan with any other product). Option 1 is for those states that, in accordance with Option 1 in Section 10 of this Act, want discount medical plan organizations to file charges and forms with the commissioner for prior approval. Option 2 is for those states that decide not to adopt Option 1 in Section 10 of this Act or for those states that decide not to adopt Section 10 of this Act altogether.

Option 1.

Drafting Note: A state should choose this option for this subsection if the state decides to adopt Option 1 in Section 10 of this Act.

C. When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the charges for each discount medical plan shall be provided in writing to the member.

Option 2.

Drafting Note: A state should choose this option for this subsection if the state decides not adopt Option 1 in Section 10 of this Act or does not adopt Section 10 of this Act altogether.

C. When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the marketer or discount medical plan organization shall:

(1) Provide the charges for each discount medical plan in writing to the member; or

(2) Reimburse the member for all periodic charges for the discount medical plan and all periodic charges for any other product if the member cancels his or her membership in accordance with Subsection B(1).

D. Any discount medical plan organization that is a health carrier licensed pursuant to [insert reference in state insurance code or other applicable state statute] that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

Section 10. Charge and Form Filing Requirements

Drafting Note: For those states that want to require discount medical plan organizations to file charges and forms with the commissioner, below are two options for this section that these states can choose from to impose such a requirement. Those states that do not want to impose such a requirement should not adopt either option. Option 1 is for those states that want to establish a prior approval system with respect to charges and forms to be used by a discount medical plan organization. Option 2 is for those states that want to establish a system under which a discount medical plan organization would be required to file with the commissioner for informational purposes all charges and forms to be used by the discount medical plan organization.

Option 1.

A. (1) A discount medical plan organization shall file with the commissioner a list of all prospective member fees and charges associated with the discount medical plan.

(2) Any fee or charge to members that is greater than an amount of [$30] per month or [$360] per year shall be submitted to the commissioner for approval prior to its use.

Drafting Note: The maximum amounts for the fees or charges in Paragraph (2) that a discount medical plan organization may charge are suggested amounts. Whatever amount a state chooses to use in this section should be consistent with the amount in Section 9B(1)(a) of this Act.

(3) The discount medical plan organization has the burden of proof that a fee or charge bears a reasonable relationship to the benefits to be received by the member.

B. (1) (a) All forms, including the form for the written document described under Section 13D of this Act, to be used by a discount medical plan organization shall first be filed with and approved by the commissioner.

(b) Each form filed shall be identified in the manner as may be required by the commissioner.

(2) (a) A charge or form shall be considered approved on the 60th day after its date of filing unless it has been previously disapproved by the commissioner.

(b) The commissioner shall disapprove any charge or form that does not meet the requirements of this section or that is unreasonable, discriminatory, misleading, or unfair.

(3) If a form filed pursuant to Paragraph (1) is disapproved, the commissioner shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

Option 2.

A. A discount medical plan organization shall file with the commissioner a list of all prospective member fees and charges associated with the discount medical plan.

B. (1) In addition to Subsection A, a discount medical plan organization shall file all forms, including the form for the written document described under Section 13D of this Act, to be used by a discount medical plan organization with the commissioner prior to use.

(2) Each form filed shall be identified in the manner as may be required by the commissioner.

Section 11. Provider Agreements; Provider Listing Requirements

A. (1) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs.

(2) A provider agreement between a discount medical plan organization and a provider shall provide the following:

(a) A list of the medical or ancillary services and products to be provided at a discount;

(b) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(c) That the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

(a) Contain the provisions described in Paragraph (2);

(b) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(c) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(4) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with Paragraph (3).

(5) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

B. (1) Each discount medical plan organization shall maintain on an Internet website page an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The Internet website address shall be prominently displayed on all of its advertisements, marketing materials, brochures and discount medical plan cards.

(2) This subsection applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

Section 12. Marketing Requirements

A. A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

B. (1) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling or distributing the discount medical plan.

(2) The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures and discount medical plan cards without the discount medical plan organization's approval in writing.

(3) The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.

C. A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures and discount cards used by marketers to market, promote, sell or distribute the discount medical plan prior to their use.

D. Upon request, a discount medical plan organization shall submit to the commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

Section 13. Marketing Restrictions and Disclosure Requirements

A. (1) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication.

(2) An advertisement, any marketing material, brochure, discount medical plan card or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

B. A discount medical plan organization shall not:

(1) Except as otherwise provided in this Act or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term "insurance";

(2) Except as otherwise provided in state law, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits;

(3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being ["licensed"] ["registered"] by the state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by the state;

(5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(6) Have restrictions on access to discount medical plan providers, including, except for hospital services, waiting periods and notification periods; or

(7) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan, unless the discount medical plan organization has an active certificate of authority to act as a third party administrator in accordance with [insert reference to state law equivalent to the NAIC Third Party Administrator Statute].

C. (1) Each discount medical plan organization shall make the following general disclosures:

(a) In writing in not less than twelve-point font;

(b) On the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan; and

(c) Along with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

(iii) Unless the discount medical plan organization has an active certificate of authority to act as a third party administrator as described in Subsection B(7), that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

Drafting Note: The introductory language in Item (iii) above is intended to clarify that if a discount medical plan organization is a third party administrator, as described in Subsection B(7), then it does not have to provide this general disclosure to plan members. If the discount medical plan organization is not a third party administrator, then it must provide the general disclosure in Item (iii).

(iv) That the plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount medical plan organization; and

(v) The toll-free telephone number and Internet website address for the [licensed] [registered] discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and up-to-date lists of providers participating in the discount medical plan.

(2) If the initial contact with a prospective member is by telephone, the disclosures required under Paragraph (1) shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

D. (1) In addition to the general disclosures required under Subsection C, each discount medical plan organization shall provide to:

(a) Each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

(b) Each new member a written document that contains the terms and conditions of the discount medical plan.

(2) The written document required under Paragraph (1)(b) shall be clear and include information on:

(a) The name of the member;

(b) The benefits to be provided under the discount medical plan;

(c) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(d) The mode of payment of any processing fees and periodic charges, such as monthly, quarterly, etc., and procedures for changing the mode of payment;

(e) Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits;

(f) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(g) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(h) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

(i) Renewal, termination and cancellation terms and conditions;

(j) Procedures for adding new members to a family discount medical plan, if applicable;

(k) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or her local state insurance department; and

(l) The name and mailing address of the [licensed] [registered] discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

Section 14. Notice of Change in Name or Address

Each discount medical plan organization shall provide the commissioner at least thirty (30) day's advance notice of any change in the discount medical plan organization's name, address, principal business address or mailing address or Internet website address.

Section 15. Annual Reports

A. If the information required in Subsection B is not provided at the time of renewal of a [license] [certificate of registration] under Section 5 of this Act, a discount medical plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner, within three (3) months after the end of each fiscal year.

B. The report shall include:

Drafting Note: Paragraph (1) has two options. Option 1 requires a discount medical plan organization to submit audited financial statements as part of the annual report in order for the commissioner to determine whether the organization is in compliance with the minimum capital requirements required under Section 6 of this Act. Option 2 requires a discount medical plan organization to submit a certification from one of its officers verifying that the discount medical plan organization is in compliance with the minimum capital requirements required under Section 6 of this Act. States should include Paragraph (1) only if they require a discount medical plan organizations to have a minimum net worth under Section 6 of this Act as a condition of licensure.

Option 1.

(1) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement and statement of changes in cash flow for the preceding year, except that, subject to the approval of the commissioner, an organization that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under Section 6 of this Act will be met by the parent entity instead of the audited financial statement of the organization;

Option 2.

(1) A certification verified by at least one principal officer of the discount medical plan organization that the organization is in compliance with the minimum capital requirements required under Section 6 of this Act;

Drafting Note: States should adopt Paragraphs (2), (3) and (4) below regardless of which option a state chooses to adopt for Paragraph (1) above.

(2) If different from the initial application for a [license] [certificate of registration] or at the time of renewal of a [license] [certificate of registration] or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount medical plan organization, including any possible conflicts of interest;

(3) The number of discount medical plan members in the state; and

(4) Any other information relating to the performance of the discount medical plan organization that may be required by the commissioner.

C. Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall:

(1) Forfeit:

(a) Up to $500 each day for the first ten (10) days during which the violation continues; and

(b) Up to $1,000 each day after the first ten (10) days during which the violation continues; and

(2) Upon notice by the commissioner, lose its authority to enroll new members or to do business in this state while the violation continues.

Section 16. Discount Prescription Drug Plan Organizations [Optional]

Drafting Note: This section is optional for those states that want to include discount prescription drug plan organizations, as that term is defined in Section 3 of this Act, within the scope of this Act.

A. Each discount prescription drug plan organization shall designate and provide the commissioner with the name, address and telephone number of a discount prescription drug plan compliance officer responsible for ensuring compliance with the provisions of this section and this Act that are applicable to discount prescription drug plans and discount prescription drug plan organizations.

B. In addition to Subsection A, a discount prescription drug plan organization shall comply with Sections 9, 10, 11, 12 and 13 of this Act and shall report any of the information described in Section 15 of this Act in the form and manner as the commissioner may require. A discount prescription drug plan organization also is subject to Sections 17 and 18 of this Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in this section, should revise Sections 17 and 18 of this Act, as appropriate, to include discount prescription drug plan organizations.

Section 17. Penalties

A. In addition to the penalties and other enforcement provisions of this Act, any person who willfully violates this Act is subject to civil penalties of up to $[insert amount] per violation.

B. A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of Section 5A of this Act commits insurance fraud and shall be subject to [insert classifications for misdemeanor and felony penalties in the state insurance code for insurance fraud], as if the [unlicensed] [unregistered] discount medical plan organization were an unauthorized insurer, and the fees, dues, charges or other consideration collected from the members by the [unlicensed] [unregistered] discount medical plan organization or marketer were insurance premium.

C. A person that collects fees for purported membership in a discount medical plan, but purposefully fails to provide the promised benefits commits a theft and upon conviction is subject to [insert classifications for misdemeanor and felony penalties that match provisions in the state's criminal code for theft offenses]. In addition, upon conviction, the person shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

Section 18. Injunctions

A. (1) In addition to the penalties and other enforcement provisions of this Act, the commissioner may seek both temporary and permanent injunctive relief when:

(a) A discount medical plan is being operated by a person or entity that is not [licensed] [registered] pursuant to this Act; or

(b) Any person, entity or discount medical plan organization has engaged in any activity prohibited by this Act or any regulation adopted pursuant to this Act.

(2) The venue for any proceeding brought pursuant to this section shall be in the circuit court of [insert appropriate jurisdiction].

B. The commissioner's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to the provisions of the [insert reference to state Administrative Procedure Act].

Section 19. Regulations

The commissioner may adopt regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 20. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 21. Effective Date

This Act shall be effective [insert date]. A person doing business in [or from] this state as a discount medical plan organization on or before the effective date of this Act shall have six (6) months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in this section.

Chronological Summary of Actions (All references are to NAIC Proceedings)

2006 Proc. 3rd Quarter 32, 35-67, 277-298 *(adopted by Plenary).*
2006 Proc. 3rd Quarter (adopted by Parent Committee).
2006 Proc. 2nd Quarter (adopted by Working Group).

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.36.505 (2005); ALASKA STAT. § 21.36.030 (1966/2005); BULLETIN 2012-2 (2012).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE. ANN. §§ 4-106-201 to 4-106-205 (1999/2005) (discount cards).
California	NO CURRENT ACTIVITY		
Colorado			COLO. REV. STAT. § 6-1-712 (2004/2013).
Connecticut	CONN. GEN. STAT. §§ 38a-479qq to 38a-479rr (2008) (portions of model).		
Delaware	DEL. CODE ANN. tit. 18, §§ 7601 to 7614 (portions of model).		
District of Columbia	NO CURRENT ACTIVITY		

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 636.202 to 636.244 (2005).
Georgia			GA. CODE. ANN. § 10-1-393(32) (1975/2015).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE. ANN. §§ 48-1601 to 48-1603 (2000).
Illinois			815 ILL. COMP. STAT. 505/2B.3 (1961/2002); 50 ILL. ADMIN. CODE 2051.210 to 2051.370 (2013).
Indiana	IND. CODE ANN. §§ 27-17-1-1 to 27–17–14–2 (2006) (portions of model).		IND. CODE §§ 24-5-21-1 to 24-5-21-7 (2001) (prescription drug discount cards).
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. §§ 50-1,100 to 50-1,105 (2000/2010).
Kentucky			KY. REV. STAT. ANN. § 367.828 (2002).
Louisiana	LA. REV. STAT. ANN. §§ 22:1260.1 to 22:1260.11 (2008) (portions of model).		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN. INS. §§ 14-601 to 14-612 (2007); MD. CODE REGS. 31.10.24.01 to 31.10.24.04 (2009); BULLETIN 36-2008 (2008); BULLETIN 12-2009 (2009).
Massachusetts			940 MASS. CODE REGS. 26.00 to 26.06 (2010).
Michigan	NO CURRENT ACTIVITY		

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. § 325F.784 (2000) (prescription drug discounts).
Mississippi			MISS. CODE ANN. § 83-64-1 (2007/2013).
Missouri	MO. REV. STAT. §§ 376.1500 to 376.1532 (2007) (portions of model).	MO. CODE REGS. ANN. tit. 20, §§ 200-19.020 to 200-19.060 (2008).	
Montana			MONT. CODE. ANN. §§ 33-38-101 to 33-38-108 (2005).
Nebraska	NEB. REV. STAT. §§ 44-8301 to 44-8316 (2008).		
Nevada			NEV. REV. STAT. §§ 695H.010 to 695H.180 (2005); NEV. ADMIN. CODE §§ 695H.010 to 695H.120 (2005/2006).
New Hampshire	N.H. REV. STAT. ANN. §§ 415-I:1 to 415-I:17 (2009).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York			GEN. COUNSEL OP. 6-9-2009 (2009).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3961.01 to 3961.09 (2007) (portions of model).		
Oklahoma	OKLA. STAT. tit. 36, § 1219.4 (2001/2012); OKLA. ADMIN. CODE §§ 365:10-23-1 to 365:10-23-4 (2006).		

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon	OR. REV. STAT. §§ 742.420 to 742.440 (2008/2018); OR. ADMIN. R. 836-200-0200 to 836-200-025 (2008/2012).		NOTICE 5-1-2008 (2008).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-74-1 to 27-74-718 (2010).		
South Carolina			S.C. CODE ANN. §§ 37-17-10 to 37-17-120 (2007).
South Dakota			S.D. CODIFIED LAWS §§ 58-17E-1 to 58-17E-47 (2006).
Tennessee			TENN. CODE. ANN. §§ 47-18-2701 to 47-18-2704 (2001); §§ 56-57-101 to 56-57-106 (2001/2005).
Texas	TEX. INS. CODE ANN. §§ 562.001 to 562.303 (2009/2013) (portions of model); §§ 7001.001 to 7001.009 (2009/2013).		28 TEX. ADMIN. CODE §§ 24.1 to 24.4 (2010).
Utah			UTAH CODE. ANN. §§ 31A-8a-101 to 31A-8a-210 (2005/2015).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE §§ 48.155.001 to 48.140 (2009) (portions of model).		WASH. ADMIN. CODE 284-155-005 to 284-155-030 (2009).

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE R. §§ 33-15E-1 to 33-15E-17 (2008/2009).		W. VA. CODE R. §§ 114-83-1 to 114-83-7 (2008/2009).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2006

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT (#98)

1. Description of the project, issues addressed, etc.

This model law was drafted to address an issue of increasing concern to state departments of insurance – the rising number of consumer complaints about discount medical cards. This new model establishes a comprehensive regulatory scheme to enable regulators to track these entities and ensure that these entities are legitimate and not fraudulent; sets out uniform disclosure requirements to ensure that consumers know what they are buying; sets out uniform marketing and advertising requirements to ensure that these cards are not being marketed to consumers in a fraudulent or misleading way; and includes strict provider contracting requirements to ensure network adequacy and the actual existence of network providers to provide the promised discounts to consumers.

2. Name of group responsible for draft the model:

Health Discount Plan Working Group of the Health Insurance and Managed Care (B) Committee and the Health Insurance and Managed Care (B) Committee

States Participating:

Florida, Chair	Montana
Alaska	Nebraska
Arkansas	Nevada
Colorado	Oklahoma
District of Columbia	Ohio
Illinois	Oregon
Indiana	South Dakota
Kansas	Utah
Maryland	Vermont
Minnesota	Wisconsin

3. Project authorized by what charge and date first given to the group:

The following charge given in 2005:

Review issues surrounding health discount plans and draft a model law or regulation, as appropriate. Report by Winter 2005 Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the Working Group. Numerous interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), CIGNA, WellPoint, Pacificare, Aetna, the Consumer Health Alliance (CHA), the National Association of Health Underwriters (NAHU), the National Association of Dental Plans (NADP); the Pharmaceutical Care Management Association (PCMA); prescription drug manufacturer representatives, such as the Pharmaceutical Research and Manufacturers of America (PhRMA), Caremark and Merck; consumer representatives, such as the American Diabetes Association and Families USA; and other interested parties, such as the Council for Affordable Health Insurance (CAHI) and the National Association of Insurance and Financial Advisors (NAIFA).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There have been nine drafts of the proposed new model. Each draft was circulated for comment to interested parties prior to discussion at NAIC quarterly meetings and during Working Group telephone conference calls. In addition, all drafts of the proposed model were posted on the NAIC web site. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the Working Group.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

There were several significant issues that arose during the drafting of this model. The first issue considered the model's scope – whether licensed health carriers and their affiliates would be subject to the requirements of this model and, if so, which of the requirements. Over the course of several meetings and several telephone conference calls and after considerable discussion, the Working Group decided that licensed health carriers that would be considered a discount medical plan organization (DMPO), as that term is defined in the model, would only be required to comply with specific provisions in the model that related to marketing requirements, refund requirements, form filing requirements and advertising and disclosure requirements. The Working Group decided that because health carriers are already subject to the jurisdiction of the insurance commissioner, they would not be required to obtain a license or comply with other provisions of the new model, such as the examination and investigation requirements, bonding requirements and optional solvency requirements, that they are already subject to as licensed health carriers. With respect to their affiliates, the Working Group decided that these entities would be subject to all of the requirements in the model. The Working Group members were concerned that, if not regulated in this manner, affiliates could be established and used as a vehicle to circumvent the model's provisions and, as such, become a potential source of fraudulent activity.

The next significant issue concerned whether the model would include a comprehensive licensing scheme or a streamlined registration scheme. Those arguing for a comprehensive licensing scheme stated that the provisions requiring background checks and fingerprinting helped to ferret out fraudulent operators because it requires any individual involved in the DMPO's operations to be identified and to submit to a background check and fingerprinting. As such, an individual involved in operating a DMPO that violated the law previously would be flagged even if the DMPO is operating under a different name. Those supporting a streamlined registration scheme stated that this regulatory scheme was more appropriate for non-risk-bearing entities, like DMPOs. They also argued that most states that have recently enacted legislation regulating DMPOs have chosen a streamlined registration scheme that did not include background checks and fingerprinting. After extensive discussion of this issue, the Working Group decided to retain the licensing scheme with its background check and fingerprinting requirements. Some working group members were concerned that deleting these requirements altogether was not appropriate for a model law. A NAIC model law should include the strongest possible protections for consumers. As a compromise, the Working Group agreed to include some options with respect to the fingerprinting and background checks. States can decide whether to include these requirements based on their staffing and financial resources.

Another issue the working group debated concerned whether the new model should impose minimum capital requirements on DMPOs. Those arguing in favor of imposing such requirements asserted that requiring DMPOs to have a minimum net worth reinforces the legitimacy of the entity. Those arguing against including such a requirement stated that it was inappropriate for a non-risk-bearing entity. As a compromise, the Working Group decided to make the minimum net worth requirement optional. The working group also added a bonding requirement to ensure that if there was a problem with a DMPO that there would be some resources that could be used for the benefit of discount medical plan members.

Another issue debated extensively throughout the drafting process concerned "bundling". As part of their marketing and sale strategy, some DMPOs bundle (combine) the discount product with non-discount products. This combined product is sold to the consumer as package. Some working group members were concerned that this practice had the potential to confuse consumers as to the actual cost of what they were buying. To address this problem and after extensive debate, the Working Group decided to retain a provision in the model that requires DMPOs to disclose the cost of the discount product to the consumer when the discount product is sold with any other product. Also, after extensive debate, the Working Group decided to add a provision to the new model to address the situation when a licensed health carrier is a DMPO and is selling an insured product with a discount product. If the discount product is incidental to the insured product, then the health carrier is not required to disclose the cost of the discount product. In addition, the health carrier also would not be subject to the model's refund requirements. However, if the discount product is more than incidental, then the health carrier must disclose the cost of the discount product to the consumer just as other DMPOs that are not licensed health carriers are required to do and is also subject to the refund requirements.

Another issue that arose during the drafting process concerned whether to include discount prescription drug plan organizations within the scope of the model and, if so, what would be the appropriate scheme for regulating them. While acknowledging that discount prescription drug plan organizations have not been the subject of as many complaints as DMPOs, some Working Group members expressed a desire to include these entities within the scope of the model in order to be able to track and identify them in the event there was a problem. After extensive discussion, the Working Group decided to include discount prescription drug plan programs within the scope of the model as an optional section. In addition, the Working Group decided to require these entities to be subject to a similar regulatory scheme as licensed health carriers that

are DMPOs. They are not required to obtain a license but must designate a compliance officer for ensuring the entity's compliance with law and provide that name to the insurance commissioner.

After the Working Group adopted the proposed model in May 2006, there was additional discussion at the Health Insurance and Managed Care (B) Committee level at the 2006 NAIC Summer National Meeting. The Committee postponed voting on the model to provide an opportunity for interested parties to submit a final round of comments to the Committee outlining their concerns and to present proposals to address those concerns. Based on the comments, the Committee held a conference call in August 2006 to consider revisions to the proposed model as presented by the Working Group. The Committee adopted revisions to the model that include giving states the option of choosing whether to require a DMPO to obtain a license or certificate of registration. The Committee also revised the bundling provision to include an option for states to choose from with respect to requirements for marketers and DMPOs to disclose the fees for each discount medical plan whenever a discount medical plan is sold together with any other product.

7. Any other important information (e.g., amending an accreditation standard).

None.

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Group Health Insurance Standards Act.

Section 2. Purpose

This Act lists the permissible groups that may be issued a policy of group health insurance coverage in this state. This Act lists the circumstances under which a group health insurance policy that is issued in another state may be offered to residents of this state. This Act describes the circumstances under which dependent coverage is permitted or required to be included in a group health insurance policy. This Act also lists the standard provisions that must be included in a policy of group health insurance.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. "Evidence of individual insurability" means medical information, or other information that indicates health status, used to determine whether coverage of an individual within the group is to be limited or excluded.

Section 4. Permitted Groups

Except as provided in Section 5, an insurer shall not deliver a group health insurance policy in this state unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer and maintained, directly or indirectly, by the participating employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) (a) The employees eligible for coverage under the policy shall be all of the employees of the employer, or all of any class or classes thereof.

(b) The policy may define "employees" to include:

(i) The employees of one or more subsidiary corporations;

(ii) The employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(iii) The retired employees, former employees and directors of a corporate employer; and

(iv) For a policy issued to insure the employees of a public body, elected or appointed officials.

(2) The premium for the policy shall be paid either from the employer's fund or from funds contributed by the insured employees, or from both.

(3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject coverage in writing.

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

B. A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

(1) The debtors eligible for coverage under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof.

(2) The policy may define "debtors" to include:

(a) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(b) The debtors of one or more subsidiary corporations; and

(c) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

(3) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both.

(4) Except as provided in Paragraph (5), a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(5) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(7) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

(8) Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members or employees of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(1) The members or employees eligible for coverage under the policy shall be all of the members or employees of the union or organization, or all of any class or classes thereof.

(2) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members or employees specifically for their insurance, or from both.

(3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured members or employees specifically for their insurance must insure all eligible members or employees, except those who reject coverage in writing.

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

D. A policy issued to a trust, or to the trustees of a fund, established by two (2) or more employers and maintained, directly or indirectly, by those participating employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) (a) The persons eligible for coverage shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof.

(b) The policy may define "employee" to include:

(i) The employees of one or more subsidiary corporations;

(ii) The employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(iii) Retired employees, former employees and directors of a corporate employer; and

(iv) The trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations.

(3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.

(4) An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

E. (1) A policy issued to an association or to a trust or to the trustees of a fund established by an association or associations otherwise eligible for issuance of a policy under this subsection and maintained, directly or indirectly, by the association or associations for the benefit of members of one or more associations.

(2) (a) An association shall not be controlled by an insurer as evidenced by the operation of the association.

(b) The following factors may be used as evidence to determine whether an association is an insurer-operated association; however, the presence of these factors shall not serve to limit or be dispositive of such a determination:

(i) Common board members, officers, executives or employees;

(ii) Common ownership of the insurer and the association or other eligible group; or

(iii) Common use of the same office space or equipment utilized by the insurer to transact insurance.

(3) An association may use the solicitation of insurance as one of its methods to obtain new members.

(4) The association or associations shall:

(a) Have at the outset a minimum of 100 persons;

(b) Have a shared or common purpose that is not primarily a business or customer relationship;

(c) Have been organized and maintained in good faith primarily for purposes other than that of obtaining insurance;

(d) Have been in active existence for at least one year; and

(e) Have a constitution and by-laws that provide that:

(i) The association or associations hold regular meetings not less than annually to further the purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) Association members have voting privileges and representation on the governing board and committees.

(5) The policy shall be subject to the following requirements:

(a) The policy may insure members of the association or associations, employees of the association or associations or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

(b) The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

(c) Except as provided in Subparagraph (d) of this paragraph, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.

(d) An insurer may exclude or limit the coverage on any individual as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under HIPAA, insurers that issue or offer to issue a health benefit plan through a bona fide association may not exclude or limit coverage to an individual or a dependent based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

(6) (a) In determining whether an association meets the standards set forth in this subsection, the commissioner shall consider whether the association's primary method of obtaining new members is not through, or in conjunction with, the solicitation of insurance.

(b) If the commissioner determines that an association uses the solicitation of insurance as its primary method of obtaining new members, the commissioner shall not use this determination as the sole criterion for the disapproval of a group under this subsection.

(7) The provisions of Paragraphs (4)(b) and (c) and (6)(a) shall not apply to any association that made available group health insurance to any of its members prior to [insert effective date for the revisions to Paragraphs (4)(b) and (c) and (6)(a)]. However, for any such association policy that would not otherwise be eligible for issuance under this subsection, the insurer shall disclose its compensation, as required by Section 6 of this Act and shall disclose the following:

(a) All costs related to joining and maintaining membership in the association, such as the membership processing fees, the initial association membership fee and the amount of the annual association dues;

(b) That membership fees or dues are in addition to the policy premium;

(c) That the association holds the master contract;

(d) That the premium charged and the terms and conditions of coverage are determined between the association and the insurer; and

(e) That the premium and the terms and conditions of coverage may be changed by agreement of the association group policyholder and the insurer, without the consent of the individual certificate holder.

(8) If an insurer collects membership fees or dues on behalf of an association, the insurer shall disclose to the members of the association that the insurer is billing and collecting membership fees and dues on behalf of the association.

Drafting Note: Any state adopting this Act that has relaxed rate or form requirements for association group policies and such policies have been or are expected to be a significant portion of the state's health insurance market may wish to consider evening the playing field for insurers writing in the individual market by, for example, similarly relaxing the requirements for individual policies.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two (2) or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(1) The members eligible for coverage shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in Paragraph (3), must insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to cover persons in a group where that group is specifically described by a law of this state as a group that may be covered for group life insurance. The provisions of the law relating to eligibility and evidence of individual insurability shall apply.

Section 5. Policies Issued Out of State or to Groups Not Meeting the Requirements of Section 4

Group health insurance coverage offered to a resident of this state or in connection with employment within this state under a group health insurance policy issued to a group other than a group described in Section 4 shall be subject to the following requirements:

A. For any such coverage to be delivered in this state the commissioner must find that:

(1) The issuance of the policy is not contrary to the best interest of the public;

(2) The issuance of the policy would result in economies of acquisition or administration; and

(3) The benefits are reasonable in relation to the premiums charged.

B. For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner in this state or the state in which the policy is issued, having requirements substantially similar to those contained in Subsection A, must make a determination that the requirements of Subsection A have been met.

Drafting Note: Alternative language to Subsection B:

Alternative 1. This alternative consists of Subsection B above and Subsection C below.

B. (1) The insurer shall file with the commissioner for information purposes:

(a) A copy of the group master contract;

(b) A copy of the statute of the state where the policy is issued, authorizing the issuance of the policy under the same or similar statute;

(c) Evidence of approval in the state where the policy is issued; and

(d) Copies of all supportive material used by the insurer to secure approval of the policy in that state including the documentation in Subsection A.

(2) The commissioner, at any time subsequent to receipt of the information required under Paragraph (1), after finding that the requirements of Subsection A have not been met, may order the insurer to stop marketing the coverage in this state.

Alternative 2. Under this alternative the language in this Subsection B below may be used as a substitute for the language in Subsection B above.

B. (1) For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner must make a determination that the requirements of Subsection A have been met.

(2) The insurer shall file with the commissioner:

(a) A copy of the group master contract;

(b) A copy of the statute of the state where the policy is issued, authorizing the issuance of the group policy under the same or similar statute;

(c) Evidence of approval in the state where the policy is issued; and

(d) Copies of all supportive material used by the insurer to secure approval of the policy in that state including the documentation required in Subsection A.

(3) If the commissioner has not made a determination within thirty (30) days of filing by the insurer, the requirements shall be deemed to have been met.

(4) The commissioner, at any time subsequent to receipt of the information required under Paragraph (2), after finding that the requirements of Subsection A have not been met, may order the insurer to stop marketing the coverage in this state.

Drafting Note: States should adopt Subsections C and D below regardless of which alternative a state chooses to adopt for Subsection B above.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

Section 6. Notice of Compensation

A. (1) With respect to an individual, blanket or franchise policy which, if issued through or in conjunction with a sponsoring or endorsing entity, would not qualify under Section 4A, B, C, D, E or F of this Act, the insurer shall distribute a written notice of compensation to prospective insureds if the insurer will or may pay compensation to a sponsoring or endorsing entity.

(2) (a) With respect to a policy issued on a group basis to a group in compliance with Section 4E of this Act, the insurer shall distribute a written notice of compensation to prospective insureds if the insurer will or may pay compensation to a policyholder or sponsoring or endorsing entity in the case of a group policy.

(b) If the compensation is solely for services performed and is not directly or indirectly for sponsoring or endorsing the insurer or any of the insurer's products, written notice of compensation is not required for:

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(i) Any compensation to the insurer for services provided to the policyholder or the sponsoring or endorsing entity; or

(ii) Any compensation to the policyholder or sponsoring or endorsing entity.

B. The notice required under Subsection A shall be placed on or accompany any application or enrollment form provided to prospective insureds.

C. The notice shall be provided, whether:

(1) The compensation is direct or indirect; or

(2) The compensation is paid to or retained by:

(a) The policyholder or sponsoring or endorsing entity; or

(b) A third party at the direction of the policyholder or sponsoring or endorsing entity, or an entity affiliated by way of ownership, contract or employment.

D. For purposes of this section, "sponsoring or endorsing entity" means an organization that has arranged for the offering of a plan of insurance in a manner that communicates that eligibility for participation in the plan is dependent upon affiliation with the organization or that it encourages participation in the plan.

Section 7. Dependent Group Health Insurance

A. Except for a policy issued under Section 4B of this Act, a group health insurance policy may be extended to insure the family members and dependents of the employees or members , or any class or classes thereof, if:

(1) The premium for the insurance is paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both.

(2) Except as provided in Subsection B, a policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons shall insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

B. An insurer may exclude or limit the coverage under the policy on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Note: Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

Section 8. Group Health Insurance Standard Provisions

A. A group health insurance policy shall not be delivered in this state unless it contains in substance the provisions of this section, or provisions that, in the opinion of the commissioner, are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder, provided that:

(1) Subsections F and H shall not apply to policies insuring debtors;

(2) The standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and

(3) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

B. A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first. During the grace period the policy shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

C. A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. Absent a showing of intentional fraud, no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement. However, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

D. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

E. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

F. (1) Except as provided in Paragraph (2), a provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, that existed prior to the effective date of the person's coverage under the policy. Except for disability income policies, any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve (12) months prior to the effective date of the person's coverage. In no event shall the exclusion or limitation apply to loss incurred commencing after the earlier of (a) the end of a continuous period of twelve (12) months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and (b) the end of the two-year period commencing on the effective date of the person's coverage. For disability income policies, any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twenty-four (24) months prior to the effective date of the person's coverage. In no event shall the exclusion or limitation apply to a disability commencing after the end of the two-year period starting on the effective date of the person's coverage.

(2) A policy that is subject to the preexisting condition exclusion requirements in Section 2701 of the Public Health Service Act, as added by Pub. L. No. 104-191, shall have a provision specifying any preexisting condition exclusions or limitations consistent with those requirements except as otherwise provided by state law.

Drafting Note: HIPAA imposes limitations on the ability of insurers offering coverage in the group market to impose preexisting condition exclusions on plan participants and beneficiaries. Language has been added to Subsection F to carve out those group policies that are subject to those restrictions under HIPAA and any provisions of state law that may be more stringent than HIPAA with respect to preexisting condition exclusion and limitation requirements.

G. If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

H. A provision that the insurer will issue to the master policyholder in electronic or paper form in accordance with any communications preferences of the master policyholder for delivery to each person insured in the group an individual certificate setting forth a statement as to the insurance coverage to which that person is entitled, to whom the insurance benefits are payable, and a statement as to a family member's or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

I. If the insurer requires prior notice of a claim, a provision that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within that time shall not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give notice and that notice was given as soon as was reasonably possible. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form in accordance with any communications preferences of the person making the claim. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.

J. If the insurer requires prior notice of a claim, a provision that the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person, such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of fifteen (15) days after the insurer received notice of a claim under the policy, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. Any forms that may be required to be furnished under this subsection may be in electronic or paper form in accordance with any communications preferences of the person making the claim or the policyholder. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.

K. A provision that, in the case of a claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that, in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety (90) days after the date of loss. Failure to furnish proof within that time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be furnished under this subsection may be in electronic or paper form in accordance with any communications preferences of the person making the claim. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.

L. A provision that all benefits payable under the policy, other than benefits for loss of time, will be payable not more than sixty (60) days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of the period will be paid as soon as possible after receipt of proof.

M. A provision that the insurer at its own expense shall have the right and opportunity to:

(1) Examine the person of the individual for whom claim is made when and as often as it may reasonably require during the pendency of claim under the policy; and

(2) Make an autopsy in case of death where it is not prohibited by law.

N. A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirement of the policy and that no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the policy.

O. In the case of a policy insuring debtors, a provision that the insurer will furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

Section 9. Regulations

The commissioner may adopt regulations related to enrollment or eligibility for coverage under a group policy to be issued under Section 4A, C, D or E of this Act, Section 5 of this Act or Section 7 this Act with respect to an individual or dependent of an individual based on the individual's or dependent's evidence of individual insurability. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers that issue or offer to issue certain policies of health insurance coverage in the group market, including bona fide associations, may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. This section provides authority for the commissioner to adopt regulations consistent with HIPAA. The commissioner may adopt the provisions of the NAIC Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 35, 447, 667, 670-676 (adopted).
1984 Proc. I 6, 32, 528, 529 (amended).
1985 Proc. I 19, 38, 571, 599-604 (amended and reprinted).
1989 Proc. I 9, 24-25, 704, 839, 842-843 (amended).
2007 Proc. 1st Quarter 72-87 (amended and reprinted).

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-20-1 to 27-20-7 (1971).
Alaska			ALASKA STAT. §§ 21.54.010 to 21.54.070 (1966/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1401 to 20-1412 (1954/2014).
Arkansas			ARK. CODE ANN. §§ 23-86-101 to 23-86-123 (1959/2011).
California			CAL. INS. CODE §§ 10270 to 10277 (1939/2013).
Colorado			COLO. REV. STAT. § 10-16-214 (1992/2013).
Connecticut			CONN. GEN. STAT. §§ 38a-512 to 38a-546 (1973/2015).
Delaware		DEL. CODE ANN. tit. 18, §§ 3501 to 3529 (1987/2013).	
District of Columbia	NO CURRENT ACTIVITY		

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 627.651 to 627.6675 (1970/2014).
Georgia			GA. CODE ANN. §§ 33-30-1 to 33-30-11 (1960/2011).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431:10A-201 to 431:10A-212 (1988).
Idaho			IDAHO CODE ANN. §§ 41-2201 to 41-2223 (1961).
Illinois			215 ILL. COMP. STAT. 5/367 to 5/367b (1953/1989).
Indiana		IND. CODE §§ 27-8-5-16 to 27-8-5-19.2 (1985/2011).	
Iowa		IOWA CODE §§ 509.1 to 509.7 (1947/2018).	
Kansas		KAN. STAT. ANN. § 40-2209 (1981/2004).	
Kentucky			KY. REV. STAT. ANN. §§ 304.18-010 to 304.18-030 (1970).
Louisiana			LA. REV. STAT. ANN. §§ 22:1024 to 22:1025 (1958/2003).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 2801 to 2847 (1981/2003).
Maryland			MD. CODE ANN., INS. §§ 15-301 to 15-310 (1963/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 110 (1910/1982).
Michigan	NO CURRENT ACTIVTY		

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. §§ 62A.10 to 62A.11 (1967/1986).
Mississippi	NO CURRENT ACTIVITY		
Missouri		MO. REV. STAT. §§ 376.421 to 376.426 (1985/2013).	
Montana			MONT. CODE ANN. §§ 33-22-501 to 33-22-530 (1959/2009).
Nebraska			NEB. REV. STAT. §§ 44-760 to 44-764 (1947/2009).
Nevada			NEV. REV. STAT. §§ 689B.010 to 689B.069 (1971/2009).
New Hampshire			N.H. REV. STAT. ANN. § 415:18; § 415:18b (1941/2014).
New Jersey			N.J. STAT. ANN. §§ 17B:27-26 to 17B:27-51.14 (1971).
New Mexico			N.M. STAT. ANN. §§ 59A-23-1 to 59A-23-5 (1985/1993).
New York			N.Y. INS. LAW § 3221 (2013); § 4235 (1984/2013); §§ 4304 to 4305 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-51-80 to 58-51-85 (1945/1993).	N.C. GEN. STAT. § 58-58-135 (1943/2011).
North Dakota		N.D. CENT. CODE § 26.1-36-05 (1985).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3923.12 (1947/1965).
Oklahoma			OKLA. STAT. tit. 36, §§ 4501 to 4507 (1957/2008).
Oregon			OR. REV. STAT. §§ 743.522 to 743.546 (1967/2013).

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			40 PA. STAT. ANN. § 756.2 (2010).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1701 to 1708 (1975/1977).
Rhode Island			230 R.I. CODE R. 20-30-1.8 to 20-30-1.10 (2001).
South Carolina			S.C. CODE ANN. §§ 38-71-710 to 38-71-810 (1988).
South Dakota			S.D. CODIFIED LAWS §§ 58-18-1 to 58-18-11.1; §§ 58-18-21 to 58-18-30 (1966).
Tennessee			TENN. CODE ANN. §§ 56-26-201 to 56-26-203 (1976/1981).
Texas			TEX. INS. CODE ANN. §§ 1251.001 to 1251.310 (2005/2009).
Utah			UTAH CODE ANN. § 31A-22-701; (1986/2001); UTAH ADMIN. CODE r. 590-126-1 to 590-126-11 (2005/2011).
Vermont			VT. STAT. ANN. tit. 8, §§ 4079 to 4082 (1953/2013).
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 901 to 913 (1968).
Virginia		VA. CODE ANN. §§ 38.2-3521 to 38.2-3543.2 (1986/2013).	
Washington			WASH. REV. CODE ANN. §§ 48.21.010 to 48.21.900 (1947).

GROUP HEALTH INSURANCE STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia			W. VA. CODE §§ 33-16-1 to 33-16-3 (1957/2006); §§ 33-16F-1 to 33-16F-10 (2006).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. STAT. ANN. §§ 26-19-101 to 26-19-115 (1967/1990/2003).

PROJECT HISTORY - 2007

GROUP HEALTH INSURANCE STANDARDS MODEL ACT (#100)

1. Description of the project, issues addressed, etc.

This model was identified in 2004 as in need of revision as part of the NAIC model law review initiative. The revisions make the model consistent with NAIC model law drafting requirements and make other changes necessary to update the model since it was last amended in 1988 to reflect HIPAA's group nondiscrimination and preexisting condition requirements. The revised model also includes new provisions related to true group associations. These revisions tightened up the requirements to help ensure that these associations are legitimate entities.

2. Name of group responsible for draft the model and states participating:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair	Montana
Arkansas	Nebraska
California	Nevada
Colorado	New Hampshire
Delaware	Ohio
Florida	Oregon
Idaho	Rhode Island
Kansas	South Dakota
Kentucky	Utah
Maine	Vermont
Missouri	Virginia

3. Project authorized by what charge and date first given to the group:

The following charge was first given in January 2004:

Review and revise, as necessary, NAIC model laws and regulations identified as in need of review and revision as a result of the NAIC model law review initiative. Report annually.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the Task Force.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of the proposed revisions to the model was circulated to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments. The Task Force reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

There was one item of controversy. It concerned whether additional requirements should be added to the model with respect to permitted association groups. After considerable discussion, the Task Force agreed on a compromise. The Task Force agreed to add the additional requirements but allow a period of time for those associations that do not meet the new requirements to come into compliance. In addition, there was considerable debate about what those additional requirements should be for associations to be considered "true" groups. After several meetings, a compromise was reached.

7. Any other important information (e.g., amending an accreditation standard).

None.

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Group Health Insurance Mandatory Conversion Privilege Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

C. "Dependent" shall be defined in the same manner as in [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the employee.

"Dependent" means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the employee or member, and an unmarried child of any age who is medically certified as disabled and dependent upon the employee or member.

D. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

E. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

F. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

G. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

H. "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

Section 3. Applicability and Scope

A. Except as provided in Subsection B, this Act shall apply to any group health benefit plan delivered or issued for delivery in this state.

B. The provisions of this Act shall not apply to a health benefit plan that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity or other fixed indemnity coverage, long-term care insurance, as defined by [insert reference in state law that defines long-term care insurance], vision care or any other supplemental benefit or to a Medicare supplement policy, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 4. Conversion Privilege

A. Any health carrier providing coverage under a group health benefit plan shall provide that an employee or member whose coverage under the plan has been terminated for any reason, including discontinuance of the group health benefit plan in its entirety or with respect to an insured class, and who has been continuously covered under the group health benefit plan and under any group health benefit plan providing similar benefits which it replaces for at least three (3) months immediately prior to termination is entitled to have issued to him or her a converted policy, without evidence of insurability, subject to the provisions of this Act.

B. A health carrier shall include a notice of the right of conversion in each certificate of coverage.

C. An employee or member or a dependent of an employee or member shall not be entitled to a converted policy if termination under the group health benefit plan occurred because:

(1) The employee or member failed to pay any required premium or contribution;

(2) The employee or member or dependent performed an act or practice that constitutes fraud in connection with the coverage;

(3) The employee or member or dependent made an intentional misrepresentation of a material fact under the terms of coverage; or

(4) The terminated coverage under the group health benefit plan was replaced by similar coverage within thirty-one (31) days after the date of termination.

D. Written application for the converted policy shall be made and the first premium paid to the health carrier no later than thirty-one (31) days after the date of termination of coverage under the group health benefit plan.

E. The effective date of the converted policy shall be the day following the date of termination of coverage under the group health benefit plan.

Section 5. Conversion Premium

A. Subject to Subsection B, the initial premium for the converted policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with the health carrier's premium rates applicable to individually underwritten standard risks, to the age and class of risk of each individual to be covered under the converted policy and to the type and amount of coverage provided. The experience under converted policies shall not be an acceptable basis for establishing rates for converted policies.

Alternate No. 1

B. If a health carrier experiences incurred losses, for a period of two (2) years, on conversion policies that have been in force for at least one year, which exceed earned premiums by more than twenty percent (20%), the health carrier may file with the commissioner amended renewal rates for the subsequent year, that will produce a loss ratio of not less than 120%.

Drafting Note: The above subsection should be inserted in states that have rate review authority.

Alternate No. 2

B. If a health carrier experiences incurred losses, for a period of two (2) years, on conversion policies that have been in force for at least one year, which exceed earned premiums by more than twenty percent (20%), the health carrier may amend renewal rates for the subsequent year, that will produce a loss ratio of not less than 120%.

Drafting Note: The above subsection should be inserted in states that do not have rate review authority.

C. Conditions pertaining to health status shall not be an acceptable basis for classification for the purposes of this section. The frequency of premium payment shall be the frequency customarily required by the health carrier for the policy form and plan selected, provided that the health carrier shall not require premium payments less frequently than quarterly.

Drafting Note: Because converted policies generally comprise a substandard class of risk, rates based on the experience of converted policies would reflect substandard morbidity. As a result, rates for policies that provide an acceptable level of benefits may very well require premiums that would be out of reach for the average converting person. In effect, such rates are based on the assumption that the converting person is a substandard risk. Such an assumption runs counter to the intent of this model law. It serves no purpose to require issue of a converted policy without evidence of insurability if the insurer is allowed to automatically assume the converting person is substandard and charge an accordingly high premium.

It is understood that premiums based on standard morbidity assumptions will generally be inadequate as is the case in life insurance conversions. It is also understood that the rate inadequacy may be handled in much the same manner as life insurance conversions by spreading the extra cost over the group business through conversion charges to the group or through an extra charge in the group premium.

Section 6. Scope of Coverage

The converted policy shall cover the employee or member and any dependents, who were covered under the group health benefit plan on the date of termination of coverage. At the option of the health carrier, a separate converted policy may be issued to cover any dependent.

Section 7. Exceptions to Guaranteed Coverage

A. A health carrier shall not be required to issue a converted policy covering an individual if the individual:

(1) Is or could be covered by Medicare;

(2) Is covered for similar benefits by another individual health benefit plan; or

(3) Is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis or similar benefits are provided or are available to the individual in accordance with any state or federal law and together with the converted policy's benefits would result in overinsurance according to the health carrier's standards for overinsurance.

B. The health carrier's standards for overinsurance, referenced under Subsection A(3), shall bear some reasonable relationship to actual health care service costs in the area in which the individual lives at the time of conversion and shall be filed with the commissioner prior to their use in denying coverage.

Section 8. Information Requested by Health Carrier

A converted policy may include a provision permitting the health carrier to request information in advance of any premium due date of the policy of any individual covered under the policy as to whether:

A. The individual is covered for similar benefits under another health benefit plan or any other plan or program;

B. The individual is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

C. Similar benefits are provided for or available to the individual in accordance with the requirements of any state or federal law.

Section 9. Exceptions to Guaranteed Renewal

A. A converted policy may permit the health carrier to refuse to renew the policy or the coverage of any individual covered under the policy for any of the following reasons only:

(1) The individual failed to pay premiums or contributions in accordance with the terms of the converted policy, including timeliness requirements;

(2) The individual performed an act or practice that constitutes fraud in connection with coverage;

(3) The individual made an intentional misrepresentation of a material fact under the terms of coverage;

(4) For a network plan, the individual no longer lives, resides or works in the health carrier's service area or the area for which the health carrier is authorized to do business, provided coverage is terminated without regard to any health status-related factor relating to any covered individual; or

(5) Any other reason approved by the commissioner.

Drafting Note: As noted in the preamble to the interim final rules implementing the individual market provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), "a conversion policy is an individual policy, not a group policy, even though prior group coverage is a prerequisite to qualifying for the conversion policy." 62 Fed. Reg. 16987 (April 8, 1997). As such, with respect to Paragraph (5), states should be aware that Public Health Service Act (PHSA) Section 2742, as added by HIPAA, lists specific exceptions to guaranteed renewability in the individual market. States may want to review PHSA Section 2742 prior to adding other exceptions to guaranteed renewal. States also should be aware that PHSA Section 2742 does not contain an exception to guaranteed renewability in the case of an individual attaining eligibility for Medicare. However, also as noted in the preamble to the interim final rules, if permitted by state law, policies that are sold to individuals before they obtain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays. 62 Fed. Reg. at 16989 (April 8, 1997).

B. For purposes of this section:

(1) "Health status-related factor" means any of the following factors:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(h) Disability.

Drafting Note: This definition tracks language contained in PHSA Section 2702(a), as amended by HIPAA.

(2) "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as health care services, are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Section 10. Level of Benefits to be Offered

A health carrier shall issue a converted policy that conforms to the requirements as prescribed by the commissioner.

Section 11. Excess Benefits

A health carrier shall not be required to issue a converted policy that provides benefits in excess of those provided under the group health benefit plan from which conversion is made.

Section 12. Preexisting Condition Provision

The converted policy shall not exclude a preexisting condition not excluded by the group health benefit plan. However, the converted policy may provide that any hospital, surgical or medical benefits payable under the policy may be reduced by the amount of any such benefits payable under the group health benefit plan after the termination of the individual's group coverage. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group health benefit plan, shall not exceed the benefits that would have been payable had the individual's coverage under the group health benefit plan remained in force and effect.

Section 13. Alternative Plans

A health carrier may offer alternative plans for group health benefit plan conversion in addition to those required by this Act.

Section 14. Other Conversion Privileges

A. If coverage would have been continued for an employee under the group health benefit plan following the employee's retirement prior to the time the employee is or could be covered by Medicare and provided that the employee would have been eligible for continuation of coverage under the group health benefit plan, the employee may elect, instead of continuing coverage under the group health benefit plan, to have the same conversion rights as would apply had the employee's coverage under the group health benefit plan terminated at retirement by reason of termination of employment or membership.

B. The conversion privilege provided in this Act shall be available to:

(1) The surviving spouse at the death of an employee or member, with respect to the spouse and any dependent children whose coverage under the group health benefit plan terminates by reason of that death or, if the group health benefit plan provides for continuation of dependent coverage following the employee's or member's death, at the end of the continuation coverage;

(2) Each surviving dependent child at the death of an employee or member whose coverage under the group health benefit plan terminates by reason of that death or, if the group health benefit plan provides for continuation of dependent coverage following the employee's death, at the end of the continuation coverage;

(3) The spouse of an employee or member upon the termination of coverage of the spouse under the group health benefit plan because the spouse becomes ineligible for coverage under that plan because of divorce, separation or otherwise, while the employee or member remains covered under the group health benefit plan, with respect to the spouse and any dependent child whose coverage under the group health benefit plan terminates at the same time; or

(4) A dependent child solely with respect to the dependent child only upon termination of the dependent child's coverage under the group health benefit plan by reason of ceasing to be eligible for coverage under the group health benefit plan, if a conversion privilege is not otherwise provided under the provisions of this Act with respect to the termination.

Section 15. Reduction of Coverage Due to Medicare

A converted policy may provide for reduction of coverage on any individual upon the individual's eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

Section 16. Group Coverage Instead of Individual Coverage

A health carrier may elect to provide coverage under a group health benefit plan instead of issuing a converted policy.

Section 17. Out-of-State Conversions

A converted policy that is delivered outside this state shall be on a form which could be delivered in any other jurisdiction as a converted policy had the group health benefit plan been issued in that jurisdiction.

Section 18. Effective Date

The provisions of this Act shall take effect [insert a date not less than twelve (12) months after the date of enactment] and shall apply to group health benefit plans delivered, issued for delivery or amended on or after this date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1976 Proc. I 7, 10-11, 381, 386-387, 493, 494-499 (adopted).
2005 Proc. 1st Quarter 217, 262 (amended adopted by parent committee).
2005 Proc. 2nd Quarter 49, 58-67 (reprinted and adopted by Plenary).

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1408 (1985).
Arkansas			ARK. CODE ANN. § 23-86-115 (1985/2001); BULLETIN 18A-2013 (2013).
California			CAL. INS. CODE §§ 12670 to 12692.5 (1981/2013).
Colorado		COLO. REV. STAT. § 10-16-108 (1992/2013).	
Connecticut			CONN. AGENCIES REGS. § 38a-546-5 (1985/1992).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida		FLA. STAT. § 627.6675 (1978/1985.	

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia		GA. COMP. R. & REGS. 120-2-10-.11 (1986/1990).	GA. CODE ANN. § 33-24-21 (1981/2009) (spousal conversion rights in group health policies).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. § 41-2210D (1996).
Illinois		215 ILL. COMP. STAT. 5/367e.1 (1979/2003).	
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. § 40-2209(D) (1981/1994) (portions of model).		
Kentucky			KY. REV. STAT. ANN. §§ 304.18-110 to 304.18-120 (1974/1986).
Louisiana			LA. REV. STAT. ANN. § 22:978; § 22:1000 (2019).
Maine		02-031 ME. CODE R. ch. 281, §§ 1 to 8 (1985).	ME. REV. STAT. ANN. tit. 24-A, § 2809-A (1981).
Maryland			MD. CODE ANN. INS. § 15-413 (1997); MD. CODE REGS. §§ 31.11.01.01 to 31.11.01.15 (1983/2015); BULLETIN 10-2008 (2008).
Massachusetts			940 MASS. CODE REGS. 9.06 (2020).
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. § 62A.21 (1981/2013); BULLETIN 2013-3 (2013).

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	NO CURRENT ACTIVITY		
Missouri		MO. REV. STAT. §§ 376.397 to 376.403 (1981/1983).	
Montana			MONT. CODE ANN. §§ 33-22-508 to 33-22-511 (1981/1991).
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. REV. STAT. ANN. § 415:18 VII to XI (1941/1990).
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. STAT. ANN. § 59A-18-16 (1985) (authority to promulgate rules).
New York			N.Y. INS. LAW § 3221(e) (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-53-45 to 58-53-115 (1981).	
North Dakota			N.D. CENT. CODE ANN. §§ 26.1-36-23 to 26.1-36-23.1 (1987/1999).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3923.122 (1975/1980) (suspended 1-1-2014 thru 1-1-2022 – see S.B. 9) (2013).
Oklahoma			OKLA. STAT. tit. 36, § 4502.1 (1981) (limited right).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania		40 PA. STAT. ANN. § 756.2 (1921/2010).	
Puerto Rico			P.R. LAWS ANN. tit. 26, § 1707 (1975/1977).

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island			230 R.I. CODE R. §§ 20-30-1.8 to 20-30-1.9 (2001).
South Carolina		S.C. CODE ANN. § 38-71-770 (1987/1990).	
South Dakota			S.D. CODIFIED LAWS §§ 58-18-7 to 58-18-7.15 (1984/1989).
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 1251.256 to 1251.260 (2005); 28 TEX. ADMIN. CODE §§ 21.5301 to 21.5322 (2014).
Utah			UTAH CODE ANN. §§ 31A-30-101 to 31A-30-117 (1986/2014).
Vermont	VT. STAT. ANN. tit. 8, §§ 4090d to 4090g (1984/1986) (portions of model).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-3541 (1986/1988).
Washington			WASH. REV. CODE §§ 48.21.260 to 48.21.270 (1984).
West Virginia	W. VA. CODE §§ 33-16A-1 to 33-16A-14 (1978/1990).		
Wisconsin			WIS. STAT. § 632.897 (1979/2013); WIS. ADMIN. CODE INS. §§ 3.41 to 3.45 (1981/1991).
Wyoming	WYO. STAT. ANN. §§ 26-22-201 to 26-22-202 (1981/1983).		

PROJECT HISTORY - 2005

GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT (#105)

1. Description of the project, issues addressed, etc.

This model was identified last year as in need of revision as part of the NAIC model law review initiative. The revisions make the model consistent with NAIC model law drafting requirements and make other changes necessary to update the model since its adoption in 1976.

2. Name of group responsible for drafting the model:

Regulatory Framework (B) Task Force

States Participating:	Wisconsin, Chair	Missouri
	Arkansas	Nebraska
	California	Nevada
	Colorado	New Hampshire
	Delaware	North Carolina
	Florida	Ohio
	Idaho	Rhode Island
	Iowa	South Dakota
	Kansas	Utah
	Kentucky	Vermont
	Maine	Virginia

3. Project authorized by what charge and date first given to the group:

The following charge given in January 2004:

Review and revise, as necessary, NAIC model laws and regulations identified as in need of review and revision as a result of the NAIC model law review initiative. Report annually.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the task force.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of the proposed revisions to the model was circulated to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments. The task force reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

There were no items of controversy.

7. Any other important information (e.g., amending an accreditation standard).

None.

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL ACT

Editor's Note: Provided for your convenience are references to the corresponding sections of the federal Public Health Service Act (PHSA). A key to the PHSA section titles appears at the end of the model. Any references to PHSA sections, including the key, are not intended to be adopted in legislation.

Section 1. Short Title

This Act shall be known and may be cited as the [Small Group Market Health Insurance Coverage Model Act].

Section 2. Purpose and Intent

The purpose and intent of this Act is to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the small group market and provide for the establishment of coverage and other benefit requirements in the small group market.

Drafting Note: The provisions of this Act are consistent with the provisions of the federal Patient Protection and Affordable Care Act (ACA) Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (and with Title XXVII of the federal Public Health Service Act as amended by those statutes) and, as applicable, the regulations issued related to provisions of the ACA. However, states should be aware that the federal preemption standards permit states to impose more stringent, consumer protection requirements.

Section 3. Definitions

For purposes of this Act:

A. "Bona fide association" means an association that meets all of the following criteria:

(1) Serves a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession;

(2) Has been actively in existence for five (5) years;

(3) Has a constitution and by-laws or other analogous governing documents;

(4) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(5) Is not owned or controlled by a carrier or affiliated with a carrier;

(6) Does not condition membership in the association on any health status-related factor;

(7) Has at least 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association;

(8) All members and dependents of members are eligible for coverage regardless of any health status-related factor;

(9) Does not make a health benefit plan offered through the association available other than in connection with a member of the association;

(10) Is governed by a board of directors and sponsors annual meetings of its members; and

(11) Producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the association.

Drafting Note: This definition of "bona fide association" is narrower than the definition of "bona fide association" contained in Section 2791(d)(3) of the PHSA because of the requirement of paragraph (1) above that the professional association serve a single profession. Specifically, Section 2791(d)(3) of the PHSA defines "bona fide association," as an association, which: (1) has been actively in existence for at least 5 years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); (4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); (5) does not make health insurance offered through the association available other than in connection with a member of the association; and (6) meets such additional requirements as may be imposed under state law. Because the definition of "bona fide association" contained in Section 2791(d)(3) explicitly permits the states to impose additional requirements, the narrower definition of "bona fide association" used in this Act does not conflict with or prevent the application of the federal law. Therefore, the states can elect to adopt either version of this definition.

Drafting Note: States should be aware that the term "bona fide association" is used in this Act in connection with providing an exception to the guaranteed renewability requirements in Section 7B(7) of this Act. Section 7B(7) of this Act only permits a health carrier to non-renew health coverage for an employer whose association membership ceases if the association is a "bona fide association" the employer's membership in the association was the basis on which the coverage is provided, and the coverage is terminated uniformly for all employers leaving the association without regard to any health status-related factor relating to any covered person. Associations that are not "bona fide associations" are not eligible for this exception. The definition of "bona fide association" does not impact how states have chosen to define "associations" for other purposes. Also, Section 7F of this Act provides, with respect to modification of coverage at renewal, different treatment related to coverage that is only offered through one or more "bona fide associations."

B. "Carrier" or "health carrier" means any entity licensed, or required to be licensed, by the Department of Insurance that offers health benefit plans covering eligible employees of one or more small employers pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

C. "COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986 (IRC), other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(2) Part 6 of subtitle B of title I of ERISA, other than Section 609 of such Act; or

(3) Title XXII of the Public Health Service Act (PHSA).

D. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "Commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

E. "Covered benefits" or "benefits" mean those health care services to which an individual is entitled under the terms of a health benefit plan.

F. "Covered person" means any individual eligible to receive covered benefits under the terms of the health benefit plan.

G. "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;

(2) A health benefit plan;

(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

(5) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or

(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

H. Except as otherwise may be defined for purposes of Section 8 of this Act, "dependent" shall be defined in the same manner as in [insert reference in state law defining dependent].

I. "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours under a *bona fide* employer-employee relationship which was not established for the purpose of obtaining small group market health insurance coverage. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees, as long as a standard of at least seventeen and one-half (17.5) hours per normal work week is applied uniformly among all of the employer's employees, and the eligibility criterion and the employees' work schedules are not established or adjusted by the employer because of any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Drafting Note: States should be aware that this definition of "eligible employee" should be used for purposes of determining eligibility to participate in the plan as determined by the small employer and should not be used for purposes of determining whether an employer is a small employer. As noted in Subsection KK(c) of this section, all employees, as the term "employee" is defined in Subsection K of this section, must be counted, including part-time employees and other employees who may not be eligible for coverage through the employer (as the employer has determined). States should also be aware that the federal rules for health insurance exchanges, as published in the *Federal Register* March 27, 2012, exclude, for purposes of participating in the Small Business Health Options Program (SHOP) Exchange, groups whose only covered employees are sole proprietors, partners or other working owners.

J. "Eligible small employer" means a small employer that either:

(1) Has its principal place of business in this state and seeks to purchase small group market health insurance coverage in this state that will be available to all of the employer's eligible employees; or

(2) Seeks to purchase small group market health insurance coverage in this state that is available to all the employer's eligible employees whose primary worksite is in this state.

K. "Employee" has the meaning given such term under Section 3(6) of ERISA.

L. (1) "Essential health benefits" has the meaning under Section 1302(b) of the Federal Act and applicable regulations.

(2) "Essential health benefits" include:

(a) Ambulatory patient services,

(b) Emergency services;

(c) Hospitalization;

(d) Laboratory services;

(e) Maternity and newborn care;

(f) Mental health and substance abuse disorder services, including behavioral health treatment;

(g) Pediatric services, including oral and vision care;

(h) Prescription drugs;

(i) Preventive and wellness services and chronic disease management; and

(j) Rehabilitative and habilitative services and devices.

M. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. "Family member" means with respect to an individual employee:

(1) A dependent of the employee; and

(2) Any other individual who is a first-degree, second-degree, third-degree or fourth-degree relative of the employee or an individual described in paragraph (1).

O. (1) "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (ACA), and any amendments thereto, or regulations or guidance issued under, those Acts.

(2) "Federal Act" includes Title XXVII of the PHSA, as amended by the ACA.

P. (1) "Genetic information" means, with respect to any individual, information about:

(a) The individual's genetic tests;

(b) The genetic tests of the individual's family members; and

(c) The manifestation of a disease or disorder in family members of the individual.

(2) "Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

(3) "Genetic information" does not include information about the sex or age of any individual.

Q. "Genetic services" means:

(1) A genetic test;

(2) Genetic counseling, including obtaining, interpreting or assessing genetic information; or

(3) Genetic education.

R. (1) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes.

(2) "Genetic test" does not mean:

(a) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; or

(b) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

S. "Geographic rating area" is an area established in accordance with Section 2701(a)(2) of the PHSA, or any federal regulation adopted thereunder, for purposes of adjusting the rates for a health benefit plan.

T. "Grandfathered health plan coverage" means coverage provided to a small employer by a health carrier on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

U. "Group health insurance plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to an employer or groups of employers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

V. "Group health plan" has the meaning given such term under Section 2791(a) of the PHSA.

W. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XXVII of the PHSA, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

X. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not "corporate persons."

Y. "Health care provider" or "provider" means a health care professional or facility.

Z. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.

AA. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

BB. "Health status-related factor" means any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care services;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities;

(8) Disability; or

(9) Any other health status-related factor determined appropriate by the Secretary.

CC. "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

DD. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

EE. "Plan sponsor" has the meaning given this term under Section 3(16)(B) of ERISA.

FF. (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition that exists prior to the enrollment date of the coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(2) Genetic information shall not be treated as a condition under paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

GG. "Premium" means all moneys paid by a small employer and its eligible employees as a condition of receiving small group market health insurance coverage from a health carrier, including any fees or other contributions associated with the health benefit plan.

HH. "Producer" means [incorporate reference to definition in state law for licensing producers].

Drafting Note: States that have not adopted the NAIC Producer Licensing Model should substitute the term "agent" or "broker" for the term "producer," as appropriate.

II. (1) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(2) "Rescission" does not include:

(a) A cancellation or discontinuance of coverage under a health benefit plan if:

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

(b) When the health benefit plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative record-keeping.

JJ. "Secretary" means the Secretary of the federal Department of Health and Human Services.

KK. (1) "Small employer" means an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Drafting Note: The Federal Act permits states to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under Subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in U.S. Department of Health and Human Services (HHS) Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act). States with different legal standards for counting employer size should review their definitions for consistency with federal law and substitute their existing definitions when appropriate.

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(e) Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

LL. "Small group market health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in the small group market in connection with such plan.

MM. "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

NN. "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the health benefit plan;

(2) The computation of premium or contribution amounts under the health benefit plan; and

(3) Other activities related to the creation, renewal or replacement of a contract of health insurance coverage.

OO. "Waiting period" means the period of time that must pass before coverage for a covered person who is otherwise eligible to enroll under the terms of the health benefit plan can become effective.

Section 4. Applicability and Scope

A. Subject to Subsection B, this Act shall apply to health carriers offering health benefit plans providing small group market health insurance coverage in this state.

B. Except for Sections 6, 7, 8, 9, 10, 11, 12, 17, 18 and 19 of this Act and to the extent provisions of other sections in this Act were in effect pursuant to Pub. L. No. 104-191 (HIPAA) and Pub. L. No. 110-233 (GINA) prior to the effective date of the Federal Act, this Act does not apply to any grandfathered health plan coverage.

Drafting Note: Generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA, if the coverage was in force on March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as "grandfathered health plan coverage." However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered plans, while other provisions apply only to grandfathered group health insurance plans. To the extent that provisions of the PHSA, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the interim final regulations on grandfathered plans (26 CFR 54.9815-1251T, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* June 17, 2010. In particular, HIPAA portability and nondiscrimination requirements and the Genetic Information Nondiscrimination Act of 2008 (GINA) requirements applicable prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. The following table lists the new health coverage reforms in part A of title XXVII of the PHSA, as amended by the ACA that apply to grandfathered health plan coverage:

List of New Health Coverage Reform ACA Provisions That Apply to Grandfathered Health Plan Coverage

PHSA Statutory Provisions	Application to Grandfathered Health Plan Coverage
§ 2704 of the PHSA—Prohibition of preexisting condition exclusion or other discrimination based on health status.	Applicable to grandfathered group health plans and group health insurance coverage. Not applicable to grandfathered individual health insurance coverage.
§ 2708 of the PHSA—Excessive waiting periods.	Applicable to grandfathered group health plan coverage.
§ 2711 of the PHSA—No lifetime or annual limits.	Lifetime limits applicable to grandfathered health plan coverage. Annual limits applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage.
§ 2712 of the PHSA—Prohibition on rescissions.	Applicable to grandfathered health plan coverage.

§ 2714 of the PHSA—Extension of dependent coverage until age 26.	Applicable to grandfathered health plan coverage. For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before Jan. 1, 2014, §2714 of the PHSA is applicable in the case of an adult child only if the adult child is not eligible for other employer-based health plan coverage.
§ 2715 of the PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions.	Applicable to grandfathered health plan coverage.
§ 2718 of the PHSA—Bringing down the cost of health care coverage (for insured coverage).	Applicable to insured grandfathered health plan coverage.

Drafting Note: As noted in the drafting note above, some requirements of the PHSA, ERISA and IRC that were applicable prior to the enactment of the ACA continue to apply to grandfathered health plan coverage. As such, HIPAA portability and nondiscrimination requirements applicable to the individual market and GINA requirements applicable to the individual market prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. States should be aware that this Act does not include many of these provisions, such as provisions related to crediting previous coverage for purposes of applying a preexisting condition exclusion period with respect to the small group market or provisions related to determining whether an individual can be treated as an "eligible individual" (or HIPAA-eligible) for purposes of qualifying for guaranteed issued coverage without the imposition of any preexisting condition exclusions with respect to the individual market. States will have to consider how they want to address this situation in retaining some provisions that continue to apply to grandfathered health plan coverage and enacting new provisions consistent with the requirements of the ACA that are applicable to health benefit plans beginning Jan. 1, 2014, in the individual and small group markets.

Section 5. Restrictions Relating to Premium Rates

A. (1) With respect to the premium rates charged by a health carrier offering a health benefit plan providing small group market health insurance coverage subject to this Act, the carrier shall develop its premium rates based on the following and vary the premium rates with respect to the particular plan or coverage only by:

(a) Whether the plan or coverage covers an individual or family;

(b) Geographic rating area, established in accordance with Section 2701(a)(2) of the PHSA;

(c) Age, except that the rate shall not vary by more than 3 to 1 for adults; and

(d) Tobacco use, except that the rate shall not vary by more than 1.5 to 1.

(2) A premium rate shall not vary with respect to any particular health benefit plan or small group market health insurance coverage by any other factor not described in paragraph (1).

(3) With respect to family coverage under a health benefit plan providing small group market health insurance coverage, the rating variations permitted under paragraph (1)(c) and (d) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

B. The premium charged with respect to any particular health benefit plan or small group market health insurance coverage shall not be adjusted more frequently than annually except that the premium rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of an employee;

(3) Changes in tobacco use, as provided in Subsection A(1)(d);

(4) Changes to the health benefit plan requested by the small employer; or

(5) Other changes required by federal law or regulations or otherwise expressly permitted by state law.

C. A health carrier shall consider all enrollees in all health benefit plans (other than grandfathered health plan coverage) offered by the carrier in the small group market, including those covered persons who do not enroll in such plans through an exchange, as established under Section 1311 of the Federal Act, to be members of a single risk pool.

Drafting Note: States should be aware that Section 1312(c)(3) of the Federal Act permits a state to merge its individual and small group health insurance markets. States should also be aware that Section 1312(c)(4) of the Federal Act prohibits states from requiring grandfathered health plan coverage to be included in the single risk pool for non-grandfathered health plan coverage.

D. The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by health carriers are consistent with the purposes of this Act, including regulations that assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design or coverage.

E. In connection with the offering for sale of small group market health insurance coverage under this Act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the coverage concerning the right to change premium rates and the factors that may affect changes in premium rates; and

Drafting Note: States should be aware that the requirement that health carriers disclose the information described in paragraph (1) above is required under Section 2709 of the PHSA. However, states may not require that this information be provided in the summary of benefits and coverage (SBC) required under Section 2715 of the PHSA and the federal regulations implementing that section.

(2) A listing of and descriptive information, including benefits and premiums, about all health insurance coverage for which the small employer is qualified.

F. (1) Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each health carrier shall file with the Commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.

(3) (a) A health carrier shall make the information and documentation described in paragraph (1) available to the Commissioner upon request.

(b) Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department of Insurance except as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

Drafting Note: States should be aware that, with respect to the information and documentation described in paragraph (1), certain provisions of the Federal Act or federal regulations or other federal law or state law or regulations may require the Department of Insurance to make public or share with other entities, such as health insurance exchanges or federal agencies.

Section 6. Guaranteed Availability of Small Group Market Health Insurance Coverage

A. (1) Subject to Subsections B-G, each health carrier that offers a health benefit plan providing small group market health insurance coverage in this state shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

(2) A health carrier described under paragraph (1):

(a) Shall offer coverage to all of the eligible employees of the eligible small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and

(b) Shall not offer coverage to only certain individuals or dependents in the small group or to only part of the small group.

B. (1) A health carrier described under Subsection A may restrict enrollment in coverage described in Subsection A to open or special enrollment periods.

(2) A health carrier described under Subsection A shall, in accordance with regulations established by the Secretary, establish special enrollment periods for qualifying events and as provided in Section 9B of this Act.

C. A health carrier described in Subsection A shall not apply any waiting period, as that term is defined in Section 300 of this Act, which exceeds ninety (90) days.

D. (1) Except as provided in this subsection, requirements used by a health carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(2) A health carrier shall not require a minimum participation level greater than:

(a) One hundred percent (100%) of eligible employees working for groups of three (3) or fewer employees; and

(b) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.

(3) In applying minimum participation requirements with respect to a small employer, a health carrier shall not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met.

(4) In applying minimum participation requirements with respect to a small employer, a health carrier shall not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

(5) A health carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

Drafting Note: States should be aware that the provisions of this Subsection D related to the minimum participation requirements in paragraphs (2), (3), (4), and (5) are subject to change depending on anticipated federal regulations or guidance on the topic.

E. (1) Subject to paragraph (3), a health carrier with respect to coverage offered through a network plan shall not be required to offer small group market health insurance coverage under that plan or accept applications for that plan pursuant to Subsection A in the case of the following:

(a) In an area outside of the carrier's established geographic service area for such network plan;

(b) To an employee, when the employee does not live, work or reside within the carrier's established geographic service area for such network plan; or

(c) Within the geographic service area for such network plan where the carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificate holders and covered persons.

(2) A health carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the small group market in the applicable geographic service area to new cases of small employer groups or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services.

(3) A health carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

F. (1) A health carrier described under Subsection A shall not be required to provide coverage if:

(a) For any period of time the carrier demonstrates, and the Commissioner determines, that the carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The carrier is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

(2) A health carrier that denies coverage in accordance with paragraph (1) may not offer coverage in the small group market in this state for the later of:

(a) A period of 180 days after the date the coverage is denied; or

(b) Until the carrier has demonstrated to the Commissioner that it has sufficient financial reserves to underwrite additional coverage.

Drafting Note: States may apply the provisions of paragraph (2) on a service-area-specific basis.

G. (1) A health carrier described under Subsection A shall not be required to provide small group market health insurance coverage if the carrier elects not to offer new coverage to small employers in this state.

Drafting Note: States should be aware that the proposed regulations issued by HHS, Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register*, Nov. 26, 2012, require health carriers to offer to any individual or small employer in the state all products that are approved for sale in the applicable market. Therefore, it appears that there will be no exception to guaranteed availability for closed blocks of business. Therefore, given this provision in the proposed regulations, states may want to consider not addressing this issue in statute and consider, instead, addressing it by regulation after final regulations are issued on the subject.

(2) A health carrier that elects not to offer new coverage under this subsection may be allowed, as determined by the Commissioner, to maintain its existing policies in this state.

(3) A health carrier that elects not to offer new coverage under paragraph (1) shall provide notice of its election to the Commissioner and shall be prohibited from writing new business in the small group market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

Section 7. Guaranteed Renewability of Small Group Market Health Insurance Coverage

A. Except as provided in this section, a health carrier offering health benefit plans providing small group market health insurance coverage in this state subject to this Act shall renew or continue in force the coverage, at the option of the small employer.

B. A health carrier may not renew or discontinue coverage under a health benefit plan subject to this Act if:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) The carrier elects to cease offering small group market health insurance coverage in this state in accordance with Subsection D and other applicable state law;

(6) In the case of a health carrier that offers coverage through a network plan, there is no longer any employee living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 6E(1)(b) of this Act;

(7) In the case of a health carrier that offers coverage in the small group market only through one or more bona fide associations, the membership of the small employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated uniformly under this paragraph without regard to any health status-related factor related to any covered person;

(8) The Commissioner:

(a) Finds that the continuation of the coverage would not be in the best interests of the certificate holders or would impair the carrier's ability to meet its contractual obligations; and

(b) Assists affected plan sponsors in finding replacement coverage; or

(9) The Commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in this state's small group market if the carrier:

(a) Provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed;

(b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All affected plan sponsors and employees and their dependents; and

(ii) The Commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents;

(c) Provides notice to each plan sponsor issued that particular type of health benefit plan (obsolete product form) that the plan sponsor has the option to purchase all other health benefit plans currently being offered by the carrier in the small group market in this state; and

(d) In exercising this option to discontinue that particular type of health benefit plan (obsolete product form) acts uniformly without regard to the claims experience of any small employer or any health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

C. (1) A health carrier that elects not to renew small group market health insurance coverage under a health benefit plan pursuant to Subsection B(2) because of the plan sponsor's fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that plan sponsor for one (1) year after the date of nonrenewal.

(2) This paragraph shall not be construed to affect the requirements of Section 7 of this Act as to other health carriers to issue coverage under any health benefit plan to the plan sponsor.

D. In any case in which a health carrier decides to discontinue offering a particular type of health benefit plan of small group market health insurance coverage, the health carrier may discontinue coverage in accordance with applicable state law only if the carrier:

(1) Provides advance notice of its decision under this subsection to the Commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:

(a) All affected plan sponsors and employees and their dependents; and

(b) The Commissioner in each state in which an affected insured individual is known to reside, provided the notice to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents;

(3) Provides notice to each plan sponsor issued that particular type of health benefit plan that the plan sponsor has the option to purchase all other health benefit plans providing small group market health insurance coverage currently being offered by the carrier in this state; and

(4) In exercising this option to discontinue that particular type of health benefit plan acts uniformly without regard to the claims experience of any small employer or any health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

E. (1) In any case in which a health carrier elects to discontinue offering small group market health insurance coverage in the small group market, or all markets, in this state, the carrier may discontinue such coverage only in accordance with applicable state law and if:

(a) The carrier provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed; and

(b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All affected plan sponsors and employees and their dependents; and

(ii) The Commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents.

(2) In the case of a discontinuance under paragraph (1), the health carrier shall be prohibited from writing new business in the market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

(3) In the case of a discontinuance under paragraph (1), the health carrier, as determined by the Commissioner, may renew its existing business in the market in the state or may be required to nonrenew all of its existing business in the market in the state.

F. At the time of coverage renewal, a health carrier may modify the coverage for a product offered in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with state law and effective on a uniform basis among small group health plans with that product.

G. In the case of a health carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in that service area

Section 8. Extension of Dependent Coverage

A. A health carrier offering a health benefit plan providing small group market health insurance coverage that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six (26) years of age.

B. (1) With respect to a child who has not attained twenty-six (26) years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the eligible employee.

(2) (a) A health carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on a factor, such as the presence or absence of the child's financial dependency upon the employee or any other person, residency with the employee or with any other person, marital status, student status, employment or any combination of those factors.

(b) In addition to Subparagraph (a) of this paragraph, a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.

C. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

D. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

Drafting Note: For purposes of this section, there is no definition of "dependent" in this section. Section 152(f)(1) of the Internal Revenue Code defines "child" as including only sons, daughters, stepchildren, adopted children, including children placed for adoption and foster children. Some states have defined "dependent" similarly, while others have not. In defining "dependent," states should keep in mind that the intent of the ACA is to require the availability of dependent coverage of children until the child reaches age 26 and that coverage cannot be conditioned based on certain dependency factors, such support, residency, student status or marital status.

Section 9. Prohibition of Preexisting Condition Exclusions; Special Enrollment Periods

A. Health carriers offering health benefit plans providing small group market health insurance coverage shall not impose any preexisting condition exclusion with respect to such coverage.

B. (1) A health carrier described in Subsection A shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the health benefit plan of the small employer during a special enrollment period if:

(a) The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;

(b) The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time;

(i) The employee's or dependent's coverage described under subparagraph (a):

(I) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or

(II) Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and

(c) Under terms of the health benefit plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subparagraph (b)(i)(I) or termination of coverage or employer contribution described in subparagraph (b)(i)(II).

(2) If an employee requests enrollment pursuant to paragraph (1)(c), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

C. (1) A health carrier described in Subsection A that makes coverage available under a health benefit plan with respect to a dependent of an employee shall provide for a dependent special enrollment period described in paragraph (2) during which the dependent and, if not otherwise enrolled, the employee may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage if:

(a) The employee is a covered person under the health benefit plan or has met any waiting period applicable to becoming a covered person under the plan and is eligible to be enrolled under the plan; and

(b) A person becomes a dependent of the employee through marriage, birth or adoption or placement for adoption.

(2) The special enrollment period for individuals that meet the provisions of paragraph (1) shall be a period of not less than thirty (30) days and begins on the later of:

(a) The date dependent coverage is made available; or

(b) The date of the marriage, birth or adoption or placement for adoption described in paragraph (1)(b).

(3) If an employee seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under paragraph (2), the coverage of the dependent shall be effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; and

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

D. A health carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the health benefit plan of the small employer during a special enrollment period if:

(1) The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under the state child health plan under title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than sixty (60) days after the date of termination of such coverage; or

(2) The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under title XIX of the Social Security Act or under the state child health plan under title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than sixty (60) days after the employee or dependent is determined to be eligible for such assistance.

Section 10. Prohibition on Discrimination Based on Health Status; Genetic Testing

A. A health carrier offering health benefit plans providing small group market insurance coverage in this state shall not establish rules for eligibility, including continuing eligibility, of any employee to enroll under the terms of coverage based on any health status-related factor in relation to the employee or dependent of the employee.

B. (1) A health carrier described in Subsection A shall not require any employee as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the employee or to an individual enrolled under the plan as a dependent of the employee.

(2) Nothing in paragraph (1) may be construed to:

(a) Restrict the amount that a small employer may be charged for coverage under the plan except as provided in paragraph (3)(a); or

(b) Prevent the health carrier from establishing premium discounts or rebates or modifying otherwise applicable copayment amounts or deductibles in return for adherence to programs of health promotion and disease prevention, as described in Section 2705(j) of the PHSA.

Drafting Note: States should be aware that Section 2705(j) of the PHSA establishes specific requirements for health promotion and disease prevention programs ("wellness programs") employers may offer.

(3) (a) For purposes of this section, a health carrier described in subsection A shall not adjust premium or contribution amounts for employees or family members covered under the plan on the basis of genetic information.

(b) Nothing in subparagraph (a) or in Subsection C(2)(a) and (b) shall be construed to preclude a health carrier from increasing the premium for a small employer based on the manifestation of a disease or disorder of an individual who is enrolled in grandfathered health plan coverage. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other small group members covered under the plan and to further increase the premium for the small employer.

Drafting Note: This section is based on Section 2705 of the PHSA. Section 2705 of PHSA includes provisions that were enacted prior to the ACA. Some of those provisions were not specifically supplanted by the ACA. However, because of ACA provisions related to premium rating restrictions, as reflected in Section 5 of this Act and a prohibition on preexisting condition exclusion periods, as reflected in Section 9 of this Act, some of these provisions are no longer permitted beginning Jan. 1, 2014. Given this, the language in paragraph (3)(b) above permitting the use of health status as a rating factor will not be permitted beginning Jan. 1, 2014, in accordance with Section 2701 of the PHSA. As noted in Section 4 of this Act, states should be aware that this provision could continue to apply to grandfathered health plan coverage.

C. (1) (a) A health carrier described in Subsection A shall not request or require an employee or a family member of an employee to undergo a genetic test.

(b) Subparagraph (a) shall not be construed to limit the authority of a health care professional who is providing health care services to an employee to request that the employee undergo a genetic test.

(c) (i) Nothing in subparagraph (a) shall be construed to preclude a health carrier described in Subsection A from obtaining and using the results of a genetic test in making a determination regarding payment (as that term is defined for purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be revised from time to time) consistent with Subsection A.

(ii) For purposes of item (i), a carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

(d) Notwithstanding subparagraph (a), a health carrier described in Subsection A may request, but not require, that a covered person undergo a genetic test if each of the following conditions is met:

(i) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulations for the protection of human subjects in research;

(ii) The carrier clearly indicates to each covered person, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(I) Compliance with the request is voluntary; and

(II) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(iii) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes;

(iv) The carrier notifies the Secretary in writing that the carrier is conducting activities pursuant to the exception provided in this paragraph, including a description of the activities conducted; and

(v) The carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(2) (a) A health carrier described in Subsection A shall not request, require or purchase genetic information for underwriting purposes.

(b) A health carrier described in Subsection A shall not request, require or purchase genetic information with respect to any individual prior to the individual's enrollment under the health benefit plan in connection with such enrollment.

(c) If a health carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase shall not be considered a violation of subparagraph (b) if such request, requirement or purchase is not in violation of subparagraph (a).

(3) Any reference in this section to genetic information concerning an employee or family member of an employee shall:

(a) With respect to the employee or family member of an employee who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

(b) With respect to an employee or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the employee or family member.

Section 11. Prohibition on Lifetime and Annual Limits

A. (1) Except as provided in Subsection B, health carriers offering health benefit plans providing small group market health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any covered person.

(2) (a) Except as provided in subparagraph (b) of this paragraph and Subsections B and C, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any covered person.

(b) A health flexible spending arrangement (FSA), as defined in Section 106(c)(2) of the Internal Revenue Code, a medical savings account (MSA), as defined in Section 220 of the Internal Revenue Code, and a health savings account (HSA), as defined in Section 223 of the Internal Revenue Code are not subject to the requirements of Subparagraph (a) of this paragraph.

B. The provisions of Subsection A shall not prevent a health carrier from placing annual or lifetime dollar per covered person limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

C. Nothing in this section prohibits a health carrier from excluding all benefits for a given condition, as otherwise permitted under federal or state law.

Section 12. Prohibition on Rescissions of Coverage

A. (1) A health carrier shall not rescind coverage under a health benefit plan providing small group market health insurance coverage with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

(2) For purposes of paragraph (1)(a), a person seeking coverage on behalf of an individual does not include a producer or employee or authorized representative of the health carrier.

B. A health carrier shall provide at least thirty (30) days advance written notice to each covered person who would be affected by the proposed rescission of coverage before coverage under the health benefit plan may be rescinded in accordance with Subsection A regardless of whether the rescission applies to the entire small group or only to an individual within the small group.

Drafting Note: States should be aware that Sections 9 and 10 of the NAIC Utilization Review and Benefit Determination Model Act include language describing what should be included in an advance notice of a rescission that is considered an adverse determination.

C. The provisions of this section apply regardless of any applicable contestability period.

Section 13. Comprehensive Health Insurance Coverage Requirements

A. (1) Health carriers offering health benefit plans providing small group market health insurance coverage in this state shall ensure that such coverage includes the essential health benefits package required under Section 1302(a) of the Federal Act, as described in Paragraph (2) of this subsection.

(2) For purposes of this subsection, "essential health benefits package" means coverage that:

(a) Provides for the essential health benefits, as defined in Section 3K of this Act;

(b) Limits cost-sharing for such coverage in accordance with Section 1302(c) of the Federal Act, as described in Subsection B; and

(c) Provides bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act as follows:

(i) Bronze level. A health benefit plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan;

(ii) Silver level. A health benefit plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;

(iii) Gold level. A health benefit plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and

(iv) Platinum level. A health benefit plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

B. A health carrier subject to Subsection A shall ensure that any annual cost-sharing imposed under the health benefit plan does not exceed the limitations provided for under paragraphs (1) and (2) of Section 1302(c) of the Federal Act.

C. This section shall not apply to a dental plan described in Section 1311(d)(2)(B)(ii) of the Federal Act.

Section 14. Coverage of Preventive Health Services

A. (1) A health carrier offering health benefit plans providing small group market health insurance coverage in this state shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

(a) Except as otherwise provided in Subsection B, evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

Drafting Note: The items and services referenced in subparagraph (a) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. States should be aware that these items and services could change over time.

(b) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

Drafting Note: The recommended immunizations for children, adolescents and adults referenced in subparagraph (b) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

(c) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

Drafting Note: The comprehensive guidelines referenced in subparagraph (c) above can be found at this link: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

(d) With respect to women, to the extent not described in paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Drafting Note: The comprehensive guidelines referenced in subparagraph (d) above can be found at this link: http://www.hrsa.gov/womensguidelines.

(2) (a) (i) A health carrier subject to this section is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (1) after the recommendation or guideline is no longer described in paragraph (1).

(ii) Other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section 2715(d)(4) of the PHSA, which requires a health carrier to give sixty (60) days advance notice to covered persons before any material modification will become effective.

(b) For purposes of paragraph (1) and for purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

(c) A health carrier shall, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

Drafting Note: This website: http://www.HealthCare.gov/center/regulations/prevention.html is provided in the interim final regulations published in the *Federal Register* July 19, 2010, which health carriers can visit once a year to find information necessary to determine any additional items or services that must be covered without cost-sharing requirements or to determine any items or services that are no longer required to be covered.

B. (1) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

(3) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

C. (1) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described in Subsection A that are delivered by an out-of-network provider.

(2) Nothing in Subsection A precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described in Subsection A that are delivered by an out-of-network provider.

D. Nothing prevents a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in Subsection A to the extent not specified in the recommendation or guideline.

E. Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in Subsection A even if the treatment results from an item or service described in Subsection A.

Drafting Note: States should be aware that, under Section 2713(c) of the PHSA, the Secretary is given the discretionary authority to develop guidelines that would permit health carriers offering health benefit plans providing small group market health insurance coverage to utilize value-based insurance designs. If the Secretary develops such guidelines, the language in this section may have to be revised.

Section 15. Coverage for Participation in Approved Clinical Trials

A. As used in this section, the following definitions apply:

(1) "Approved clinical trial" means a phase I, a phase II, a phase III or a phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and the trial must be:

(a) Conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);

(b) Exempt from obtaining an investigational new drug application; or

(c) Approved or funded by:

(i) The National Institutes of Health, the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services or a cooperative group or center of any of the entities described in this item;

(ii) A cooperative group or center of the U.S. Department of Defense or the U.S. Department of Veterans Affairs;

(iii) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(iv) The U.S. Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the Secretary to:

(I) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(II) Provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

(2) "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(3) "Qualified individual" means an individual with small group market health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life threatening condition because:

(a) The referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or

(b) The individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.

(4) (a) "Routine patient costs" include all items and services covered by the health benefit plan of small group market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

(b) "Routine patient costs" do not include:

(i) An investigational item, device or service that is part of the trial;

(ii) An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or services is not used in the direct clinical management of the patient;

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(iv) An item or service customarily provided and paid for by the sponsor of a trial.

B. A health carrier that offers a health benefit plan providing small group market health insurance coverage in this state may not:

(1) Deny participation by a qualified individual in an approved clinical trial;

(2) Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial; or

(3) Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

C. A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

D. This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

E. This section shall not be construed to require a health carrier offering small group market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

F. Nothing in this section shall be construed to limit a health carrier's coverage with respect to clinical trials.

Section 16. Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements

A. (1) (a) If a health carrier providing small group market health insurance coverage under a health benefit plan requires or provides for the designation by a covered person of a participating primary health care professional, the health carrier shall permit each covered person to:

(i) Designate any participating primary care health care professional who is available to accept the covered person; and

(ii) For a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.

(b) The provisions of subparagraph (a)(ii) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(2) (a) If a health carrier provides small group market health insurance coverage under a health benefit plan for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:

(i) Shall not require any covered person's, including a primary care health care professional's, authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and

(ii) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to item (i), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

(b) (i) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.

(ii) For purposes of item (i), a health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.

(c) The provisions of Subparagraph (b)(i) shall not be construed to:

(i) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or

(ii) Preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

B. (1) A health carrier shall provide notice to covered persons of the terms and conditions of the health benefit plan related to the designation of a participating health care professional provided in Subsection A and of a covered person's rights with respect to those provisions.

(2) The notice described in paragraph (1) shall be included whenever the health carrier provides a covered person with a summary plan description or other similar description of benefits under the health benefit plan.

Section 17. Provision of Summary of Benefits and Coverage Explanation

A. Health carriers offering health benefit plans providing small group market health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the Secretary under Section 2715(a) of the PHSA to:

(1) An applicant at the time of application;

(2) A covered person prior to the time of enrollment or reenrollment, as applicable; and

(3) A certificate holder at the time of issuance of the certificate.

B. A health carrier described in Subsection A shall be deemed to have complied with Subsection A if the summary of benefits and coverage described in Section 2715(a) of the PHSA is provided in paper or electronic form in accordance with the standards adopted by the Secretary under Section 2715(d) of the PHSA.

C. Except with respect to a renewal or reissuance of coverage, if a health carrier makes any material modifications in any of the terms of the coverage, as defined for purposes of Section 102 of ERISA, that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective.

Drafting Note: Under Section 2715(f) of the PHSA, a health carrier that willfully fails to provide the information required under Section 2715 of the PHSA is subject to a federal civil penalty of not more than $1,000 for each such failure. In addition, Section 2715(f) of the PHSA provides that such failure with respect to each covered person shall constitute a separate offense.

Drafting Note: The language of this section reflects the provisions of Section 2715 of the PHSA. Regulations issued by the Secretary related to Section 2715 of the PHSA provide more specific information and requirements not reflected in this section. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 18. Certification of Creditable Coverage

A. A health carrier offering health benefit plans providing small group market health insurance coverage shall provide written certification of creditable coverage to individuals in accordance with Subsection B.

B. (1) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in subparagraph (a) or (b), whichever is later.

(2) The certification under paragraph (1) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

C. The certification described in this subsection is a written certification of:

(1) The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under such COBRA continuation provision; and

(2) The waiting period, if any, and affiliation period, if applicable, imposed on the individual for any coverage under the health benefit plan.

Drafting Note: Federal regulations issued pursuant to Section 2704(e) of the PHSA include additional information that must be included in a certificate of creditable coverage. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 19. Standards to Assure Fair Marketing

A. Subject to Section 6A(1) of this Act, each health carrier shall actively market all health benefit plans sold by the carrier to eligible small employers in this state.

B. (1) Except as provided in paragraph (2), a health carrier or a producer shall not, directly or indirectly, engage in the following activities:

(a) Encourage or direct small employers to refrain from filing an application for coverage with the carrier because of any health status-related factor or because of the industry, occupation or geographic location of the small employer;

(b) Encourage or direct small employers to seek coverage from another carrier because of any health status-related factor or because of the industry, occupation or geographic location of the small employer.

(2) The provisions of paragraph (1) shall not apply with respect to information provided by a health carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a health carrier.

C. (1) Except as provided in paragraph (2), a health carrier shall not, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer that does not vary because of any health status-related factor, industry, occupation or geographic area of the small employer.

D. A health carrier shall not terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor, occupation or geographic location of the small employers placed by the producer with the carrier.

E. A health carrier or producer shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent of an employee from coverage or benefits provided in connection with the employee's employment.

F. Denial by a health carrier of an application for coverage from a small employer shall be in writing or electronically provided and shall state the reason or reasons for the denial. Nothing in this subsection allows any denial by a health carrier that is not in compliance with Sections 6 and 7 of this Act.

G. The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

H. (1) A violation of this section by a health carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a health carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third party administrator shall be subject to this section as if it were a health carrier.

Drafting Note: States should be aware that the provisions of Section 19 of this Act are subject to change depending on whether federal regulations or guidance are issued on the topic.

Section 20. Quality of Care Reporting Requirements

A. (1) Health carriers offering health benefit plans providing small group market health insurance coverage in this state shall annually submit to the Secretary and the Commissioner in each state the carrier is licensed and to covered persons under the coverage, a report on whether the benefits under the coverage satisfy the elements described in Subsection B.

(2) The report required under paragraph (1) shall be made available to a covered person under the coverage during each open enrollment period.

B. (1) For purposes of Subsection A, using the reporting requirements developed by the Secretary, a health carrier shall report on coverage benefits and health care provider reimbursement structures that:

(a) Improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model, as defined for purposes of Section 3602 of the Federal Act, for treatment or services under the coverage;

(b) Implement activities that prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;

(c) Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the coverage; and

(d) Implement wellness and health promotion activities.

(2) For purposes of paragraph (1)(d), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

(a) Smoking cessation;

(b) Weight management;

(c) Stress management;

(d) Physical fitness;

(e) Nutrition;

(f) Heart disease prevention;

(g) Healthy lifestyle support; and

(h) Diabetes prevention.

Section 21. Prohibited Activities

The Commissioner may by regulation prescribe standards for determining whether a policy issued as a stop loss policy is a health benefit plan for the purposes of this Act.

Section 22. Risk Adjustment Mechanism

The Commissioner may establish an assessment and payment mechanism for health carriers providing small group market health insurance coverage to adjust for actuarial risk that is consistent with the criteria and methods developed by the Secretary in accordance with Section 1343(b) of the Federal Act.

Drafting Note: States should be aware that, in guidance issued by HHS, HHS indicated that it would operate the risk adjustment program in those states that do not establish a State-based Exchange (SBE).

Section 23. Regulations

The Commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 24. Severability

If any provision of this Act or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 25. Effective Date

This Act shall be effective on [insert date].

Public Health Service Act sections:

§ 2701 PHSA—Fair health insurance premiums
§ 2702 PHSA—Guaranteed availability of coverage
§ 2703 PHSA—Guaranteed renewability of coverage
§ 2704 PHSA—Prohibition on preexisting condition exclusions or other discrimination based on health status
§ 2705 PHSA—Prohibiting discrimination against individual participants and beneficiaries based on health status
§ 2706 PHSA—Non-discrimination in healthcare
§ 2707 PHSA—Comprehensive health insurance coverage
§ 2708 PHSA—Prohibition on excessive waiting periods
§ 2709 PHSA—Coverage for individuals participating in approved clinical trials

Public Health Service Act sections (cont.)

§ 2709 PHSA—Disclosure of Information
§ 2711 PHSA—No lifetime or annual limits
§ 2712 PHSA—Prohibition on rescissions
§ 2713 PHSA—Coverage of preventive health services
§ 2714 PHSA—Extension of dependent coverage
§ 2715 PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions
§ 2716 PHSA—Prohibition on discrimination in favor of highly compensated individuals
§ 2717 PHSA—Ensuring the quality of care
§ 2719A PHSA—Patient Protections

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2013 Proc. 1st Quarter 107-110, 121, 128, 215-257, 590, 705-706 (adopted).

SMALL GROUP HEALTH INSURANCE COVERAGE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SMALL GROUP HEALTH INSURANCE COVERAGE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. ANN. §§ 21.56.110 to 21.56.250 (1993/2016).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado			3 COLO. CODE REGS. § 702-4:4-6-8 (2009/2016).
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, §§ 7201 to 7218 (1991).
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. ADMIN. CODE ANN. r. 69O-149.030 to 69O-149.044 (1993/2002).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

SMALL GROUP HEALTH INSURANCE COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. §§ 41-4701 to 41-4716 (1993).
Illinois	NO CURRENT ACTIVITY		
Indiana			IND. CODE ANN. §§ 27-8-15-1 to 27-8-15-34.1 (1998).
Iowa			IOWA CODE ANN. §§ 513B.1 to 513B.18 (2007); IOWA ADMIN. CODE r. 191-71.1 to 191-71.26 (2008).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. STAT. ANN. § 22:1067 (2008).
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts			211 MASS. CODE REGS. 66.01 to 66:13 (2007).
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		

SMALL GROUP HEALTH INSURANCE COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico			N.M. STAT. ANN. §§ 59A-23C-1 to 59A-23C-10 (1991).
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. ANN. § 58-68-40 (1997/2006).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. §§ 38-71-910 to 38-71-990 (1991).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. STAT. ANN. §§ 635.01 to 635.19 (1999).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2013

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL ACT (#106)

1. Description of the Project, Issues Addressed, etc.

At the 2011 Spring National Meeting, the Regulatory Framework (B) Task Force discussed a work plan to develop one or more new NAIC models that would incorporate the 2014 market reforms under the Patient Protection and Affordable Care Act (ACA) and its Sept. 23, 2010 immediate reform provisions. At the 2012 Spring National Meeting, the Regulatory Framework (B) Task Force decided to develop two new NAIC model acts: one for the non-group market and the second for the small group market. The Regulatory Framework (B) Task Force adopted the Small Group Market Health Insurance Coverage Model Act Nov. 29 at the 2012 Fall National Meeting and presented it to the Health Insurance and Managed Care (B) Committee for its consideration. As part of the Task Force's report, the Health Insurance and Managed Care (B) Committee adopted the Small Group Market Health Insurance Coverage Model Act on Nov. 30.

Major provisions in the model act include:

Provisions reflecting the ACA's 2014 market reforms:

- Restrictions Relating to Premium Rates (Section 5)
- Guaranteed Availability of Small Group Market Health Insurance Coverage (Section 6)
- Guaranteed Renewability of Small Group Market Health Insurance Coverage (Section 7)
- Prohibition of Preexisting Condition Exclusions (Section 9)
- Comprehensive Health Insurance Coverage Requirements (Section 13)
- Coverage for Participation in Approved Clinical Trials (Section 15)
- Provision of Summary of Benefits and Coverage Explanation (Section 17)
- Quality of Care Reporting Requirements (Section 20)

Provisions using the model language template language from the ACA's Sept. 23, 2010 immediate reform provisions:

- Extension of Dependent Coverage (Section 8)
- Prohibition on Lifetime and Annual Limits (Section 11)
- Prohibition on Rescissions of Coverage (Section 12)
- Coverage of Preventive Health Services (Section 14)
- Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements (Section 16)

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force drafted the model language. The members of the Task Force are: South Dakota, Chair, Idaho, Vice Chair, California, Colorado, District of Columbia, Florida, Illinois, Kansas, Kentucky, Maine, Minnesota, Montana, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, Virginia, Washington, West Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. The Task Force also has a specific charge to consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations affected by federal legislation and final federal regulations promulgated pursuant to such legislation.

After the enactment of the ACA in March 2010, consistent with its charges, the Health Insurance and Managed Care (B) Committee directed the Regulatory Framework (B) Task Force to review and revise existing NAIC models impacted by the ACA or, as necessary, develop new NAIC models to assist the states in implementing the ACA. This proposed new NAIC model act is consistent with that directive.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model act was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2012 National Meetings and at a June 26, 2012 interim meeting during which the drafts and comments received on the drafts were discussed. The drafts and comments received on the drafts were also discussed during open conference calls held on Sept. 19, Oct. 24 and Nov. 19, 2012. All drafts and comments were posted on the Task Force's page on the NAIC Internet website. During these in-person meetings and open conference calls representatives from various stakeholder groups participated, including consumer representatives, such as Georgetown University Health Policy Institute, Consumers for Affordable Health Care, Center on Budget and Policy Priorities (CBPP), Consumers Union and Families USA; and industry representatives, such as America's Health Insurance Plans (AHIP), BlueCross and BlueShield Association (BCBSA), WellPoint and Golden Rule.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The model act was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2012 National Meetings and at a June 26, 2012 interim meeting during which the drafts and comments received on the drafts were discussed. The drafts and comments received on the drafts were also discussed during open conference calls held on Sept. 19, Oct. 24 and Nov. 19, 2012. All drafts and comments were posted on the Task Force's page on the NAIC Internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There were no significant issues discussed during the drafting process for this model act.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

Table of Contents

Section 1. Title

This regulation shall be known and may be cited as the Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation.

Section 2. Purpose

The purpose of this regulation is to incorporate the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations that prohibit carriers providing health insurance coverage under a health benefit plan in the group market from discriminating against individual participants or beneficiaries in these plans with respect to plan eligibility and in setting premium and contribution rates based on any health factor of the participants or beneficiaries.

Section 3. Definitions

As used in this regulation:

A. "Affiliation period" means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.

B. "Beneficiary" has the meaning stated in Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

C. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. For the purposes of this regulation, carrier includes a sickness and accident insurance company, a nonprofit hospital and health service corporation, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Drafting Note: HIPAA uses the term "health insurance issuer" instead of "carrier." The definition of "health insurance issuer" contained in HIPAA is consistent with the term "carrier," as defined in Subsection C of this section.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. Where jurisdiction of managed care organizations lies with some other state agency, or dual regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

E. (1) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(a) A group health plan;

(b) A health benefit plan;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

(e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents). For purposes of Chapter 55 of Title 10, U.S.C., "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

(i) A public health plan, which for purposes of this regulation, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

Drafting Note: States may wish to grant the commissioner rulemaking authority to further define the coverage that falls within the definition above. However, the commissioner's authority is limited by the requirements of HIPAA with respect to creditable coverage. The definition of "creditable coverage" is governed by HIPAA's preemption rule relating to state provisions addressing preexisting conditions, which is more stringent than the general preemption test under HIPAA. State provisions relating to preexisting conditions are preempted if they differ from the requirements of HIPAA, unless the state provision falls into one of seven explicit exceptions. However, one of these seven exceptions is broad and permits a state requirement to stand if the requirement "prohibits the imposition of any preexisting condition exclusion in cases not described in Section 2701(d) or expands the exceptions described in such section." PHSA Section 2723(b)(2)(v). The language of this section permits states to continue to prohibit preexisting condition exclusions in a number of situations not specifically addressed by HIPAA.

F. "Dependent" shall be defined in the same manner as [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the following definition:

> "Dependent" means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the participant, and an unmarried child of any age who is medically certified as disabled and dependent upon the participant.

Drafting Note: If using the suggested definition above, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the participant.

G. "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

H. (1) "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member.

(2) "Genetic information" includes information regarding an individual's carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

I. (1) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of ERISA, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this regulation:

(a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b) of this paragraph, as an employee welfare benefit plan that is a group health plan;

(b) In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and

(c) In the case of a group health plan, the term "participant," as defined in Subsection P, also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

(ii) In connection with a group health plan maintained by a self-employed individual, under which, one or more employees are participants, the individual is the self-employed individual.

Drafting Note: Paragraph (1) of the definition of "group health plan" tracks the federal definition of "group health plan" found in PHSA Section 2791(a)(1), as amended by HIPAA. However, the federal law's definition of "group health plan" also defines "medical care" as part of the definition of "group health plan." In this model regulation, the definition of "medical care" is separate from the definition of "group health plan" and is found in Subsection N of this section. The definition of "group health plan" in this model also differs from the federal definition in that it contains Paragraph (2), which tracks the language of PHSA Section 2721(e), as amended by HIPAA, addressing the treatment of partnerships.

J. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(2) "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

Drafting Note: HIPAA uses the term "health insurance coverage." "Health benefit plan," as defined in this model regulation, is intended to be consistent with the definition of "health insurance coverage" contained in HIPAA. Paragraphs (3), (4), (5), and (6) below track the language of HIPAA that addresses "excepted benefits," i.e., those benefits that are excepted from the requirements of HIPAA.

(3) "Health benefit plan" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Liability insurance, including general liability insurance and automobile liability insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) "Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) "Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under a group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(6) "Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or

(c) Similar supplemental coverage provided to coverage under a group health plan.

K. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.

L. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

M. (1) "Health factor" means, in relation to an individual, any of the following health status-related factors:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses, as defined in Subsection O;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including:

(i) Conditions arising out of acts of domestic violence; or

(ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or

(h) Disability.

(2) For purposes of this subsection, "health factor" does not include the decision whether to elect health insurance coverage, including the time chosen to enroll, such as under special enrollment or late enrollment.

Drafting Note: This definition tracks the language contained in PHSA Section 2702(a), as amended by HIPAA, and federal final interim regulations.

N. "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

O. (1) "Medical condition" means any condition, whether physical or mental, including any condition resulting from illness, injury, accident, pregnancy or congenital malformation.

(2) For purposes of Paragraph (1), genetic information is not a condition.

P. "Participant" has the meaning stated in Section 3(7) of ERISA.

Q. (1) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.

(2) "Preexisting condition" shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

(3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

R. "Significant break in coverage" means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

S. "Waiting period" means, with respect to a health benefit plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection E(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

This regulation shall apply to any carrier that provides coverage under a health benefit plan in the group market.

Section 5. Prohibited Discrimination in Rules for Eligibility

A. A carrier subject to this regulation shall not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.

B. For purposes of this section, rules of eligibility include rules relating to:

(1) Enrollment;

(2) The effective date of coverage;

(3) Waiting or affiliation periods;

(4) Late and special enrollment;

(5) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;

(6) Benefits, including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Section 7A and B of this regulation;

(7) Continued eligibility; and

(8) Terminating coverage, including disenrollment, of an individual under the plan.

C. Nothing in this section prohibits a carrier subject to this regulation from:

(1) Establishing more favorable rules of eligibility for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor; or

(2) Subject to state law, charging a higher premium or contribution with respect to an individual with an adverse health factor if the individual would not be eligible for coverage, but for the adverse health factor.

Section 6. Prohibited Discrimination in Premium and Contribution Rates

A. (1) A carrier subject to this regulation shall not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution rate that is greater than the premium or contribution rate for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(2) In determining an individual's premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.

B. (1) Subject to Paragraph (2), nothing in this section restricts the aggregate amount that a carrier subject to this regulation may charge an employer for coverage under a plan.

(2) A carrier subject to this regulation shall not quote or charge an employer or an individual participant or beneficiary a different premium than that quoted or charged an individual in a group of similarly situated individuals based on a health factor unless permitted under Section 5C(2) of this regulation or Subsection D of this section.

C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

D. Nothing in this section prohibits a carrier subject to this regulation from charging an individual a premium or contribution rate that is less than the premium or contribution rate for similarly situated individuals if the lower charge is based on an adverse health factor of the individual, such as a disability.

Section 7. Application of Section 5 to Plan Benefits; Preexisting Condition Exclusions; Similarly Situated Individuals

A. (1) Subject to Paragraph (2), Section 5 of this regulation does not require a carrier subject to this regulation to provide coverage for any particular benefit to any group of similarly situated individuals.

(2) (a) A carrier subject to this regulation shall make the benefits provided under a plan available uniformly to all similarly situated individuals, as those groups are determined under Subsection C.

(b) For any restriction on a benefit or benefits provided under a plan, a carrier subject to this regulation:

(i) Shall apply the restriction uniformly to all similarly situated individuals; and

(ii) Shall not direct the restriction, as determined based on all of the relevant facts and circumstances, at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(c) A carrier subject to this regulation may impose annual, lifetime or other limits on benefits and may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the limit or cost-sharing requirement:

(i) Applies uniformly to all similarly situated individuals; and

(ii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(d) For purposes of this paragraph, a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(3) If a carrier subject to this regulation generally provides benefits for a type of injury, the plan or carrier shall not deny an individual participant or beneficiary benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition.

(4) A carrier subject to this regulation with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual, based on a health factor of that individual or dependent of that individual, than for a similarly situated individual under the plan, does not violate this subsection if the payment differential is based on whether the individual has complied with the requirements of a bona fide wellness program.

B. (1) Section 5 of this regulation does not prohibit a carrier subject to this regulation from imposing a preexisting condition exclusion period if the preexisting exclusion period:

(a) Complies with the requirements for imposing a preexisting condition exclusion period established by federal regulation;

(b) Is applied uniformly to all similarly situated individuals, as those groups are determined under Subsection C; and

(c) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(2) For purposes of this subsection, a plan amendment relating to a preexisting condition exclusion that is applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

C. (1) This subsection applies only within a group of individuals who are treated as similarly situated individuals.

(2) (a) Subject to Paragraph (4) of this subsection, Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating participants as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among groups of participants is based on a bona fide employment-based classification that is consistent with the employer's usual business practice.

(b) (i) Whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.

(ii) For purposes of Item (i), relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage, such classifications may include:

(I) Full-time versus part-time status;

(II) Geographic location;

(III) Membership in a collective bargaining unit;

(IV) Date of hire;

(V) Length of service;

(VI) Current employee versus former employee status; and

(VII) Occupation.

(iii) A classification based on a health factor shall not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Section 5C and Section 6D of this regulation are satisfied.

(3) (a) Subject to Paragraph (4), Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating beneficiaries as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups of beneficiaries is based on any of the following factors:

(i) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(ii) Relationship to the participant (e.g., as a spouse or as a dependent child);

(iii) Marital status;

(iv) With respect to a child of the participant, age or student status; or

(v) Any other factor, if the factor is not a health factor.

(b) Subparagraph (a) of this paragraph shall not be construed to prevent a carrier subject to this regulation from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Section 5C and Section 6D of this regulation.

(4) Notwithstanding Paragraphs (2) and (3), unless permitted under Section 5C or Section 6D of this regulation, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on a health factor of the participants or beneficiaries, the classification is not permitted under this subsection.

Section 8. Application of Sections 5 and 6 to Nonconfinement and Actively-at-Work Provisions

A. Except to the extent permitted under Subsection B(2) or Subsection C, in accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule of eligibility or set an individual's premium or contribution rate based on:

(1) Whether the individual is confined in a hospital or other health care institution; or

(2) The individual's ability to engage in normal life activities.

B. (1) In accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule for eligibility or set an individual's premium or contribution rate based on whether the individual is actively-at-work, including whether an individual is continuously employed, unless absence from work due to any health factor is treated, for purposes of the plan, as being actively-at-work.

(2) Notwithstanding Paragraph (1), a carrier subject to this regulation may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.

C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a rule of eligibility or set an individual's premium or contribution rate with respect to similarly situated individuals, as those groups are determined under Section 7C of this regulation.

Section 9. Enforcement

A. The commissioner shall conduct a reasonable investigation based on a complaint [add any means by which the commissioner receives complaints] received by the commissioner and issue a prompt determination as to whether a violation of this regulation may have occurred.

B. If the commissioner finds from the investigation that a violation of this regulation may have occurred, the commissioner shall promptly begin an adjudicatory proceeding.

C. The commissioner may address a violation of this regulation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these.

D. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 10. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2002 Proc.1st Quarter 13, 14, 177, 184, 211-218 (adopted).

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, § 3574 (2001/2013) (rate discrimination).
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. § 97/25 (1997) (eligibility discrimination).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-15.11 (1963/2009).
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.17A-200 (1998) (eligibility and rate discrimination).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. § 15-1407 (1997) (rate discrimination).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi			19 CODE MISS. R. Pt. 1, R. 26.01 to 26.09 (2012).
Missouri	NO CURRENT ACTIVITIY		
Montana	NO CURRENT ACTIVITIY		
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. § 689B.550 (1997) (eligibility discrimination); NEV. ADMIN. CODE § 689B.305 (2002) (rate discrimination).

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire	N.H. CODE ADMIN. R. INS. 1907.03 to 1907.07 (2006).		
New Jersey			N.J. STAT. ANN. § 17B:27-64 (1997) (eligibility discrimination); § 17B:27-65 (1997) (rate discrimination).
New Mexico			N.M STAT. ANN. §§ 59a-23e-11 to 59a-23e-12 (1997/1998).
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3923.571 (1999) (rate discrimination).
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 743B.104 (1999/2015) (eligibility discrimination).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS § 27-18.6-4 (2000) (eligibility discrimination).
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. §§ 20:06:46:01 to 20:06:46:15 (2002).
Tennessee			TENN. CODE ANN. §§ 56-7-2801 to 56-7-2814 (1997).

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE § 33-16-3n (1997) (eligibility discrimination).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2002

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION (#107)

1. Description of the project, issues addressed, etc.

The Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation incorporates requirements set forth in an interim final rule issued by the three federal agencies charged with administering the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This regulation prohibits group health carriers from discriminating against individual participants or beneficiaries based on any health factor. This regulation will apply to any health carrier that provides health insurance coverage in the group market.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair
Arizona
Arkansas
Arizona
California
Delaware
Florida
Hawaii
Idaho
Indiana
Kansas
Maryland
Mississippi
Montana
New Hampshire
New Mexico
North Carolina
Ohio
Oklahoma
Oregon
Pennsylvania
South Dakota
Vermont
Virginia
Washington

3. Project authorized by what charge and date first given to the group:

The following charge was given to the Regulatory Framework (B) Task Force in 1999:

Consider the revision of NAIC model laws and regulations affected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and final federal regulations promulgated pursuant to HIPAA to comport with the requirements of HIPAA and final federal regulations.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The proposed model regulation was drafted by the task force. Numerous interested parties participated, including insurance industry representatives, such as the American Association of Health Plans (AAHP), the Health Insurance Association of America (HIAA), and the BlueCross BlueShield Association (BCBSA); and representatives of key federal agencies, the Department of Labor (DOL) and the Health Care Financing Administration (HCFA).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Beginning with the 2001 NAIC Summer National Meeting, drafts of the proposed model regulation were reviewed and discussed at each National Meeting. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed model regulation were posted on the NAIC web site.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

There were no significant issues raised during the drafting process.

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted by [title of supervisory authority] pursuant to Section [insert applicable section] of the [insert state] Insurance Code.

Section 2. Scope

This regulation is applicable to all insurance policies and subscriber contracts issued or provided by a carrier on a group or group-type basis covering persons as employees of employers or as members of unions or associations.

Section 3. Definitions

For purposes of this Act:

A. (1) "Carrier" means a person or an entity that offers or provides a policy, contract or certificate of insurance coverage in this state.

(2) "Carrier" includes an insurer, a health maintenance organization, a nonprofit service corporation or any other person or entity providing a policy, contract or certificate of insurance coverage subject to state insurance regulation.

B. "Group-type basis" means a benefit plan, other than a "salary budget" plan utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

(1) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;

(2) The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;

(3) There are arrangements for bulk payment of premiums or subscription charges to the carrier; and

(4) There is sponsorship of the plan by the employer, union or association.

C. (1) "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(2) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub.L.No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(4) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or

(c) Similar supplemental coverage provided to coverage under a group health plan.

Section 4. Effective Date of Discontinuance for Non-Payment of Premium or Subscription Charges

A. If a policy or contract subject to this regulation provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

B. If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

Section 5. Requirements for Notice of Discontinuance

A. A notice of discontinuance given by the carrier shall include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy, contract or certificate will discontinue and to advise that, unless otherwise provided in the policy, contract or certificate the carrier shall not be liable for claims for losses incurred after the date of discontinuance. The notice of discontinuance also shall advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

B. The carrier shall prepare and furnish to the policyholder or other entity at the same time it gives a notice of discontinuance a supply of notice forms to be distributed to the employees or members concerned, indicating the discontinuance and the effective date of the discontinuance, and urging the employees or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon the discontinuance.

Section 6. Extension of Benefits

A. Every group policy, contract or certificate subject to this regulation issued on or after the effective date of this regulation, or under which the level of benefits is altered, modified or amended on or after the effective date of this regulation, shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract or certificate as required by the following subsections of this section.

B. In the case of a group life plan that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy, contract or certificate shall not operate to terminate the extension.

C. In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the group policy, contract or certificate during a disability shall have no effect on benefits payable for that disability or confinement.

D. (1) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required.

(2) An extension of benefits or accrued liability provision will be considered "reasonable" if:

(a) It provides an extension of at least twelve (12) months under "major medical" and "comprehensive medical" type coverages; and

(b) Under other types of hospital or medical expense coverages, it provides:

(i) An extension of benefits of at least ninety (90) days; or

(ii) An accrued liability for expenses incurred during a period of disability or during a period of at least ninety (90) days starting with a specific event that occurred while coverage was in force (e.g., an accident).

E. (1) An applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension of benefits or accrued liability may be subject to the policy's, contract's or certificate's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.

(2) For hospital or medical expense coverages, the benefit payments may be limited to payments applicable to the disabling condition only.

Section 7. Continuance of Coverage in Situations Involving Replacement of One Carrier by Another

A. This section shall indicate the carrier responsible for liability in those instances in which one carrier's (succeeding carrier) policy, contract or certificate replaces a plan of similar benefits of another (prior carrier).

B. After discontinuance of the policy, contract or certificate, the prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

C. (1) (a) If the individual was validly covered under the prior plan on the date of discontinuance, each individual who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to the class or classes of individuals eligible for coverage under the succeeding carrier's plan and any actively-at-work and nonconfinement rules and requests enrollment shall be enrolled and covered by the succeeding carrier's plan of benefits.

(b) In the case of health insurance coverage:

(i) A succeeding carrier shall not have any nonconfinement rules in its plan of benefits; and

(ii) Any actively-at-work rules provided in the succeeding carrier's plan of benefits shall provide that absence from work due to any health status-related factor be treated as being actively-at-work.

(c) For purposes of this paragraph, "health status-related factor" means any of the following factors:

(i) Health status;

(ii) Medical condition, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(viii) Disability.

Drafting Note: This definition tracks the language contained in Public Health Service Act Section 2702(a), as amended by HIPAA.

(2) (a) Each person not covered under the succeeding carrier's plan of benefits in accordance with Paragraph (1) shall nevertheless be covered by the succeeding carrier in accordance with the following rules if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

(b) The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

(c) Coverage shall be provided by the succeeding carrier until the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding carrier's plan as described in Paragraph (1);

(ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage, such as at termination of employment or ceasing to be an eligible dependent; or

(iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which Section 6 of this regulation requires an extension of benefits or accrued liability, the end of any period of extension benefits or accrued liability that is required of the prior carrier by Section 6 of this regulation, or if the prior carrier's policy, contract or certificate is not subject to that section, but would have been required of the prior carrier had the policy, contract or certificate been subject to Section 6 of this regulation at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan.

(3) For health insurance coverage, in the case of an individual who was totally disabled at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan, and in the case in which Section 6 of this regulation requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits paid by the prior plan.

(4) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of individuals becoming covered by the succeeding carrier's plan in accordance with this paragraph during the period of time this limitation applies under the new plan shall be the lesser of:

(a) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(b) The benefits of the prior plan.

(5) The succeeding carrier, in applying any deductibles or coinsurance amounts applicable to the out-of-pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety (90) days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision.

(6) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

Section 8. Effective Date

This regulation shall take effect on [insert a date at least 120 days after promulgation].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1972 Proc. II 10, 13, 410, 483, 484-487 (adopted).
2002 Proc. 1st Quarter 218-222 (model adopted later is printed here).
2002 Proc. 2nd Quarter 14, 15, 166, 168-169 (amendments adopted).

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE 20-6-208 (1979/2007).		
Arkansas			ARK. CODE ANN. § 23-86-116 (1987/2001); § 23-86-311 (1997/2003) (notice).
California			CAL. INS. CODE §§ 10128 to 10128.4 (1977/2003); § 10133.56 (1998/2004).
Colorado			COLO. REV. STAT. ANN. § 10-16-214 (2013) (includes Section 7 from model).
Connecticut	CONN. AGENCIES REGS. §§ 38a-546-1 to 38a-546-5 (1985/2010).		CONN. GEN. STAT. §§ 38a-537 (1982).
Delaware			DEL. CODE ANN. tit. 18, § 3513 (1987) (grace period).
District of Columbia	NO CURRENT ACTIVITY		

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 627.666 to 627.667 (1975/1992).
Georgia	GA. COMP. R. & REGS. 120-2-10-.10 (1967/1990).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. §§ 41-2211 to 41-2215 (1978).
Illinois	ILL. ADMIN. CODE. tit. 50, §§ 2013.10 to 2013.70 (1990/1994).		215 ILL. COMP. STAT. ANN. 5/367i (1990).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	KY. REV. STAT. ANN. §§ 304.18-124 to 304.18-127 (1990) (portions of model).		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 2848 to 2850-D (1990/2009).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. R. §§ 2755.0100 to 2755.0500 (1984/1989) (includes Section 7 from model).

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi			MISS. CODE ANN. § 83-9-35 (1982/1993) (includes Section 7 from model).
Missouri	MO. REV. STAT. §§ 376.431 to 376.442 (1986).		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. § 689B.065 (1987).
New Hampshire	N.H. CODE ADMIN. R. INS. 6101.01 to 6101.5 (2018).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-13.1 to 11:2-13.7 (1975/2000).		
New Mexico	N.M. ADMIN. CODE 13.10.5 (1998).		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. § 58-51-110 (1989).
North Dakota	N.D. ADMIN. CODE 45-08-02-01 to 45-08-02-07 (1988/2004).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit.36, §§ 4509 to 4509.1 (1988/1992) (includes Section 7 of model).
Oregon			OR. REV. STAT. ANN. §§ 743B.320 to 743B.330 (2015); OR. ADMIN. R. 836-082-0055 (1990) (includes Section 7 from model).

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-30-1.9 (2001).		
South Carolina	S.C. CODE ANN. § 38-71-760 (1988/2002).		
South Dakota			S.D. CODIFIED LAWS § 58-18-7.11 (2009).
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 1251.251 to 1251.260 (2005/2009); §§ 1251.301 to 1251.310 (2005).
Utah	NO CURRENT ACTIVITY		
Vermont	VT. STAT. ANN. tit. 8, §§ 4091a to 4091f (1989).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 6.51 (1982).		
Wyoming			WYO. STAT. ANN. §§ 26-19-201 to 26-19-204 (1989) (includes Section 7 from model).

PROJECT HISTORY - 2002

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION (#110)

1. Description of the project, issues addressed, etc.

The Group Coverage Discontinuance and Replacement Model Regulation incorporates requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, the amendments to the model regulation comply with a bulletin issued by the Centers for Medicare & Medicaid Services. This regulation outlines the requirements that group carriers must follow when a group health benefit plan is discontinued and replaced with a plan of similar benefits, including the extent to which the prior carrier is liable for payment of benefits. The amendments also specify the requirements that both the prior carrier and the succeeding carrier must follow with respect to disabled individuals to be enrolled in the succeeding carrier's health benefit plan.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair
Arizona
California
Delaware
District of Columbia
Florida
Hawaii
Idaho
Illinois
Indiana
Kansas
Maryland
Mississippi
Missouri
Montana
New Hampshire
New Mexico
North Carolina
Ohio
Oklahoma
Pennsylvania
South Dakota
Vermont
Virginia
Washington

3. Project authorized by what charge and date first given to the group:

The following charge was given to the Regulatory Framework (B) Task Force in 1999:

Consider the revision of NAIC model laws and regulations affected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and final federal regulations promulgated pursuant to HIPAA to comport with the requirements of HIPAA and final federal regulations.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The proposed revisions to the model regulation were drafted by the task force. Numerous interested parties participated, including insurance industry representatives, such as the American Association of Health Plans (AAHP), the Health Insurance Association of America (HIAA), and the BlueCross BlueShield Association (BCBSA); and representatives of key federal agencies, the Department of Labor (DOL) and the Centers for Medicare & Medicaid Services (CMS).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Beginning with the 2000 NAIC Winter National Meeting, drafts of the proposed revisions to the model regulation were reviewed and discussed at each National Meeting. Comments were requested throughout the drafting process. In addition, all of the drafts of the proposed revisions to the model regulation were posted on the NAIC web site.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

There were no significant issues raised during the drafting process.

COORDINATION OF BENEFITS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted and promulgated by the Commissioner of Insurance pursuant to Section [insert section] of the Insurance Code.

Section 2. Purpose

The purpose of this regulation is to:

A. Establish a uniform order of benefit determination under which plans pay claims;

B. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first; and

C. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

Section 3. Definitions

As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise:

A. (1) "Allowable expense," except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

(2) If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

(3) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(4) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

(5) The following are examples of expenses that are not allowable expenses:

(a) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(b) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(c) If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

Drafting Note: Many plans negotiate rates with physicians, hospitals and other providers that are lower than the providers' usual and customary charges using other reimbursement methodology, such as relative value schedule reimbursement or other similar reimbursement methodology. Because the provider has agreed to accept the negotiated payment, less any required deductibles, coinsurance or copayments for the services, COB is not to be used to increase the provider payment. Conversely, because the provider has agreed to accept the negotiated payment, less any required deductibles, coinsurance or copayments for the services, COB is not to be used to decrease the amount the provider has negotiated to accept in payment for the services. This provision limits COB allowable expense to the negotiated rate. Plans should include provisions in their provider contracts to account for payments under coordination of benefits.

(6) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

Drafting Note: The intent of this provision is to permit plans to limit the extent of coordination to plans with similar types of coverages or benefits, e.g., coordination of health plans with health plans or dental plans with dental plans, etc.

(7) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(8) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

(a) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

(b) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

B. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

C. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(1) Services (including supplies);

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of Paragraphs (1) and (2); or

(4) An indemnification.

D. "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

E. "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

F. "Coordination of benefits" or "COB" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

G. "Custodial parent" means:

(1) The parent awarded custody of a child by a court decree; or

(2) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

H. (1) "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

(2) "Group-type contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

I. "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

J. (1) "Hospital indemnity benefits" means benefits not related to expenses incurred.

(2) "Hospital indemnity benefits" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

K. (1) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

Drafting Note: A state may choose to allow coordination only between group plans within its COB rules. In that case, a state would need to modify Section 3K(4) to exempt certain coverages from the definition of "plan."

(2) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection. The definition of "plan" in the model COB provision in Appendix A is an example.

(3) "Plan" includes:

(a) Group and nongroup insurance contracts and subscriber contracts;

(b) Uninsured arrangements of group or group-type coverage;

(c) Group and nongroup coverage through closed panel plans;

(d) Group-type contracts;

(e) The medical care components of long-term care contracts, such as skilled nursing care;

(f) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

(g) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

(h) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(4) "Plan" does not include:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(b) Accident only coverage;

(c) Specified disease or specified accident coverage;

(d) Limited benefit health coverage, as defined in [insert reference in state law equivalent to Section 7 of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act];

(e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(f) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(g) Medicare supplement policies;

(h) A state plan under Medicaid; or

(i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

L. "Policyholder" means the primary insured named in a nongroup insurance policy.

M. "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

(1) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

(2) All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

N. "Secondary plan" means a plan that is not a primary plan.

Section 4. Applicability and Scope

This regulation applies to all plans that are issued on or after the effective date of this regulation, which is [insert date].

Section 5. Use of Model COB Contract Provision

A. Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections B, C and D and to the provisions of Section 6 of this regulation.

B. Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (2) or more plans will pay for or provide benefits.

C. The COB provision contained in Appendix A and the plain language explanation in Appendix B do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(1) Another plan exists and the covered person did not enroll in that plan;

(2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accordance with the rules permitted by this regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of Section 7 of this regulation to determine the amount it should pay for the benefit.

G. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Section 3K of this regulation.

Section 6. Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "med pay"), which is included in the definition of "plan" under Section 3K(3) of this model regulation, does not normally contain order of benefit determinations provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

(d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.

(3) Active Employee or Retired or Laid-Off Employee

(a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation, the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1) applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Section 7. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Section 8. Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Section 9. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (non-complying plan) on the following basis:

(a) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(c) If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

(2) If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

(3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Section 10. Effective Date for Existing Contracts

A. A contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by:

(1) The later of:

(a) The next anniversary date or renewal date of the contract; or

(b) Twelve (12) months following [insert date that the amended regulation is adopted]; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

B. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance pursuant to Subsection A, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.

APPENDIX A
MODEL COB CONTRACT PROVISIONS

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other

Plan does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility for **COB** administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for **COB** administration] is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B
CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and

- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

or

- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.

- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1971 Proc. I 54, 58, 208, 225, 226-230 (adopted).
1980 Proc. II 22, 26, 588, 592-593 (added section on divorced parents).
1983 Proc. I 6, 35, 644, 693, 699 (added section on laid-off and retired employees).
1984 Proc. II 9, 20, 536, 616, 625-636 (revised and added birthdate rule and reprinted).
1985 Proc. II 11, 23, 609, 615, 627-638 (adopted easy-to-read version).
1986 Proc. I 9-10, 23, 665, 673 (footnote added).
1988 Proc. I 9, 20-21, 630, 713, 715-728 (amended and reprinted).
1989 Proc. I 9, 24-25, 703-704, 839, 843-846 (amended).
1990 Proc. II 7, 16, 600, 676-677, 678-683 (amended).
1991 Proc. I 9, 17-18, 609, 648-652 (amended).
1995 Proc. 3rd Quarter 4, 18, 692, 696, 703-717 (amended and reprinted).
2004 Proc. 4th Quarter 683, 738, 739-761 (amended and reprinted, adopted by parent).
2005 Proc. 1st Quarter 48 (adopted by Plenary).
2013 Proc. 2nd Quarter 113, 127-130, 364-370 (amended).

COORDINATION OF BENEFITS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

COORDINATION OF BENEFITS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE R. 482-1-128-.01 to 482-1-128-.11; APPS. A & B (2007) (birthday rule eff. 8/29/87).	ALA. CODE § 27-1-17 (1981/2003) (includes payment of claims rules related to COB).
Alaska			ALASKA STAT. § 21.42.205 (1997) (authority to adopt regulations).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. ADMIN. CODE R. 20-6-214 (1979/2007) (birthday rule eff. 1-1-87).
Arkansas			ARK. ADMIN. CODE 054.00.21-1 to 054.00.21-7 (1988) (birthday rule eff. 1-13-86).
California			CAL. CODE REGS. tit. 10, §§ 2232.52 to 2232.59 (1975/1986) (birthday rule eff. 1-1-87).
Colorado	3 COLO. CODE REGS. § 702-4:4-6-2 (2010/2018).		
Connecticut		CONN. AGENGIES REGS. 38A-480-1 to 38A-480-7 (1988) (birthday rule eff. 4-1-88).	CONN. GEN. STAT. § 38a-546 (1958/2011); BULLETIN 6-20-2008 (2008).

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware		18 DEL. ADMIN. CODE §§ 1307-1.0 to 1307-8.0; App. A (1988/2007) (birthday rule eff. 10-26-88).	
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.4235 (1974/1992) (birthday rule eff. 10-1-85) (different coordination rule for Medicare beneficiaries).
Georgia		GA. COMP. R. & REGS. 120-2-48 (1991) (birthday rule eff. 1-1-91).	
Guam			10 GUAM CODE ANN. §§ 95100 to 95105 (2018).
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO ADMIN. CODE R. 18.04.15 (2013).		
Illinois	ILL. ADMIN. CODE. tit. 50, §§ 2009.10 to 2009.60; Ex. A (1988/2015) (portions of model).		
Indiana		760 IND. ADMIN. CODE 1-38.1-1 to 1-38.1-22 (1990) (birthday rule eff. 7-1-88).	
Iowa		IOWA ADMIN. CODE R. 191-38.12 to 191-38.19 (2005) (birthday rule eff. 4-15-87).	
Kansas	KAN. ADMIN. REGS. § 40-4-34 (1981/2016) (incorporated by reference).		
Kentucky			806 KY. ADMIN. REGS. 18:030 (1987/2018) (birthday rule eff. 1-1-87).

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.301 to XIII.325 (Regulation 32) (1971/2016).		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2723-A (1999/2005); tit. 24, § 2332-A; tit. 24-A, § 2844 (1991/1998); 02-031 ME CODE R. 790 (2004).
Maryland			MD. CODE ANN., INS. § 15-104 (1983/1997).
Massachusetts	211 MASS. CODE REGS. §§ 38.01 to 38.10 (2017).		
Michigan			MICH. COMP. LAWS §§ 550.251 to 550.254 (1984/1996) (birthday rule eff. 4-1-85).
Minnesota			MINN. R. §§ 2742.0100 to 2742.0500 (1986) (birthday rule eff. 7-4-87); § 4685.0950 (1989) (applies to HMOs) (birthday rule eff. 10-9-89); MINN. STAT. § 62A.046 (1990/2010).
Mississippi			19 CODE MISS. R. Pt. 3, R. 7.01 (2012).
Missouri		MO. CODE REGS. ANN. tit. 20, § 400-2.030 (1991) (birthday rule eff. 1-1-86).	
Montana		MONT. ADMIN. R. 6.6.2401 to 6.6.2411 (1987/2013) (birthday rule eff. 10-16-87).	
Nebraska	210 NEB. ADMIN. CODE § 39 (2016).		
Nevada			NEV. REV. STAT. §§ 689B.063 to 689B.064 (1987) (birthday rule eff. 7-1-87).
New Hampshire		N.H. ADMIN. R. ANN. INS. 1904 (1986/2005) (birthday rule eff. 2-22-87).	

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey			N.J. ADMIN. CODE §§ 11:4-28.1 to 11:4-28.12 (1988/2002) (birthday rule eff. 10-17-88); §§ 11:3-37.1 to 11:3-37.14 (1991) (coordination with auto).
New Mexico			N.M. CODE R. § 6.50.9 (2014).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, § 52.23 (REGULATION 62) (1987/2009) (birthday rule eff. 1-15-87); N.Y. INS. LAW § 3224-c (2009).
North Carolina			11 N.C. ADMIN. CODE § 12.0514 (1978/1992) (birthday rule eff. 7-1-86).
North Dakota		N.D. ADMIN. CODE §§ 45-08-01.2 to 45-08-01.2-07; APPS. A & B (2006) (birthday rule eff. 7-1-85).	N.D. CENT. CODE § 26.1-18.1-25 (1971/1983) (HMOs); § 26.1-36-10 (1985/1993) (allows coordination with individual policies).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3902.11 to 3902.14 (1988/1991) (birthday rule eff. 6-29-88); OHIO ADMIN. CODE § 3901-8-01 (2008); BULLETIN 90-6 (1990).
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-11-1 to 365:10-11-11 (1985/2015) (birthday rule eff. 1-1-87).	
Oregon	OR. ADMIN. R. §§ 836-020-0770 to 836-020-0806 (2006/2014).		
Pennsylvania			40 PA. STAT. ANN. § 981-6 (1998).
Puerto Rico	NO CURRENT ACTIVITY		

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	230 R.I. CODE R. 20-30-2.1 to 20-30-2.10 (2018).		27 R.I. GEN. LAWS ANN. §§ 27-20.6-1 to 27-20.6-6 (1998).
South Carolina		S.C. CODE ANN. REGS. 69-43 (1990) (previous version of model) (birthday rule eff. 5-24-90).	
South Dakota	S.D. CODIFIED LAWS §§ 58-18A-53 to 58-18A-83 (2006/2015) (portions of model).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-53 (1987/2007).		MEMORANDUM 5-3-90 (1990) (HMOs).
Texas	28 TEX. ADMIN. CODE §§ 3.3501 to 3.3510 (1985/2014) (birthday rule eff. 1-1-87).		TEX. INS. CODE ANN. §§ 1203.002 to 1203.003 (2005) (may not coordinate with supplemental policies).
Utah		UTAH ADMIN. CODE R590-131 (2007/2008) (birthday rule eff. 1-1-87).	UTAH CODE ANN. § 31A-22-619 (1989/2009); BULLETIN 89-4 (1989); BULLETIN 91-1 (1991).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-3405 (1986/1995) (allows coordination between two health insurance plans); § 38.2-3543.1 (1994) (authority to adopt regulation); § 38-2.-3407.13:1 (2000) (requires notice in individual or group plans that intend to coordinate benefits).
Washington		WASH. ADMIN. CODE 284-51-190 to 284-51-260 (2007/2011).	

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia		W.VA. CODE R. §§ 114-28-1 to 114-28-8 (1991/2010) (birthday rule eff. 8-1-91).	
Wisconsin			WIS. ADMIN. CODE INS. 3.40 (1987/2014) (birthday rule eff. 7-1-86).
Wyoming			WYO. STAT. ANN. § 26-34-133 (1995) (HMOs).

PROJECT HISTORY - 2013

COORDINATION OF BENEFITS MODEL REGULATION (#120)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Coordination of Benefits Model Regulation* (#120) were made to address issues related to medical benefits (med pay) coverage in automobile "no fault" and traditional automobile "fault" type contracts and, as provided in Section 2714 of the federal Public Health Services Act (PHSA), as amended by the federal Affordable Care Act (ACA), the extension of dependent coverage to age 26. The revisions also make it clear that dental coverage is considered a "plan" under the model for purposes of ensuring that a coordination of benefits provision can be included in such coverage and therefore, subject to coordination, which is particularly important given that pediatric dental is an essential benefit under the ACA and might be subject to new cost-sharing limitations. Adoption of these changes will help ensure that a state's coordination of benefits requirements is consistent with the ACA.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force was responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair; Idaho, Vice Chair; Arizona; California; Colorado; Connecticut; District of Columbia; Florida; Illinois; Indiana; Kansas; Kentucky; Maine; Massachusetts; Minnesota; Montana; Nebraska; New Jersey; Ohio; Oklahoma; Oregon; Pennsylvania; Tennessee; Utah; Virginia; Washington; West Virginia; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force was given a charge in 2012 to: review and revise, as necessary, the *Coordination of Benefits Model Regulation* (#120) to address issues related to medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts and, as provided in section 2714 of the Public Health Service Act (PHSA), the extension of dependent coverage to age 26. *Important*

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The revisions were drafted by the Regulatory Framework (B) Task Force, which developed three drafts of proposed revisions to Model #120 prior to its adoption. The Task Force discussed the drafts and the comments received on the drafts at the 2012 Spring National Meeting, 2012 Summer National Meeting, 2012 Fall National Meeting and 2013 Spring National Meeting. All drafts and comments were posted on the Task Force's Web page. Numerous interested parties participated in the drafting process, including consumer representatives and industry representatives.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The Regulatory Framework (B) Task Force discussed the drafts and comments received on them during person-to-person meetings at the 2012 Spring National Meeting, 2012 Summer National Meeting, 2012 Fall National Meeting and 2013 Spring National Meeting. All drafts and comments were posted on the Task Force's Web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2004

COORDINATION OF BENEFITS MODEL REGULATION (#120)

1. Description of the project, issues addressed, etc.

The amendments to the NAIC Group Coordination of Benefits Model Regulation revise the model to reflect changes in the health care delivery system since the model was last revised in 1995. The revisions also make the model easier to implement and understand by eliminating unused provisions and rewording esoteric language.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair

Arkansas	Nebraska
California	Nevada
Colorado	New Hampshire
Delaware	New Mexico
Florida	North Carolina
Idaho	Rhode Island
Iowa	South Dakota
Kansas	Vermont
Louisiana	Virginia
Maine	West Virginia

3. Project authorized by what charge and date first given to the group:

The following charge given in January 2002: Review and revise the Group Coordination of Benefits Model Regulation to reflect the changes in health care delivery systems since the model was adopted.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the task force and former members of the Coordination of Benefits Working Group.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of proposed revisions to the COB model was circulated by email to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments on each draft. The task force and former members of the Coordination of Benefits Working Group reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the process and the group's response.

There were two controversial issues: (1) whether to revise the model to permit individual-to-group plan coordination; and (2) whether to delete the benefit reserve provision. On the first issue, after extensive discussion of the pros and cons of permitting such coordination, the task force decided to revise the model regulation to permit individual-to-group plan coordination. Those in favor of permitting such coordination based their reasoning on the idea that an individual should not be able to profit from filing claims under both the individual and group policy. This can happen when individual-to-group plan coordination is not permitted. Those opposed to this revision stated that because consumers paid the premium on both policies, they should be able to reap the benefit even if it permitted double-dipping.

With respect to the second issue, those in favor of eliminating the benefit reserve provision argued that only a handful of states have the provision in their COB laws. One reason for this is that the benefit reserve is too difficult and too costly to administer. In those states that require the benefit reserve, few health carriers have been able to consistently apply it correctly. Those arguing in favor of retaining the provision reminded everyone that the reason for requiring the benefit reserve. Requiring the benefit reserve helped to ensure that the covered person is covered 100% for all allowable expenses, including deductibles and copayments. After considering these arguments, the task force voted to delete the provision. Given the cost of administering the provision and the possible benefit to the consumer, the task force decided that the administrative cost of administering the benefit reserve outweighed any possible benefit.

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Small Group Market Health Insurance Coverage Model Act ("Act"). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the small group market and provide for the establishment of coverage and other benefit requirements in the small group market.

Section 2. Definitions

As used in this regulation:

A. "Actuarial Value" or "AV" means the percentage paid by a health benefit plan of the total allowed costs of benefits.

B. "Annual open enrollment period" means the period each year during which a small employer, eligible employee or covered person may enroll or change coverage in a health benefit plan.

C. "CMS" means the federal Centers for Medicare and Medicaid Services.

D. (1) "Cost-sharing" means any expenditure required by or on behalf of a covered person with respect to essential health benefits.

(2) "Cost-sharing" includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

E. "EHB-benchmark plan" means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.

F. "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

G. "HHS" means the U.S. Department of Health and Human Services.

H. (1) "Health factor" means, in relation to any individual, any of the following health status-related factors:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care services;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including:

(i) Conditions arising out of acts of domestic violence; or

(ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or

(h) Disability.

(2) For purposes of this subsection, "health factor" does not include the decision whether to elect small group market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.

I. "Late enrollee" means an individual whose enrollment in a health benefit plan is a late enrollment.

J. "Late enrollment" means enrollment of an individual in a health benefit plan providing small group market health insurance coverage other than the earliest date on which coverage can be effective for the individual under the terms of the plan other than through a special enrollment period.

K. "Minimum essential coverage" has the meaning stated in Section 5000A(f) of the Internal Revenue Code (Code).

L. "Percentage of the total allowed costs of benefits" means the anticipated covered medical spending for EHB coverage, as defined in Section 3L of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

M. "Plan" means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in Section 1302(d) and (e) of the Federal Act, and service area. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.

N. "Plan year" means the year that is designated as the plan year in the plan document of a health benefit plan providing small group market health insurance coverage, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and the policy is not renewed on a yearly basis, the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

O. "Product" means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type (e.g. HMO, PPO, EPO, POS or indemnity) within a geographic service area.

P. "Special enrollment period" means a period during which an eligible employee or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the annual open enrollment periods.

Q. "Wellness program" means a program of health promotion or disease prevention.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing small group market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

A. The premium rate charged by a health carrier offering a health benefit plan providing small group market health insurance coverage, in accordance with Section 5 of this regulation, may vary only, with respect to the particular coverage involved, on the basis of the following:

(1) Whether the plan covers an individual or family:

(a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), the total family premium shall include only the premiums for all covered family members over the age of twenty-one (21) and the three (3) oldest covered children under the age of twenty-one (21);

(b) For family coverage, any rating premium variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(2), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Subparagraphs (a) and (b) of this paragraph, but only if the state does not permit any rating variation for age and tobacco use as described in Paragraphs (3) and (4). If the state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Subparagraphs (a) and (b) of this paragraph will apply in that state.

(c) The total premium charged to the small group is determined by summing the premiums of covered persons in accordance with Subparagraphs (a) and (b) of this paragraph, or for a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4), the methodology established by the state for calculating total premium; and

Drafting Note: States should be aware that the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule (79 FR 13743) published in the *Federal Register* March 11, 2014, provides in 45 CFR §147.102(c)(3) that a state may require a health carrier to offer, or a health carrier may voluntarily offer, to a small employer group premiums that are based on the average covered amounts provided the total small employer group premium is the same total amount derived in accordance with Subparagraphs (a) and (b) of this paragraph or determined using the methodology to calculate premium established by a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4). If a state requires a health carrier to offer, or a health carrier decides to voluntarily offer, small employer group premiums that are based on the average covered person amounts or a health carrier voluntarily offers such premiums, then effective for plan years beginning on or after Jan. 1, 2015, the health carrier must comply with the additional requirements found in 45 CFR §147.102(c)(3)(iii).

(2) (a) (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Item (ii) of this subparagraph; and

(ii) The commissioner may adopt regulations establishing uniform geographic rating area subject to the provisions of 45 CFR §147.102(b); and

Drafting Note: States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this paragraph, such as Item (iii).

Drafting Note: States should be aware that 45 CFR §147.102(b) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state's geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

(b) For purposes of this paragraph, geographic rating area is to be determined in the small group market using the small employer's principal business address;

(3) Age:

(a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);

(b) The rate for each covered person must be based on the covered person's age as of the date of plan issuance, renewal or addition to the plan;

(c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and

(d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:

(i) A single age band for individuals age 0 through 20;

(ii) One-year age bands for individuals age 21 through 63; and

(iii) A single age band for individuals age 64 and older; and

Drafting Note: States should be aware that 45 CFR §147.102(e) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(4) Subject to Section 2705 of the Public Health Service Act (PHSA) and its implementing regulations (related to prohibiting discrimination based on health status and programs of health promotion or disease prevention), tobacco use:

(a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;

(b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;

(c) A rating charge for "tobacco use" may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and

(d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider "tobacco use" in terms of when a tobacco product was last used.

Drafting Note: The reference to Section 2705 of the PHSA in the introductory language for this paragraph is meant to reflect the requirement that a health carrier can only impose a rating surcharge for tobacco use if the carrier has a wellness program that offers a tobacco cessation program in which covered persons may participate.

Drafting Note: States may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this regulation as provided in Paragraph (4) above.

B. A premium rate may not vary with respect to a particular coverage by any other factor not described in Subsection A.

C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 5. Single Risk Pool

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must consider the claims experience of all covered persons in all health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the small group market in a state, including covered persons who do not enroll in such plans through the exchange, to be members of a single risk pool.

Drafting Note: As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

B. (1) (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the small group market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.

(b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).

(c) The premium rate for all of the health carrier's plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).

(2) For plan years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(a) The actuarial value and cost-sharing design of the plan;

(b) The plan's provider network, delivery system characteristics and utilization management practices;

(c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits; and

(d) Administrative costs, excluding exchange user fees.

(3) (a) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually, except as provided in Subparagraph (b) of this paragraph.

(b) Beginning the quarter after HHS issues notification that the federally-facilitated Small Business Health Options Program (SHOP), as that term is defined in 45 CFR §155.20, can process quarterly rate updates, a health carrier in the small group market (not including a merged market) may establish index rates and make the market-wide adjustments pursuant to Paragraph (1), and make the plan-level adjustments pursuant to Paragraph (2), no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1 or October 1.

C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 6. Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods

A. Subject to Subsections B through D and Section 6 of the Act, a health carrier offering a health benefit plan providing small group market health insurance coverage must offer to any small employer in the state all products that are approved for sale in the small group market and must accept any small employer that applies for coverage under any of those products.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for network plans, limited financial capacity, etc.) to guaranteed availability of coverage can be found in Section 6 of the *Small Group Market Health Insurance Coverage Model Act* (#106). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

C. (1) Subject to Paragraph (2), a health carrier must allow a small employer to purchase health insurance coverage at any point during the year.

(2) A health carrier may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as provided in Section 6D of the Act and Section 7B(3) of this regulation, and pursuant to applicable state law.

D. (1) A health carrier must establish special enrollment periods for qualifying events consistent with the requirements of Section 9 of the Act and as defined under section 603 of ERISA. These special enrollment periods are in addition to any other special enrollment periods required under state or federal law.

(2) In addition to the provisions of Paragraph (1), a health carrier must permit an individual within a group, who is otherwise eligible to enroll, to enroll in a health benefit plan when:

(a) The individual is enrolled in a health benefit plan that is a network plan that does not provide benefits to individuals who no longer reside, live or work in the service area and the individual loses coverage under the plan because the individual no longer resides, lives or works in the service area; and

(b) The individual is enrolled in a health benefit plan that no longer offers any benefits to the class of similarly situated individuals, as described in Section 10C of this regulation that includes the individual.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow individuals to purchase coverage more frequently than the federal minimum requirements.

E. (1) A health carrier must provide covered persons thirty (30) days after the date of the qualifying event described in Subsection D to elect coverage.

(2) (a) The health carrier must offer to special enrollees all of the benefit packages available to similarly situated individuals who enroll when first eligible for coverage and may not require a special enrollee to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible for coverage.

(b) Any difference in benefits or cost-sharing requirements for different individuals is a different benefit package.

(3) The coverage must become effective consistent with the following based on when the health carrier receives the election:

(a) Between the first and fifteenth day of any month, the health carrier must ensure a coverage effective date of the first day of the following month; and

(b) Between the sixteenth and the last day of any month, the health carrier must ensure a coverage effective date of the first day of the second following month.

F. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed availability provisions under section 2711 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 7. Guaranteed Renewability of Small Group Market Health Insurance Coverage

A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a health benefit plan providing small employer market health insurance coverage subject to the Act must renew or continue in force the coverage at the option of the small employer.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for product discontinuation, market exit, loss of association membership, etc.) to guaranteed renewability of coverage can be found in Section 7 of the *Small Group Market Health Insurance Coverage Model Act* (#106). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:

(1) The plan sponsor has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

(3) The plan sponsor has failed to comply with a material provision related to employer contribution or group participation requirements, pursuant to applicable state law. For purposes of this paragraph the following apply:

(a) The term "employer contribution requirement" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and employee dependents; and

(b) The term "group participation requirement" means a requirement relating to the minimum number of employees or employee dependents that must be enrolled in relation to a specified percentage or number of eligible employees of a small employer;

(4) The carrier is ceasing to offer coverage in the market in accordance with section 7D (discontinuing a particular product) or section 7E (discontinuing all coverage) of the Act and applicable state law; or

(5) For network plans, there is no longer any employee who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business) using the same criteria under which the carrier would deny enrollment in the plan under Section 6E of the Act.

C. (1) At the time of coverage renewal only, a health carrier may modify the health insurance coverage for a product offered in the small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with federal or state law and is effective uniformly among small group market health insurance plans with that product.

(2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state requirements is considered a uniform modification of coverage if:

(a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

(b) The modification is directly related to the imposition or modification of the federal or state requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the small group market health insurance coverage for the product meets all of the following criteria:

(a) The product is offered by the same health carrier, as that term is defined in section 3B of the Act;

(b) The product is offered as the same product network type;

(c) The product continues to cover at least a majority of the same service area;

(d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in section 1302(d) and (e) of the Federal Act; and

(e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in Section 5B of this regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(e)(4) permits a state to broaden the standards described in Paragraph (3)(c) and (d) above.

D. If a health carrier is renewing small group market health insurance coverage as described in Subsection A, or uniformly modifying coverage as described in Subsection C, the health carrier must provide to each plan sponsor written notice of the renewal at least sixty (60) calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

E. In the case of group health insurance coverage that is made available by a health carrier in the small group market to small employers only through one or more associations, the reference to "plan sponsor" is deemed, with respect to coverage provided to a small employer member of the association, to include a reference to the small employer.

F. Nothing in this section should be construed to require a health carrier to renew or continue in force small group market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.

G. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under section 2712 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition on Waiting Periods Exceeding Ninety (90) Days

A. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may not apply any waiting period longer than ninety (90) days.

(2) (a) A health carrier may not consider the period before an individual's late or special enrollment date a waiting period.

(b) (i) If an individual loses eligibility for coverage under the health benefit plan and subsequently becomes eligible for coverage, a health carrier may only consider the individual's most recent period of eligibility in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage.

(ii) Similarly, a health carrier must apply the provisions of Item (i) to an individual who becomes eligible for coverage under the health benefit plan after a suspension of coverage that applied generally under the plan.

B. (1) (a) Except as provided in Paragraphs (2) and (3), an individual is otherwise eligible to enroll under the terms of a health benefit plan if the individual has met the plan's substantive eligibility conditions, such as being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms or satisfying a reasonable bona fide employment-based orientation period.

(b) A plan sponsor is not required to offer small group market health insurance coverage to any particular individual or class of individuals despite the individual being otherwise eligible to enroll under the plan, but individuals otherwise eligible for coverage under the plan may not be required to wait more than ninety (90) days before coverage is effective.

(2) Conditions of eligibility to enroll for coverage under the terms of a health benefit plan may be based solely on the lapse of a time period, but only for a time period of no more than ninety (90) days.

(3) (a) Other conditions of eligibility to enroll for coverage under the terms of a health benefit plan are permitted unless the condition is designed to avoid compliance with this section as determined in accordance with the following provisions:

(i) Subject to Subparagraph (b) of this paragraph, if eligibility is based on an employee having a specified number of hours of service per pay period, or working full-time, and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period, or work full-time, the terms of the health benefit plan may allow a reasonable period of time, not to exceed twelve (12) months and beginning on any date between the employee's employment start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition; or

(ii) If eligibility is based on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.

(b) Except for cases in which the health benefit plan imposes a waiting period exceeding a 90-day period in addition to a measurement period, as described in Subparagraph (a)(i) of this paragraph, the time period for determining whether the employee meets the plan's eligibility requirements will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no more than thirteen (13) months after the employee's employment start date plus the time remaining until the first day of the next calendar month if the employee's employment start date is not the first day of a calendar month.

(c) (i) To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month.

(ii) For purposes of Item (i), one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position otherwise eligible for small group market health insurance coverage under the health benefit plan.

C. The health carrier may treat an employee whose employment has terminated and then rehired as newly eligible to enroll for coverage upon rehire and, therefore, required to meet the health benefit plan's eligibility requirements and waiting period anew, if reasonable under the circumstances and the termination and rehiring is not used or designed as a subterfuge to avoid compliance with the 90-day waiting period limitation.

D. (1) Under this section, all calendar days are counted beginning on the enrollment date, including weekends and holidays.

(2) For administrative convenience, a health carrier that imposes a 90-day waiting period may choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

E. A health carrier satisfies the requirements of this section if, under the terms of the health benefit plan, an individual employee can elect coverage that begins on a date before the end of a 90-day waiting period and may not be considered in violation of this section if an individual employee takes, or is permitted to take, additional time beyond any 90-day waiting period to elect coverage.

F. A health carrier that relies on the eligibility information reported to it by the small employer will not be considered to violate the requirements of this section with respect to the carrier's administration of any waiting period if the following is satisfied:

(1) The carrier requires the small employer to make a representation and update this representation with any changes regarding the terms of any eligibility conditions or waiting periods imposed before an individual is eligible for coverage under the health benefit plan; and

(2) The carrier has no specific knowledge of a waiting period imposed that exceeds the permitted 90-day period.

Section 9. Prohibition of Preexisting Condition Exclusions

A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.

Section 10. Prohibition on Discrimination Based on Health Factors

Drafting Note: The Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments) published joint final regulations implementing the HIPAA nondiscrimination and wellness provisions Dec. 13, 2006, at 71 FR 75014 (the 2006 regulations). These regulations implemented the provisions of Section 2702 of the Public Health Service Act (PHSA), as enacted by HIPAA, which generally prohibited group health plans and group health insurance issuers from discriminating against individual employees and their dependents in eligibility, benefits or premiums based on a health factor. These regulations, however, permitted group health plans and group health insurance issuers to establish certain rules which, under the ACA, are no longer permitted. One example of such rules is a provision in the 2006 regulations permitting group health plans and group health insurance issuers to impose preexisting condition exclusions (with some limitations) for the group market. Because such provisions from the 2006 regulations are no longer permitted due to the ACA, they have not been included in this section. However, states should be aware that they may want to somehow retain these provisions for purposes of continued enforcement related to grandfathered health plan coverage and some group health benefit plan coverage with plans years that extend into 2014 (and possibly additional years, as permitted). States also should be beware that the ACA retained provisions from Section 2702 of the PHSA, now Section 2705 of the PHSA, as enacted by Section 1201 the ACA. For the group market only, this section provides for a general exception to the prohibition on discrimination based on a health factor to allow premium discounts or rebates and modification to otherwise applicable cost sharing, including copayments, deductibles or coinsurance, in return for adherence to certain programs of health promotion and disease prevention. States also should be aware that Section 2705 of the PHSA also extends the HIPAA nondiscrimination protections to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market.

A. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an employee to enroll for benefits under the plan that discriminates based on any health factor that relates to the employee or dependent of the employee.

(2) For purposes of this section, a rule of eligibility includes a rule relating to:

(a) Enrollment;

(b) The effective date of coverage;

(c) Waiting or affiliation periods;

(d) Late and special enrollment;

(e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;

(f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);

(g) Continued eligibility; and

(h) Terminating coverage, including disenrollment, of an individual under the plan.

(3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.

B. (1) (a) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not require an employee, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution rate that is greater than the premium or contribution rate for a similarly situated individual enrolled in the plan based on any health factor that relates to the employee or a dependent of the employee.

(b) In determining an individual employee's premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.

(2) (a) Subject to Subparagraph (b) of this paragraph, nothing in this subsection restricts the aggregate amount that a health carrier may charge a small employer for coverage under a plan.

(b) A health carrier may not quote or charge a small employer or an individual employee or dependent of an employee a different premium than that quoted or charged an individual employee in a group of similarly situated individuals based on a health factor unless permitted under Paragraph (3) or under Section 4 of this regulation.

(3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may establish a premium or contribution differential based on whether an individual has complied with the requirements of a wellness program that satisfies the requirements of Subsection E.

C. (1) (a) Subject to federal or state law or regulations and Subparagraph (b) of this paragraph, Subsection A does not require a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act to provide coverage for any particular benefit to any group of similarly situated individuals.

(b) (i) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all similarly situated individuals, as those groups are determined under Paragraph (2).

(ii) For any restriction on a benefit or benefits provided under a plan, the health carrier:

(I) Shall apply the restriction uniformly to all similarly situated individuals; and

(II) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at individual employees or dependents of employees based on any health factor of the individual employee or a dependent of the individual employee.

(iii) The health carrier may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:

(I) Applies uniformly to all similarly situated individuals;

(II) Is not directed at individual employees or dependents of individual employees based on any health factor of the individual employee or dependent of an individual employee; and

(III) Does not apply to preventive services specified in Section 2713 of the Public Health Service Act (PHSA).

(iv) For purposes of this paragraph, a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual employee or dependent of an individual employee.

(c) If the health carrier generally provides benefits for a type of injury, the health carrier may not deny an individual employee or dependent of an employee benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury

(d) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual employee, based on a health factor of that individual employee or dependent of the individual employee, than for a similarly situated individual under the plan, does not violate this subsection if the payment differential is based on whether the individual has complied with the requirements of a wellness program that satisfies the requirements of Subsection E.

(2) (a) This paragraph applies only within a group of individuals who are treated as similarly situated individuals.

(b) (i) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act from treating dependents of employees as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among groups of dependents is based on a bona fide employment-based classification that is consistent with the small employer's usual business practice.

(ii) Whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.

(iii) For purposes of Item (ii), relevant facts and circumstances include whether the small employer uses the classification for purposes independent of qualification for health insurance coverage, such classifications may include:

(I) Full-time versus part-time status;

(II) Geographic location;

(III) Membership in a collective bargaining unit;

(IV) Date of hire;

(V) Length of service;

(VI) Current employee versus former employee status; and

(VII) Occupation.

(iv) A classification based on a health factor may not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Subsection A(3) and Subsection B(3) are satisfied.

(c) (i) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act from treating dependents of individual employees as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups is based on any of the following factors:

(I) A bona fide employment-based classification of the individual employee through whom the dependent is receiving coverage;

(II) Relationship to the individual employee (e.g., as a spouse or as a dependent child);

(III) Marital status;

(IV) With respect to a dependent child of the individual employee, age or student status to the extent that such treatment does not conflict with the requirements of section 2714 of the PHSA; or

(V) Any other factor, if the factor is not a health factor.

(ii) Item (i) may not be construed to prevent the health carrier from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Subsection A(3) and Subsection B(3).

(d) Notwithstanding Subparagraphs (b) and (c) of this paragraph, unless permitted under Subsection A(3) or Subsection B(4), if the creation or modification of an employment or coverage classification is directed at individual employees or dependents of individual employees based on a health factor of an individual employee or a dependent of an individual employee, the classification is not permitted under this subsection.

D. (1) Except to the extent permitted under Paragraph (2)(b) or Paragraph (3), in accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual employee's premium or contribution rate based on:

(a) Whether the individual employee is confined in a hospital or other health care institution; or

(b) The individual employee's ability to engage in normal life activities.

(2) (a) In accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule for eligibility or set an individual's premium or contribution rate based on whether the individual is actively-at-work, including whether the individual is continuously employed, unless absence from work due to any health factor is treated, for purposes of the plan, as being actively-at-work.

(b) Notwithstanding Subparagraph (a) of this paragraph, the health carrier may establish a rule for eligibility that requires an individual to begin work for the small employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.

(3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may establish a rule of eligibility or set an individual's premium or contribution rate with respect to similarly situated individuals, as those groups are determined under Subsection C(2).

E. (1) For purposes of this subsection, the following terms have the meanings indicated:

(a) (i) "Activity-only wellness program" means a health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but does not require the individual to attain or maintain a specific health outcome.

(ii) Examples of an "activity-only wellness program" include walking, diet or exercise programs, which some individuals may be unable to participate or complete (or have difficulty participating or completing) due to a health factor, such as severe asthma, pregnancy or a recent surgery.

(b) (i) "Health-contingent wellness program" means a wellness program that requires an individual to:

(I) Satisfy a standard related to a health factor to obtain a reward; or

(II) Undertake more than a similarly situated individual based on a health factor in order to obtain the same reward.

(ii) "Health-contingent wellness program" includes a wellness program that is an activity-only wellness program or an outcome-based wellness program.

(c) (i) "Outcome-based wellness program" means a health-contingent wellness program that requires an individual to attain or maintain a specific health outcome, such as not smoking or attaining certain results on biometric screenings, in order to obtain a reward.

(ii) To comply with this subsection, an "outcome-based wellness program" typically has two tiers:

(I) For individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program; and

(II) If a measurement, test or program screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified conditions or risk factors, including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index or high glucose level, and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range or at risk to take additional steps, such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program or complying with a health care provider's plan of care, to obtain the same reward, the program is an outcome-based wellness program and is subject to the requirements of Paragraph (5) for health-contingent wellness programs that are outcome-based wellness programs.

(d) (i) "Participatory wellness program" means a wellness program that:

(I) Does not base any condition for obtaining an award on an individual satisfying a standard that is related to a health factor; or

(II) Does not provide a reward.

(ii) Examples of "participatory wellness program" include:

(I) A program that reimburses employees for all or part of the cost for membership in a fitness program;

(II) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;

(III) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a health benefit plan for the costs of, for example, prenatal care or well-baby visits;

(IV) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking;

(V) A program that provides a reward to employees for attending a monthly, no-cost health education seminar; and

(VI) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action, educational or otherwise, required by the employee with regard to the health issues identified as part of the assessment.

(e) (i) Except where expressly provided otherwise, references in this section to an individual obtaining a "reward" include both obtaining a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and avoiding a penalty, such as the absence of a premium surcharge or other financial or nonfinancial disincentive.

(ii) Except where expressly provided otherwise, references in this section to a health benefit plan providing a "reward" include both providing a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and imposing a penalty, such as a premium surcharge or other financial or nonfinancial disincentive.

(2) Subsection B(3) and Subsection C(2)(c) provide exceptions to the general prohibition against discrimination based on a health factor for a health benefit plan that varies benefits, including cost-sharing mechanisms, or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this subsection.

(3) A participatory wellness program, as defined in Paragraph (1)(d), does not violate the provisions of this section only if participation in the program is made available to all similarly situated individuals, regardless of health status.

(4) A health-contingent wellness program that is an activity-only wellness program, as defined in Paragraph (1)(a), does not violate the provisions of this section only if all of the following requirements are satisfied:

(a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year;

(b) (i) The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage provided in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled.

(ii) For purposes if this subparagraph, the cost of coverage is determined based on the total amount of employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;

(c) (i) The program must be reasonably designed to promote health or prevent disease.

(ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:

(I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and

(II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;

(d) (i) The full reward under the activity-only wellness program must be available to all similarly situated individuals.

(ii) Under this subparagraph, a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

(I) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, is it medically inadvisable to attempt to satisfy the otherwise applicable standard.

(iii) While a carrier is not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either Item (ii)(I) or (II), a reasonable alternative standard must be furnished by the carrier upon the individual's request or the condition for obtaining the reward must be waived;

(iv) All of the facts and circumstances are taken into account in determining whether a carrier has furnished a reasonable alternative standard, including but not limited to the following:

(I) If the reasonable alternative standard is completion of an educational program, the carrier must make the educational program available or, instead of requiring the employee to find such a program unassisted, assist the employee in finding such a program, and may not require an individual to pay for the cost of the program;

(II) The time commitment required must be reasonable;

(III) If the reasonable alternative standard is a diet program, the carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and

(IV) If an individual's personal physician states that a plan standard, including, if applicable, the recommendations of the plan's medical professional, is not medically appropriate for that individual, the carrier must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations;

(v) (I) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this paragraph in the same manner as if it were an initial program standard.

(II) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of Paragraph (5), including Paragraph (5)(d)(iv);

(vi) If reasonable under the circumstances, a carrier may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. Carriers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request; and

(e) The carrier must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in Paragraph (7) of this subsection.

(5) A health-contingent wellness program that is an outcome-based wellness program, as defined in Paragraph (1)(c), does not violate the provisions of this subsection only if all of the following are satisfied:

(a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year;

(b) (i) The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage, as defined in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents of the employee are enrolled;

(ii) For purposes of this subparagraph, the cost of coverage is determined based on the total amount of small employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;

(c) (i) The program must be reasonably designed to promote health or prevent disease;

(ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:

(I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and

(II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;

(iii) To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test or screening that is related to a health factor, as explained in Subparagraph (d) of this paragraph;

(d) (i) The full reward under the outcome-based wellness program must be available to all similarly situated individuals;

(ii) Under this subparagraph, a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test or screening, as described in this subparagraph;

(iii) While health carriers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in Item (ii), a reasonable alternative standard must be furnished by the carrier upon the individual's request or the condition for obtaining the reward must be waived;

(iv) All of the facts and circumstances are taken into account in determining whether a health carrier has furnished a reasonable alternative standard, including but not limited to the following:

(I) If the reasonable alternative standard is the completion of an educational program, the health carrier must make the educational program available or, instead of requiring an employee to find an educational program unassisted, assist the employee in finding such a program and may not require the employee to pay for the cost of the program;

(II) The time commitment required must be reasonable;

(III) If the reasonable alternative standard is a diet program, the health carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and

(IV) If an individual's personal physician states that a plan standard, including, if applicable, the recommendations of the plan's medical professional, is not medically appropriate for that individual, the health carrier must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Health carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations;

(v) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of Paragraph (4) in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this paragraph, subject to the following special rules:

(I) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances; and

(II) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the carrier, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness;

(vi) (I) It is not reasonable to seek verification, such as a statement from an individual's personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard;

(II) However, if a health carrier provides an alternative standard to otherwise applicable measurement, test or screening that involves an activity that is related to a health factor, then the rules of Paragraph (4) for activity-only wellness programs apply to that component of the wellness program and the health carrier may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity or it is medically inadvisable to attempt to perform or complete the activity; and

(e) The health carrier must disclose in all plan materials describing the terms of an outcome-based wellness program the availability of a reasonable alternative standard to qualify for the reward and, in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in Paragraph (7).

(6) (a) For purposes of this subsection, the applicable percentage is thirty (30) percent, except that the applicable percentage is increased by an additional twenty (20) percentage points to fifty (50) percent to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.

(b) The rules of this paragraph are illustrated in examples found in 45 CFR 146.121(f)(5).

(7) The following language, or substantially similar language, can be used to satisfy the notice requirement of Paragraphs (4) and (5):

"Your health benefit plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

Section 11. Essential Health Benefits Package

A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:

(1) Are substantially equal to the EHB-benchmark plan including:

(a) Covered benefits;

(b) Limitations on coverage including coverage of benefit amount, duration and scope; and

(c) Prescription drug benefits that meet the requirements of Section 10 of this regulation;

(2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;

(4) Include preventive health services, as provided in Section 14 of the Act;

(5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:

(a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;

(b) Is determined by the health carrier and reported to HHS; or

(c) As determined by the state as provided in 45 CFR §156.110(f).

B. A health carrier offering a health benefit plan in the small group market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.

(1) Substitutes a benefit that:

(a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);

(b) Is made only within the same essential health benefit category; and

(c) Is not a prescription drug benefit; and

(2) Submits evidence of actuarial equivalence that is:

(a) Certified by a member of the American Academy of Actuaries;

(b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(c) Based on a standardized plan population; and

(d) Determined regardless of cost-sharing.

C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

D. A health carrier offering a health benefit plan in the small group market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.

E. A health carrier offering health benefit plan in the small group market providing essential health benefits may not impose annual and lifetime dollar limits on essential health benefits in accordance with 45 CFR §147.126.

Section 12. Parity in Mental Health and Substance Use Disorder Benefits

A. The provisions of 45 CFR §146.136 apply to a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act, as the term "small employer" is defined in Section 2791 of the PHSA as provided in Section 11 of this regulation.

Drafting Note: Section 1304 of the Federal Act gives states the option, prior to Jan. 1, 2016, to define a "small employer" as an employer that employed an average of at least one (1), but not more than fifty (50) employees on business days during the preceding calendar year and that employs at least one (1) employee on the first day of the plan year. On or after Jan. 1, 2016, a "small employer" must be defined as an employer that employed an average of at least one (1) but not more than one hundred (100) employees on business days during the preceding calendar year and who employs at least one (1) employee on the first day of the plan year. As such, the small employer exemption provided in Section 2726 of the PHSA and implementing regulations will continue to apply to employers with fifty-one (51) or more employees in 2016 when the upper limit of the small employer size increases in accordance with Section 1304 of the Federal Act. For more information, states can refer to page 68248 of the final rules published in the *Federal Register* (78 FR 68240), Nov. 13, 2013.

B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 13. Prescription Drug Benefits

A. A health benefit plan does not provide essential health benefits unless it:

(1) Except as provided in Subsection B, covers at least the greater of:

(a) One drug in every United States Pharmacopeia (USP) category and class; or

(b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the state.

B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

C. (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.

(2) (a) The procedures must include a process for an enrollee, the enrollee's designee or the enrollee's prescribing physician or other prescriber to request an expedited review based on exigent circumstances.

(b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.

(d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Section 14. Prohibition on Discrimination in Providing Essential Health Benefits

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.

B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 15. Cost-Sharing Requirements

A. (1) For a plan year beginning in calendar year 2014, cost-sharing may not exceed the following:

(a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or

(b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.

(2) For a plan year beginning in a calendar year after 2014, cost-sharing may not exceed the following:

(a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or

(b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.

B. In the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in Subsection A does not apply to benefits provided out-of-network, other than benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably accessible within the network.

Drafting Note: Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. Federal law does not prevent a state from establishing lower cost-sharing limits, or establishing limits that apply to out-of-network benefits.

C. For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsection A that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.

D. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

E. Nothing in this section is in derogation of the requirements of Section 14 of the Act.

F. Emergency department services must be provided as follows:

(1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act*].

Section 16. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.

B. If a health benefit plan's design is not compatible with the AV Calculator, the health carrier must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:

(a) Calculate the plan's AV by:

(i) Estimating the fit of its plan design into the parameters of the AV calculator; and

(ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and

(2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.

C. For health benefit plans offered in the small group market that, at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health benefit plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(a) Any current year HSA contributions are accounted for; and

(b) The amounts newly made available under such integrated HRAs for the current year are accounted for.

D. (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.

(2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.

(3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.

E. (1) The AV, calculated as described in Subsections A through D, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.

(2) The levels of coverage are:

(a) A bronze plan is a health benefit plan that has an AV of 60%.

(b) A silver plan is a health benefit plan that has an AV of 70%.

(c) A gold plan is a health benefit plan that has an AV of 80%.

(d) A platinum plan is a health benefit plan that has an AV of 90%.

(3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.

F. Any health benefit plan offered in the small group market that meets any of the levels of coverage described in Subsection E satisfies minimum value.

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, have issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs) and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. The drafting note below details this sub-regulatory guidance and issuer enforcement safe harbors.

Drafting Note: The Departments have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The Departments confirmed their intent in the Affordable Care Act Implementation FAQs Part XIX, Q8 issued May 2, 2014, "in recognition of and to ensure a smooth transition to new market changes in 2014,"to extend the following previously-issued enforcement and transition relief guidance until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies' basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer's obligation to provide an SBC with respect to benefits it does not insure);
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);
- Affordable Care Act Implementation FAQs Part XIV, Q2 (regarding providing information about MEC (minimum essential coverage) and MV (minimum value) without changing the SBC template);
- Affordable Care Act Implementation FAQs Part XIV, Q3 (removal of the row on the SBC template related to annual limits information);
- Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding carve-out arrangements);
- Affordable Care Act Implementation FAQs Part XIV, Q7 (regarding anti-duplication rule for student health insurance coverage);
- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage); and
- Affordable Care Act Implementation FAQs Part XIV, Q6 (an enforcement safe harbor related to closed blocks of business).

The May 2, 2014, guidance also noted that "[t]his guidance supersedes any previous sub-regulatory guidance, including FAQs, stating that certain enforcement relief for the SBC and uniform glossary requirements is limited to the first or second year of applicability."

A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to persons and individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

B. (1) A health carrier offering a health benefit plan providing small group health insurance coverage must provide the SBC to the plan sponsor upon application for coverage, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.

(2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.

(3) If a health carrier renews or reissues the certificate or contract of coverage, the health carrier must provide a new SBC as follows:

(a) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(b) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new certificate or contract of insurance or the receipt of the written confirmation of intent to renew whichever is earlier.

(4) If a plan sponsor requests an SBC or summary information about a health insurance product from a health carrier, the health carrier must provide an SBC as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

C. (1) A health carrier must provide an SBC to covered persons and, consistent with Subsection D, with respect to each benefit package offered by the carrier for which the covered person is eligible.

(2) A health carrier must provide an SBC as part of any written application materials that are distributed by the carrier for enrollment. If the carrier does not distribute written application materials for enrollment, the carrier must distribute the SBC no later than the first date on which the employee is eligible to enroll in coverage for the employee and any dependents of the employee.

(3) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the covered person no later than the first day of coverage.

(4) A health carrier must provide the SBC to special enrollees, as described in Section 6 of this regulation, no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA Section 104(b)(1)(A) and its implementing regulations, which is ninety (90) days from enrollment.

(5) If a health carrier requires covered persons to renew in order to maintain coverage, the carrier must provide a new SBC when the coverage is renewed as follows:

(a) If written application is required for renewal in either paper or electronic form, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or

(b) If the renewal is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before the 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issue of the new certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(6) A health carrier must provide the SBC to covered persons upon request for an SBC or summary information about health coverage, as soon as practicable, but in no event no later than seven (7) business days following receipt of the request.

D. (1) A person required to provide an SBC under this section with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the requirements of this section. Therefore, for example, in the case of a health benefit plan providing small group market health insurance coverage, the person satisfies the requirement to provide an SBC with respect to an individual if the health carrier provides a timely and complete SBC to the individual.

(2) If a health carrier provides a single SBC to an employee and any dependents of the employee at the employee's last known address, then the requirement to provide the SBC to the employee and any dependents of the employee is generally satisfied. However, if an employee's dependent's last known address is different than the employee's last known address, the health carrier must provide a separate SBC to the employee's dependent at the dependent's last known address.

(3) With respect to a health benefit plan providing small group health insurance coverage that offers multiple benefit packages, the health carrier must provide a new SBC automatically upon renewal only with respect to the benefit package in which the covered person is enrolled. A health carrier is not required to provide SBCs automatically upon renewal with respect to benefit packages in which the covered person is not enrolled. However, if the covered person requests an SBC with respect to another benefit package or more than one other benefit package for which the covered person is eligible, the health carrier must provide the SBC, or in the case of a request for SBCs relating to more than one benefit package, upon request as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

E. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:

(a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;

(b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;

(c) The exceptions, reductions and limitations of coverage;

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

(e) The renewability and continuation of coverage provisions;

(f) Coverage examples in accordance with Paragraph (2);

(g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage's share of the total allowed costs of benefits provided under the coverage meets applicable requirements;

(h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;

(j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;

(k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and

(l) An Internet address for obtaining the uniform glossary, as described in Subsection G, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(2) (a) The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.

(b) For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(c) (i) For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.

(ii) The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.

(3) (a) In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Drafting Note: In Frequently Asked Questions (FAQs), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

(b) In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.

F. (1) A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: "To the extent a plan's terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."

(2) The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.

(3) The carrier must provide the SBC as a stand-alone document.

G. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC in paper form.

(2) In lieu of providing an SBC in paper form under Paragraph (1), a health carrier may provide an SBC electronically, such as by email or an Internet posting, if the following is satisfied:

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

(a) The form is readily accessible by the plan sponsor;

(b) The SBC is provide in paper form free of charge upon request; and

(c) If the electronic form is an Internet posting, the carrier timely advises the plan sponsor in paper form or email that the documents are available on the Internet and provides the Internet address.

(3) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC to a covered person in paper form.

H. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.

I. If a health carrier offering a health benefit plan providing small group market health insurance coverage makes any material modification, as defined under Section 102 of ERISA, in any terms of coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the health carrier must provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with Subsection G.

J. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must make available to covered persons, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).

(2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:

(a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;

(b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.

(3) A health carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.

(4) A health carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 10295) in the *Federal Register* Feb. 24, 2014, finalizing their proposed rule to amend 45 CFR §146.115 to eliminate the requirement for the group market to provide certificates of credible coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §146.115 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.

B. The provisions of this section apply beginning December 31, 2014.

Section 19. Rules Related to Fair Marketing

A. A health carrier offering health benefit plans providing small group market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for health benefit plans providing small group market health insurance coverage not subject to Section 6 of the Act, a health carrier must offer coverage upon request and is not required to actively market such coverage.

B. (1) (a) A health carrier offering health benefit plans providing small group market health insurance coverage must actively offer all health benefit plans it actively markets in this state to any small employer that applies for or makes an inquiry regarding small group market health insurance coverage from the carrier.

(b) The offer may be provided directly to the small employer or delivered through a producer.

(2) The offer must be in writing and must include at least the following information:

(a) A general description of the benefits contained in the health benefit plan being offered to the small employer, and

(b) Information describing how the small employer may enroll in the plans.

(3) The carrier must provide a price quote to a small employer directly or through an authorized producer within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. The carrier must notify a small employer directly or through an authorized producer within five (5) working days of receiving a request for a price quote of any additional information needed by the carrier to provide the quote.

(4) Subject to Section 6A of the Act, the carrier must issue any health benefit plan to any eligible small employer that applies for the plan.

(5) The carrier may not directly or indirectly use group size or any health status-related factor as criteria for establishing eligibility for a health benefit plan.

C. A health carrier must establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans providing small group health insurance coverage in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of health benefit plans providing small group health insurance coverage in their state.

D. (1) The health carrier may not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the carrier or for the issuance of any health benefit plan offered by the carrier.

(2) A health carrier may modify the terms of a policy issued to a small employer that is not a member of the association provided the modifications do not affect the policy's benefit design or other substantive terms of coverage.

Drafting Note: The provisions of Paragraph (2) are intended to allow a carrier to make necessary technical or administrative modifications to a health benefit plan issued to a small employer that is not a member of an association.

E. A health carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

F. (1) Health carriers offering health benefit plans providing small group health insurance coverage in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this regulation.

(2) Health carriers must elicit the following information from applicants for such plans at the time of application:

(a) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(b) Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

(3) If a health carrier offering a health benefit plan providing small group health insurance coverage fails to comply with Paragraph (2), the carrier will be deemed to be on notice of any information that could reasonably have been attained if the carrier had complied with Paragraph (2).

G. (1) A health carrier must file annually the following information with the commissioner related to small group market health benefit plans issued by the carrier to individuals in this state:

(a) The number of small employer that were issued, or received renewals of, small group market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of small group market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic regions.

(c) The number of small group market health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; and

(d) The number of small group market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

H. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its small group market health benefit plans. The commissioner shall have authority to review a carrier's commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its small group market health benefit plans are created by the structure.

I. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.

Section 21. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 22. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2015 Proc. 1st Quarter I 3-10 (adopted).

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE §§ 191-71.1 to 191-71.26 (1993/2018).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2015

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION (#126)

1. Description of the Project, Issues Addressed, etc.

At the 2013 Fall National Meeting, the Regulatory Framework (B) Task Force began its review of an initial draft of the Small Group Market Health Insurance Coverage Model Regulation as a companion regulation to the *Small Group Market Health Insurance Coverage Model Act* (#106). The draft model regulation incorporates the provisions of various federal regulations implementing the 2014 market reform provisions and other relevant provisions of the federal Affordable Care Act (ACA). The Task Force adopted the Small Group Market Health Insurance Coverage Model Regulation Nov. 16 at the 2014 Fall National Meeting and presented it to the Health Insurance and Managed Care (B) Committee for its consideration. As part of the Task Force's report, the Committee adopted the Small Group Market Health Insurance Coverage Model Regulation Nov. 17.

Major provisions in the model regulation include:

- Restrictions Relating to Premium Rates (Section 4)
- Single Risk Pool (Section 5)
- Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods (Section 6)
- Guaranteed Renewability of Small Group Market Health Insurance Coverage (Section 7)
- Prohibition on Waiting Periods Exceeding Ninety (90) Days (Section 8)
- Prohibition on Preexisting Condition Exclusions (Section 9)
- Essential Health Benefits Package (Section 11*)*
- Prescription Drug Benefits (Section 13)
- Cost-Sharing Requirements (Section 15)
- Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage (Section 16)
- Provision of Summary of Benefits and Coverage; Uniform Glossary (Section 17)
- Certification and Disclosure of Prior Creditable Coverage (Section 18)

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force drafted the model regulation. The members of the Task Force at the time of adoption were: Wisconsin, Chair; Utah, Vice Chair; Arizona; California; Colorado; Connecticut; Delaware; Florida; Idaho; Illinois; Indiana; Kansas; Kentucky; Maine; Minnesota; Missouri; Montana; Nebraska; Nevada; New Jersey; N. Marina Islands; Ohio; Oklahoma; Oregon; Pennsylvania; Puerto Rico; South Dakota; Tennessee; Virginia; and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. The Task Force also has a specific charge to consider the development of new NAIC model laws and regulations, as well as the revision of existing NAIC model laws and regulations affected by federal legislation and final federal regulations promulgated pursuant to such legislation.

After the enactment of the ACA in March 2010, consistent with its charges, the Health Insurance and Managed Care (B) Committee directed the Task Force to review and revise existing NAIC models affected by the ACA or, as necessary, develop new NAIC models to assist the states in implementing the ACA. This proposed new NAIC model regulation is consistent with that directive.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model regulation was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2013 and 2014 National Meetings and several open conference calls, during which the drafts and comments received on the drafts were discussed. All drafts and comments were posted on the Task Force's page on the NAIC website. During these in-person meetings and open conference calls, representatives from various stakeholder groups participated, including consumer representatives, such as the Georgetown University Health Policy Institute, the Center on Budget and Policy Priorities (CBPP), the Consumers Union and Families USA, and the Alzheimer's Foundation of America; industry

representatives, such as the America's Health Insurance Plans (AHIP), the BlueCross and BlueShield Association (BCBSA) and the Pharmaceutical Research and Manufacturers of America (PhRMA); and individual consumers.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The model regulation was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2013 and 2014 National Meetings and several open conference calls, during which the drafts and comments received on the drafts were discussed. All drafts and comments were posted on the Task Force's page on the NAIC website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was only one significant issue discussed at the end of the drafting process. During the last public comment period, more than 40 comment letters were received concerning an issue related to network plans found in Section 15B. The issue related to a provision in the final federal regulations concerning the application of non-network cost-sharing to the annual limitation on cost-sharing. As provided in 45 CFR §156.130, in the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in 45 CFR §156.130(a), does not apply to benefits provided out-of-network. Section 15B of the model regulation reflected the federal provision, but included a drafting note alerting state insurance regulators that subject to state or federal law or regulations, nothing prohibits a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in the federal regulations or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. A majority of the comment letters received on this issue urged the Regulatory Framework (B) Task Force to consider revising the model regulation, at a minimum, to provide that the out-of-network cost-sharing that results from an exceptions or appeal process permitting a covered person to obtain covered benefits from an out-of-network provider should apply to the annual cost-sharing limitation.

During its meeting at the 2014 Fall National Meeting, the Task Force discussed the comment letters received on this issue and the suggested revisions to address it. The Task Force voted unanimously to revise Section 15B to permit benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably available within the network to be applied to the annual cost-sharing limitation. The Task Force also voted unanimously to add a sentence to the drafting note specifically alerting the states that federal law does not prevent a state from establishing lower cost-sharing limits or establishing limits that apply to out-of-network benefits.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

Table of Contents

Section 1. General

A. Every policy, rider or endorsement form affecting benefits that is submitted for approval shall be accompanied by a rate filing unless the rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to the policy, rider or endorsement shall also be filed.

B. General Contents of All Rate Filings

The purpose of this guideline, including its Appendix, is to provide appropriate guidelines for the submission and the filing of individual health insurance rates and to establish standards for determining the reasonableness of the relationship of benefits to premiums. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the entire rate filing is in compliance with the applicable laws and regulations of the state to which it is submitted and that the benefits are reasonable in relation to premiums.

Drafting Note: Assumptions applying to the future "period for which rates are computed" should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

C. Previously Approved Forms

Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

(1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form;

(2) A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefore;

(3) A history of the experience under existing rates, including at least the data indicated in Section 1D. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities, determination of loss ratios with the increase in policy reserves subtracted from premiums rather than added to benefits, accumulation of experience fund balances, substitution of net level policy reserves for preliminary term policy reserves, reserve adjustments arising because of select period loss experience, adjustment of premiums to an annual mode basis, or other adjustments or schedules suited to the form and to the records of the company. All additional data shall be reconciled, as appropriate, to the required data; and

(4) The date and magnitude of each previous rate change, if any.

D. Experience Records

(1) Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms that are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider of endorsement form to the extent appropriate. Subject to approval of the commissioner, experience under forms that provide substantially similar coverage and provisions that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined for purposes of evaluating experience data in relation to premium rates and rate revisions, particularly where statistical credibility would be materially improved by the combination. Once such a combining of forms is adopted, however, the insurer may not afterward again separate the experience, except with approval of the commissioner.

(2) The data shall be for all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). For example, for policies originally filed under this guideline, experience since inception would be required because of the utilization of the rule in Section 2B(2)(b)(ii). Here, it is permissible to combine experience for calendar years prior to the most recent five.

E. Evaluating Experience Data

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

(1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency;

(2) Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations. Where this consideration is pertinent, ratios of actual to expected claims, on a select basis, will often be appropriate for an adequate evaluation; and

(4) The mix of business by risk classification.

Section 2. Reasonableness of Benefits in Relation to Premiums

A. New Forms

(1) With respect to a new form under which the average annual premium as defined in Paragraph (5) below, is expected to be at least as large as the maximum $X in Paragraph (3) below but not more than the minimum $X in Paragraph (4) below, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

(2) Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

(3) Low Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is low (as defined below), the appropriate ratio from the table above should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

Where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor
X is the average annual premium up to a maximum of I .250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{293.3}$$

where:

(a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics;

(c) The CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 293.3;

(d) Hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.

(4) High Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is high (as defined below), the appropriate ratio from the table above should be adjusted upward by the following formula:

$$RN = R \times \frac{(I \times 4000) + X}{(I \times 5500)}$$

Where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (3) above), or
X is an average annual premium exceeding I . 1500.

In no event, however, shall RN exceed the lesser of:

(a) R + 5 percentage points, or
(b) 63%.

(5) Determination of Average Premium

The average annual premium per policy shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The value of X should be determined on the basis of the rates being filed. Thus, where this adjustment is applicable to a rate revision under Section 2B of these guidelines, rather than to a new form, X should be determined on the basis of anticipated average size premium immediately after the revised rates have fully taken effect.

(6) Medicare Supplement Forms

For Medicare supplement policies, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least sixty percent (60%).

(7) Conflict with Specific Statutes or Regulations

The above anticipated loss ratio standards do not apply to a class of business where the standards are in conflict with specific statutes or regulations.

(8) Forms with Indexing of Benefits

Certain policy forms provide for automatic indexing of benefits in relation to some base that is not subject to control by the insurer or the insured. Medicare supplement plans under which benefits automatically adjust in response to changes in the Part A or Part B deductibles under federal Medicare are a common example. Other possibilities exist, under disability income, major medical and other forms of coverage.

In such cases, the insurer should be permitted to file rates on a basis that provides for automatic adjustment of premiums, on an actuarial basis appropriate in relation to the automatic adjustment in the benefits. While such premium adjustment would thus be considered "pre-filed," to apply "automatically," it should nevertheless be subject to ongoing monitoring of the continuing loss experience and there should be some agreement with the insurer that the commissioner may require, from time to time, renewed justification that the automatic premium adjustments remain appropriate and reasonable.

B. Rate Revisions

(1) With respect to filing of rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits shall be deemed reasonable in relation to premiums, provided the revised rates meet the standards applicable to the prior rate filing for the form or forms.

In general, the rule that applies is that any rate revision is subject to the guideline basis under which the previous rates were filed (with consideration of all relevant rating factors: morbidity, expenses, persistency, interest, etc.), and to those regulatory guidelines, if any, that were in effect at the time of the filing. Where there was no written guideline applicable to the prior rate filing, the regulatory benchmark then generally recognized, such as the 1953 NAIC benchmark (1953 *Proceedings of the NAIC*, Vol. II, p. 542), will continue to govern rate revisions of the prior rate filings.

(2) With respect to filings of rate revisions for a form approved subject to these guidelines, benefits will be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in Section 2A of these guidelines:

(a) The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;

Drafting Note: Assumptions applying to the future "period for which rates are computed" should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

(b) The lifetime anticipated loss ratio derived by dividing (i) by (ii) where (i) is the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and (ii) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and the accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

C. Anticipated loss ratios lower than those indicated in Subsection B(2)(a) and (2)(b) will require justification based on the special circumstances that may be applicable.

(1) Examples of coverages requiring special consideration are as follows:

(a) Accident only;

(b) Short term non-renewable, e.g., airline trip, student accident;

(c) Specified peril, e.g., cancer, common carrier;

(d) Other special risks.

(2) (a) Examples of other factors requiring special consideration are as follows:

(i) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;

(ii) Extraordinary expenses, or, in the case of a rate increase, expenses in excess of those expected under the previous rate filing;

(iii) High risk of claim fluctuation because of the low loss frequency or the catastrophic, or experimental nature of the coverage;

(iv) Product features such as long elimination periods, high deductibles and high maximum limits; and

(v) The industrial or debit method of distribution.

(b) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing exceptionally large rate increases.

Appendix. Rate Filing Guidelines

A basic actuarial requirement in the establishment of a premium rate scale is that the benefits provided be reasonable in relation to premiums. This requirement has been incorporated in the statutes of many jurisdictions and in the regulations and operating rules, formal and informal, of the insurance departments of probably all jurisdictions.

One of the principal objectives of these guidelines is to establish a basis for assisting both those filing rates and those responsible for regulatory review of filings in deciding whether a premium rate filing meets this requirement.

The individuals who drafted these guidelines recognized that the guidelines would be applicable to the wide range of products marketed by a diversity of methods under the general title "Individual Health Insurance." For this reason, they decided it would be inappropriate to establish rigid rules or inflexible standards. It should be recognized, therefore, that the guidelines are intended to be only guidelines, and they must be interpreted and applied flexibly.

Section 2A of the guidelines includes a table of numerical values representing loss ratios that "shall be deemed reasonable in relation to premium." This "deemer level" of loss ratio is meant to be the initial guideline test for establishing the reasonableness of the premiums in relation to benefits. Satisfying this test establishes that the premiums are reasonable in relation to benefits. However, premium rates not meeting this test may still have benefits that are reasonable in relation to premiums based on further considerations.

Other parts of Section 2, and particularly Subsection C, give examples of situations where considerations beyond the initial test would be appropriate in determining the reasonableness of premiums in relation to benefits.

Although expenses are not addressed in detail in the guidelines, the variations in loss ratio benchmarks by average annual premiums per policy is clearly intended to provide for the fact that a substantial amount of general expense is not a function of premium but is flat per policy. Thus, the guidelines intend to make realistic provision for actual expenses as incurred. As inflation causes unit expenses to rise, despite the gains from improved productivity through greater mechanization, etc., the possibility of lower loss ratios may have to be confronted for some forms.

One of the purposes of Section 1 of the guidelines is to set the requirements for rate filings. The usefulness of this section is enhanced by showing herein the minimum requirements as to the documentation of these rate filings.

In developing the checklist below, consideration was merely given to pointing out some of the factors that may be involved in calculating the rates, e.g., interest, mortality, morbidity, selection, lapse, expenses, inflation, etc., and spell out how those factors might be used in such calculations. It was felt, however, that this approach would produce details not always necessary to justify or review the rate filing while leaving out possibly essential information.

The checklists are separate for filing of rates for a new product and filing of rate increases.

Checklist of Items to be included in Individual Health Insurance Rate Filing Submissions

Rates for a New Product

I. Policy Form, application, and endorsements required by State Law.

II. Rate Sheet

III. Actuarial Memorandum

A. Brief description of the type of policy, benefits, renewability, general marketing method, and issue age limits.

B. Brief description of how rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy or dollars per unit of benefit, or both.

C. Estimated average annual premium per policy.

D. Anticipated loss ratio, including a brief description of how it was calculated.

E. Anticipated loss ratio presumed reasonable according to the guidelines.

F. If Subsection D is less than Subsection E, supporting documentation for the use of the proposed premium rates.

G. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

[IV. A statement as to the status of this rate filing in the company's home state.]

Rate Increases for an Existing Product for which Rates are Subject to this Guideline

I. New Rate Sheet

II. Actuarial Memorandum

A. Brief description of the type of policy, benefits, renewability, general marketing method and issue age limits.

B. Scope and reason for rate revision including a statement of whether the revision applies only to new business, only to in force business, or to both, and outline of all past rate increases on this form.

C. Estimated average annual premium per policy, before and after rate increase. Descriptive relationship of proposed rate scale to current rate scale.

D. Past experience, as specified in Section 2D of the guidelines, any other available data the insurer may wish to provide.

E. Brief description of how revised rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy, or dollars per unit of benefit, or both.

F. The anticipated future loss ratio and description of how it was calculated.

G. The anticipated loss ratio that combines cumulative and future experience, and description of how it was calculated.

H. Anticipated loss ratio presumed reasonable according to the guidelines.

I. If Subsection F or G is less than Subsection H, supporting documentation for the use of such premium rates.

J. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

The test in Section 2B(2) is an innovation of these guidelines. It seems appropriate, therefore, that this appendix include an example of how it works.

The first test in Section 2B(2)(a) is the same for a new form, new business on an existing form, or experience on existing business following a rate revision. Suppose that we are talking about an OR form with an average annual premium exceeding $X, defined in the guidelines, and the new rates are originally set to provide the benchmark loss ratio of sixty percent (60%).

When the new rates are applied to existing business in force and we calculate the present value of future premiums and benefits, we obtain the following results.

Table 1 - Future Projection

	Present Value at Current Volume from next year anniversaries
Premiums	$30,000,000
Benefits	18,000,000
Loss Ratio	.60

Then we look at the accumulated experience for the past. Suppose it can be summarized as follows: The poor recent experience has prompted the need for the current increase request.

Table 2 - Accumulated Experience

	Prior to 3 years	Last 3 years	From last year end to next anniversary	Total
Premiums	$50,000,000	$10,000,000	$10,000,000	$70,000,000
Benefits	20,000,000	9,000,000	11,000,000	40,000,000
Loss Ratio	.400	.900	1.100	.571

When the accumulated and present value figures are combined, the following results appear.

Table 3 - Combined Experiences

	Accumulated	Present Value	Total
Premiums	$70,000,000	$30,000,000	$100,000,000
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.600	.580

The test in Section 2B(2)(b) is not met.

With respect to future premiums on the existing volume, the rates proposed must be reduced so that the .58 result is increased to .60. Since the benefits are what they are and the present value is settled, we can work backwards to determine that the total premiums must be $96,666,667 ($58,000,000 - .60). Thus the present value of future premiums must be $26,666,667 and the proposed rates, applicable to new business, must be reduced by one-ninth, with respect to the existing volume. The new table which meets the Section 2B(2)(b) test is as follows.

Table 4 - Revised Combined Experiences

	Accumulated	Present Value	Total
Premiums	$70,000,000	$26,666,667	$96,666,667
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.675	.600

The next rate increase request will depend on how experience develops, if the company wishes to charge the same rates for new business and renewal, one way it could do so would be by reducing the rates otherwise proposed for new business. An alternative approach would be to combine the experience under new and existing business in a similar analysis to arrive at a single rate structure applying to both.

If the early experience under the form was poor, the losses would not be recoverable. Suppose, for instance, that only the last three years and the estimate for the last year-end to the next year's anniversary in the above example existed and the proposed new business rates applied. Then, the following test from Section 2B(2)(b) appears:

Table 5 - Alternate Combined Experiences

	Accumulated	Present Value	Total
Premiums	$20,000,000	$30,000,000	$50,000,000
Benefits	20,000,000	18,000,000	38,000,000
Loss Ratio	1.000	.600	.760

While the present value of future premiums could be increased under the Section 2B(2)(b) test to recover past losses and still meet the 60% benchmark, the test in Section 2B(2)(a) would preclude such an increase.

It is believed that this test will be rather simple to apply, in practice, from readily available records. It will be an effective tool in reviewing the reasonableness of rate increases.

Section 2B, as amended, is not intended to substitute new standards retroactively in place of standards in effect before the date of these guidelines. It is not intended that the rules be changed in the middle of the contract period. On the other hand, the principles of these guidelines may have been implicit in a state's former rules and guidelines.

It should be emphasized again that the tests in Section 2A and 2B have to do with benchmarks, not legal minimums. Section 2C mentions some situations in which lower loss ratios may be justifiable. If, however, a rate submission meets the benchmark standards and includes full documentation as described in the guidelines and this appendix, the requirement that benefits be reasonable in relation to premiums should be considered met.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1980 Proc. I 29, 38, 406, 410, 413, 416-425 (adopted).
1983 Proc. I 6, 35, 644, 652-659 (revised).
1983 Proc. II 16, 22, 638, 644, 646-655 (amended and reprinted).

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			BULLETIN 2010-8 (2010).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. ADMIN. CODE R20-6-607 (1981); CIRCULAR LETTER 7-24-81 (1981).
Arkansas			BULLETIN 12-81 (1981) (loss ratios).
California			CAL. CODE REGS. tit. 10, §§ 2219 to 2220.31 (1972) (standards for review).
Colorado			3 COLO. CODE REGS. § 702-4:4-2-11 (1992/2013); BULLETIN 7-2001 (2001); BULLETIN B-4.47 (2012).
Connecticut			CONN. AGENCIES REGS. §§ 38a-481-1 to 38a-481-4 (1990/2006) BULLETIN HC-88 (2011).
Delaware			DEL. CODE ANN. tit. 18, §§ 2501 to 2531 (1953); § 3333 (1953).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-149.002 to 69O-149.010 (1985/2013) (portions of model); 69O-149.022 (2005).		FLA. ADMIN. CODE ANN. r. 69O-149.205 to 69O-149.207 (2005/2006); MEMORANDUM 2006-012 (2006).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-36.9 to 191-36.12 (1982).		
Kansas	KAN. ADMIN. REGS. § 40-4-1 (1981/2003) (adopted by reference subject to stated exceptions).		BULLETIN 2010-1 (2010).
Kentucky	806 KY. ADMIN. REGS. 17:070 (1982/1995) (portions of model).		806 K.Y. ADMIN. REGS. 14:007 (2002/2008).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2736 (1979).
Maryland	NO CURRENT ACTIVITY		
Massachusetts			211 MASS. CODE REGS. 41.06 (1997/2002).
Michigan			MICH. ADMIN. CODE r. 500.801 to 500.806 (1974) (includes standards for review).
Minnesota	NO CURRENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi			19 CODE MISS. R. Pt. 1, 38.01 to 38.09 (2012).
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. CODE ADMIN. R. INS. §§ 401.01 to 401.16 (1982/2013).
New Jersey			N.J. ADMIN. CODE §§ 11:4-18.1 to 11:4-18.10 (1980/1996) (includes standards for review).
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.40 to 52.42 (Regulation 62) (1983/1996) (filing procedures).
North Carolina	NO CURRENT ACTIVITY		11 N.C. ADMIN. CODE § 16.0205 (1992/2005).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. ADMIN. R. 836-010-0011 (1994/2014).
Pennsylvania			31 PA. CODE § 89.83 (1975) (standards for review).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			27 R.I. GEN. LAWS ANN. § 27-41-29.2 (2012); § 27-18-8 (1956/2012).

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. § 38-71-310 (1988/1989) (adopted by reference).		BULLETIN 11-2011 (2011); BULLETIN 1-2013 (2013).
South Dakota			S.D. CODIFIED LAWS § 58-18B-3.1 (2011); BULLETIN 2011-7 (2011).
Tennessee	TENN. COMP. R. & REGS. 0780-1-92 (1981/1994).		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE r. 590-85 (1980/2003).		UTAH ADMIN. CODE r. 590-220-1 to 590-220-19 (2004/2013).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-130-10 to 5-130-100 (1981/2013).		
Washington			WASH. ADMIN. CODE §§ 284-60-010 to 284-60-100 (1983) (standards for review).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. ADMIN. CODE INS. 3.13(6) (1958/2009) (filing requirements).
Wyoming	NO CURRENT ACTIVITY		

NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

Table of Contents

Section 1. Applicability

The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until at least age fifty (50), or in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

Section 2. Guaranteed Renewable Policies Defined

Except as provided above, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until at least age fifty (50), or in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

The foregoing limitation on use of the term "non-cancellable" shall also apply to any synonymous term such as "guaranteed continuable."

Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

Comment: These minimum requirements have been prepared in an effort to make the language conform as closely as possible with various suggestions in the past and to be consistent with existing NAIC language, with state rulings, letters and existing law, and with the U.S. Senate Committee Report on HR 4245 of 1959 (life insurance company taxation). The recommended limiting ages are consistent with the NAIC Uniform Individual Accident and Sickness Policy Provisions Law with the definition used in 1956 (See 1956 NAIC Proceedings II 293) and with the definition in California's law for non-cancellable insurance. We further recommend that your committee affirm the opinion that any required or optional provision contained in the 1950 NAIC Uniform Individual Accident and Sickness Policy Provisions Law which may be used in a "non-cancellable" or "non-cancellable and guaranteed renewable" policy may also be used in a "guaranteed renewable policy."

Drafting Note: Section 7 of the NAIC Rules Governing the Advertisement of Accident and Sickness Insurance provides that any advertisement of a policy which refers to renewability or cancellability must disclose in a manner which would not minimize or render obscure any qualifications relating to renewability or cancellability. The same requirement of clear disclosure should also apply with respect to policy forms.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1960 Proc. I 148, 153-154, 157 (adopted).

NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

What are the state pages?

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How do you use them?

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Who do I speak to if I have questions?

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NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. ANN. § 21.36.225 (2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. INS. CODE §§ 10273 to 10273.5 (1961).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	DEL. ADMIN. CODE tit. 18, § 1309 (1995/2003).		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-154.004 (1974).		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, § 2003 (1965/2001).		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. ADMIN. REGS § 40-4-4 (1966/1986).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2737 (1970) (includes definition of "noncancellable").
Maryland			MD. CODE ANN., INS. § 27-602 (2006/2009).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	19 MISS. ADMIN. CODE Pt. 3, R. 3.01 (2012).		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE § 11:4-18.3 (1980/1989).		

NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, § 52.17 (Regulation 62) (1972/1992).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennesee	TENN. CODE ANN. § 56-26-101 (1976).		
Texas	28 TEX. ADMIN. CODE §§ 3.3019 to 3.3020 (1977).		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. ADMIN. CODE 284-50-330 (1976).

NONCANCELLABLE AND GUARANTEED RENEWABLE TERMINOLOGY DEFINED

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 3.13(2)(e) (1964/2009).		
Wyoming	NO CURRENT ACTIVITY		

OFF-LABEL DRUG USE MODEL ACT

Table of Contents

Drafting Note: Each state should determine where the provisions of this model act should be incorporated into its statutory or regulatory scheme. For example, it might be appropriate to include these provisions in a state's Unfair Trade Practices Act.

Section 1. Purpose

In order to prevent unfair discrimination among insured persons in this state and to prohibit unfair competition among health carriers that include coverage for drugs as part of health benefit plans, standards for payment or reimbursement of costs associated with prescription drugs are required. Some health benefit plans deny payment for drugs that have been approved by the federal Food and Drug Administration (FDA) when the drugs are used for indications other than those stated in the labeling approved by the FDA (this use is hereinafter referred to as "off-label use") while other health benefit plans with similar drug coverage pay or reimburse for off-label use. Denial of payment or reimbursement for off-label use can interrupt or effectively deny access to necessary and appropriate treatment for persons being treated for life-threatening illnesses. In addition, drugs for off-label use may provide efficacious treatment at a lower cost.

Drafting Note: States may want to consider utilizing the term "lawfully marketed to be prescribed for at least one indication" instead of the term "approved by the FDA" in this section and throughout this model. States that elect to utilize the term "lawfully marketed to be prescribed for at least one indication" may also want to define the term "prescribed" to be limited to the lawful prescriptive authority of the state.

Section 2. Scope

This Act applies to all health benefit plans that are issued, amended, delivered or renewed on or after the effective date of this Act and provide coverage for drugs, and to all persons making determinations regarding payment of reimbursement for prescription drugs under these health benefit plans.

Drafting Note: States that have appropriate statutory authority may wish to consider framing this model as a regulation rather than as an Act.

Section 3. Definitions

A. "Commissioner" means the commissioner of insurance.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. "Drug" or "drugs" means any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease that is taken by mouth; injected into a muscle, the skin, a blood vessel or cavity of the body; applied to the skin; or otherwise assimilated by the body. The term includes only those substances that are approved by the FDA for at least one indication.

C. "FDA" means the federal Food and Drug Administration.

D. "Health benefit plan" means a risk transferring contract entered into to provide, deliver, arrange for, pay for or reimburse the cost of health care services.

E. "Health carrier" means a person that contracts or offers to contract on a risk assuming basis to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services unless the person assuming the risk is accepting the risk from a duly licensed health carrier.

F. "Peer-reviewed medical literature" means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

G. "Standard reference compendia" means:

(1) The American Hospital Formulary Service-Drug Information;

(2) The American Medical Association Drug Evaluation; or

(3) The United States Pharmacopoeia-Drug Information.

Section 4. Minimum Standards of Coverage

A. A health benefit plan that provides coverage for drugs shall provide for any drug prescribed to treat a covered indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

B. Coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug.

C. This section shall not be construed to require coverage for a drug when the FDA has determined its use to be contra-indicated for treatment of the current indication.

D. A drug use that is covered by reason of Subsection A shall not be denied coverage based on a "medical necessity" requirement except for reasons that are unrelated to the legal status of the drug use.

E. The following drugs or services shall not be subject to coverage under Subsection A:

(1) Drugs that are used in research trials sponsored by their manufacturers or a government entity; or

(2) Drugs or services furnished in a research trial, if the sponsor of the research trial furnishes the drugs or services without charge to any participant in the research trial.

Drafting Note: Some states may wish to authorize the commissioner to appoint a panel of medical experts to review specific indications and make written recommendations for approval by the commissioner as to what drugs are recognized for treatment in substantially accepted peer-reviewed medical literature. States choosing to authorize this procedure would need to add language to Section 4A to include drugs recognized and approved by the commissioner through this peer-review panel process. States may wish to ensure that members of such panels have training in assessing new drugs or new usage of existing drugs, follow scientifically sound and objective protocols, and have no financial or other conflicts of interest. A review panel would be subject to the state administrative procedures and open meetings laws.

Section 5. Effective Date

This Act is effective on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1995 Proc. 2nd Quarter 2, 36, 552, 570, 573-574 (adopted).

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Alabama			ALA. CODE § 27-1-10.1 (1994).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-2326 (2000) (accountable health plans) (cancer drugs).
Arkansas			ARK. CODE ANN. § 23-79-147 (1995/1999) (cancer drugs).
California			CAL. INS. CODE § 10123.195 (1992); CAL. HEALTH & SAFETY CODE § 1367.21 (1992) (health care service plans).
Colorado			COLO. REV. STAT. ANN. § 10-16-104.6 (2010) (cancer drugs).
Connecticut			CONN. GEN. STAT. § 38a-492b; § 38a-518b (1994) (cancer drugs).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

OFF-LABEL DRUG USE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 627.4239 (1995) (cancer drugs).
Georgia			GA. CODE ANN. § 33-53-2 (1993) (cancer drugs); § 33-24-59.11 (2003) (drugs used for life-threatening illness).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/356z.7 (1992) (cancer drugs for group policies).
Indiana			IND. CODE §§ 27-8-20-1 to 27-8-20-9 (1993).
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. §§ 40-2,167 to 40-2,170 (1999) (cancer drugs).
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. § 22:999 (2011) (cancer drugs).
Maine			ME. REV. STAT. ANN. tit. 24, § 2320-F (1997); § 2320-G (1999) (HIV); §2745-E (1997); § 2745-F (1999) (individual); § 2837-F (1997); 2837-G (1999) (group); § 4234-D (1997); § 4234-E (1997) (HMOs) (cancer and HIV drugs).
Maryland			MD. CODE ANN., INS. § 15-804 (1994/1997).

OFF-LABEL DRUG USE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 47K to 47L (1992) (cancer drugs); §§ 47O to 47P (1994) (AIDS drugs).
Michigan			MICH. COMP. LAWS § 500.3406q (2002); § 550.1416c (2002).
Minnesota			MINN. STAT. § 62Q. 525 (1999) (cancer drugs).
Mississippi			MISS. CODE ANN. § 83-9-8 (1997) (cancer drugs).
Missouri			MO. REV. STAT. § 376.429 (2002) (cancer drugs as part of a clinical study).
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. § 689A.0404 (1999) (cancer drugs).
New Hampshire			N.H. REV. STAT. ANN. § 415:6-g (1999); § 415:18-j (1999).
New Jersey			N.J. STAT. ANN. § 17:48-6h (1993); § 17:48A-7g (1993); § 17:48E-35.5 (1993); § 17B:26-2.1g (1993); § 17B:27-46.1g (1993).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. § 58-51-59 (1993) (cancer treatment); § 58-65-94 (1993) (cancer treatment); § 58-67-78 (1993) (cancer treatment).
North Dakota			N.D. CENT. CODE § 26.1-36-06.1 (1997).

OFF-LABEL DRUG USE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3923.60 (2011); § 1751.66 (2011) (cancer drugs); § 1753.23 (1997).
Oklahoma	NO CURRENT ACTIVITY		OKLA. STAT. ANN. tit. 63, § 1-2605 (1993) (cancer treatment).
Oregon			OR. REV. STAT. § 743A.062 (1997).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			26 P.R. LAWS §§ 9981 to 9984 (2011).
Rhode Island			R.I. GEN. LAWS §§ 27-55-1 to 27-55-3 (1994) (cancer drugs).
South Carolina			S.C. CODE ANN. § 38-71-275 (1996) (cancer drugs).
South Dakota			S.D. CODIFIED LAWS § 58-17-101 (2000) (cancer or life threatening illness).
Tennessee			TENN. CODE ANN. § 56-7-2352 (1997).
Texas			TEX. INS. CODE ANN. §§ 1369.001 to 1369.005 (2005); 28 TEX. ADMIN. CODE §§ 21.3010 to 21.3011 (2000).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, § 4100e (2005).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-3407.5 (1995/1997).
Washington			WASH. ADMIN. CODE 284-30-450 (1994).

OFF-LABEL DRUG USE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOOUS VERSION	RELATED ACTIVITY
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Newborn and Adopted Children Coverage Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide for uniformity of coverage requirements for newborn and newly adopted children and children placed for adoption under both group and individual health benefit plans.

Drafting Note: This model was designed to promote the uniformity of coverage for newborn infants under both individual and group health benefit plans. It was proposed by outside organizations to the NAIC as a way to clarify that a plan that provides coverage for dependents should cover a newborn from the moment of birth. *1974 Proc I 413, 415*. Since its endorsement in 1973, a majority of health benefit plans now provide coverage consistent with the model's intent and purpose for both individual and group health benefit plans. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, for the group health benefit plans only, health carriers to provide immediate coverage to newborn children from the moment of birth, newly adopted children from the date of adoption and children placed for adoption from the date of placement. This revised model retains the model's purpose to require coverage of newborn children from the moment of birth and extends these coverage requirements for individual health benefit plans to newly adopted children and children placed for adoption, including preexisting exclusion provision requirements.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

C. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

D. "Dependent" shall be defined in the same manner as in [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, status should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the covered person.

"Dependent" means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the covered person, and an unmarried child of any age who is medically certified as disabled and dependent upon the covered person.

E. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

F. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

G. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

H. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

Section 4. Applicability

A. Except as provided in Subsection B, this Act shall apply to health benefit plans that provide coverage for a dependent of a covered person.

B. The provisions of this Act shall not apply to a health benefit plan that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity or other fixed indemnity coverage, long-term care insurance, as defined by [insert reference in state law that defines long-term care insurance], vision care or any other supplemental benefit or to a Medicare supplement policy, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Coverage Requirements

A. Each health benefit plan subject to this Act shall provide coverage to:

(1) A newborn child of a covered person from the moment of birth; or

(2) A newly adopted child of a covered person from the earlier of:

(a) The date of placement for the purpose of adoption and continues in the same manner as other dependents of the covered person unless the placement is disrupted prior to legal adoption and the child is removed from placement;

(b) The date of entry of an order granting the covered person custody of the child for purposes of adoption; or

(c) The effective date of adoption.

B. To the extent the health care service or treatment is a covered benefit under the health benefit plan and the birth, adoption or placement of adoption described under Subsection A occurs while the covered person is eligible for coverage under the health benefit plan, the coverage required under Subsection A:

(1) Shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and

(2) Is not subject to any preexisting condition exclusion.

Section 6. Notification Requirements

A. For a newborn child:

(1) If payment of a specific premium or subscription fee is required to provide coverage for a newborn child, as described in Section 5 of this Act, the health benefit plan may require the covered person to notify the health carrier of the birth of the child and furnish payment of the required premium or fees be furnished to the health carrier within sixty (60) days after the date of birth.

(2) If notice is not provided, the health carrier may refuse to continue coverage for the child under the health benefit plan beyond the sixty-day period unless within four (4) months after the birth of the child the covered person makes all past-due payments and in addition pays interest on the payments at the rate of 5 1/2% per year.

(3) If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child under the health benefit plan, the health carrier may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the covered person does not furnish the notice.

B. For a newly adopted child or child placed for adoption:

(1) If payment of a specific premium or subscription fee is required to provide coverage under the health benefit plan for a newly adopted child or child placed for adoption, as described in Section 5 of this Act, the health benefit plan may require the covered person to notify the health carrier of the adoption or placement for adoption and furnish payment of the required premium or fees to the health carrier within sixty (60) days after coverage is required to begin under Section 5A(2) of this Act.

(2) If the covered person fails to provide the notice or make payment within the sixty-day period, the health carrier shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.

Section 7. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 9. Effective Date

The requirements of this Act shall apply to all health benefit plans delivered or issued for delivery in this state more than 120 days after the effective date of the Act.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1974 Proc. I 12, 14, 405, 413, 425-426 (endorsed but not adopted).
2005 Proc. 1st Quarter 261-262 (amended and adopted as an NAIC model by the parent committee).
2005 Proc. 2nd Quarter 49, 53-56 (reprinted and adopted by the Plenary).

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

What are the state pages?

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NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE § 27-19-38 (1975).
Alaska			ALASKA STAT. § 21.42.345 (1975/1997).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1342 (1982/1987) (individual); § 20-1402 (1982/1987) (group); § 20-826 (1982/2014) (service corps).
Arkansas		ARK. CODE ANN. § 23-79-129 (1975/2013).	BULLETIN 3-75 (1975).
California			CAL. INS. CODE § 10119 (1971/2013).
Colorado		COLO. REV. STAT. § 10-16-104 (1992/2013).	
Connecticut		CONN. GEN. STAT. § 38a-490 (1974/2012).	
Delaware		DEL. CODE ANN. tit. 18, § 3335 (1975).	
District of Columbia			D.C. CODE §§ 31-3801 to 31-3805 (1979).

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 627.641 (1982/1992) (individual); § 627.6575 (1982/1992) (group).
Georgia		GA. CODE ANN. § 33-24-22 (1974).	
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:10A-115 (1988) (individual); § 431:10A-206 (1988) (group); § 432:1-602 (1987) (mutual benefit societies).
Idaho			IDAHO CODE ANN. § 41-2140 (1976) (individual); § 41-2210 (1976) (group).
Illinois		215 ILL. COMP. STAT. 5/356c (1979/1987).	215 ILL. COMP. STAT. 165/15.3 (1979).
Indiana		IND. CODE §§ 27-8-5.6-1 to 27-8-5.6-3 (1975/1987).	
Iowa	IOWA CODE § 514C.1 (1974).		
Kansas		KAN. STAT. ANN. § 40-2,102 (1974/1997).	
Kentucky		KY. REV. STAT. ANN. § 304.17-042 (1976) (individual).	KY. REV. STAT. ANN. § 304.18-032 (1976) (group); § 304.38-198 (1982) (HMOs).
Louisiana			LA. REV. STAT. ANN. § 22:215.1 (1979); § 22:1065 (2008).
Maine		ME. REV. STAT. ANN. tit. 24, § 2319 (1975).	ME. REV. STAT. ANN. tit. 24-A, § 2743 (1975); tit. 24-A, § 2834; tit. 24, § 4234-C (1976/1998).
Maryland		MD. CODE ANN., INS. § 15-401 (1975/1997).	

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ch. 175, § 47C (1975) (general); MASS. GEN. LAWS ch. 176A, § 8B (1975) (nonprofit hospital service corp.); MASS. GEN. LAWS ch. 176B, § 4C (1975) (medical service corp).
Michigan		MICH. COMP. LAWS § 500.3403 (1975).	
Minnesota			MINN. STAT. § 62A.042 (1973/1984); § 62C.14(14) (1980) (health service plan corps).
Mississippi		MISS. CODE ANN. § 83-9-33 (1974/1979).	
Missouri		MO. REV. STAT. § 376.406 (1974/1983).	
Montana		MONT. CODE ANN. § 33-22-301 (1974/2003) (individual).	MONT. CODE ANN. § 33-22-504 (1959/1987) (group) (previous version of model); § 33-30-1001 (1981) (health service corps).
Nebraska		NEB. REV. STAT. § 44-710.19 (1976/1994).	
Nevada		NEV. REV. STAT. § 689A.043 (1975/1989) (individual).	NEV. REV. STAT. § 689B.033 (1975/2013) (group); § 695C.173 (1975/1989) (HMOs).
New Hampshire		N.H. REV. STAT. ANN. § 415:22 (1975/1996).	
New Jersey			N.J. STAT. ANN. § 17B:27-30 (1976) (group); § 17:48-6(d) (1980) (hospital service corps); § 17:48A-5(d) (1981) (medical service corps).
New Mexico			N.M. STAT. ANN. § 59A-22-34 (1985) (individual) (previous version of model); § 59A-47-27 (1985) (nonprofit health care plans).

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York			N.Y. INS. LAW § 3216(c)(4)(C) (1984/2013) (individual); § 4235(f)(2) (1984/1989) (group); § 4304(d)(1) (1984/1989) (individual hospital service corps); § 4305(c)(1) (1984/1991) (group hospital service corps).
North Carolina			N.C. GEN. STAT. § 58-51-30 (1973/2005).
North Dakota		N.D. CENT. CODE § 26.1-36-07 (1985).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. § 3923.26 (1973/1978).	
Oklahoma		OKLA. STAT. tit. 36, § 6058 (1975/1985).	
Oregon	OR. REV. STAT. § 743A.090 (1975) (portions of model).		
Pennsylvania			40 PA. STAT. ANN. § 772 (1975); § 775.1 (1994).
Puerto Rico	26 P.R. LAWS ANN. §§ 10021to 10026 (2011).		
Rhode Island			230 R.I. CODE R. 20-30-1.5 (2001).
South Carolina		S.C. CODE ANN. § 38-71-140 (1988).	
South Dakota		S.D. CODIFIED LAWS §§ 58-17-30.2 to 58-17.30.4 (1974/2001).	
Tennessee		TENN. CODE ANN. § 56-7-2301 (1974/1980).	
Texas			TEX. INS. CODE ANN. §§ 1367.001 to 1367.003 (2005); 28 TEX. ADMIN. CODE §§ 3.3401 to 3.3403 (1976/1982).

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah			UTAH CODE ANN. § 31A-22-610 (1986/2003).
Vermont		VT. STAT. ANN. tit. 8, § 4092 (1975/2013).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		VA. CODE ANN. § 38.2-3411 (1986/2013).	
Washington		WASH. REV. CODE ANN. § 48.20.430 (1974) (individual).	WASH. REV. CODE ANN. § 48.21.155 (1974) (group); § 48.44.212 (1974) (health care service plan).
West Virginia		W. VA. CODE § 33-6-32 (1975).	
Wisconsin		WIS. STAT. § 632.895 (5) (1976/1992).	WIS. ADMIN. CODE INS. § 3.38 (1977/1992).
Wyoming		WYO. STAT. ANN. §§ 26-20-101 to 26-20-104 (1975/1983).	

PROJECT HISTORY - 2005

NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT (#155)

1. Description of the project, issues addressed, etc.

This model was identified last year as in need of revision as part of the NAIC model law review initiative. The revisions make the model consistent with HIPAA with respect to the group market requirements for coverage of newborns and newly adopted children while also extending these coverages to the individual market.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair	
Arkansas	Nebraska
California	Nevada
Colorado	New Hampshire
Delaware	New Mexico
Florida	North Carolina
Idaho	Rhode Island
Iowa	Vermont
Kansas	Virginia
Louisiana	West Virginia

3. Project authorized by what charge and date first given to the group:

The following charge given in January 2004:

Review and revise, as necessary, NAIC model laws and regulations identified as in need of review and revision as a result of the NAIC model law review initiative. Report annually.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the task force.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of the proposed revisions to the model was circulated to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments. The task force reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

The only controversial issue that was raised was the length of time that a parent should be given to notify the health carrier of a newly born child or newly adopted child. The original model provided for a 31-day notification period. Task force members were concerned that this time frame was too short, and a 60-day notification period was proposed. One task force member suggested having a 1-year notification period for newborn children. After extensive discussion, the task force compromised and approved, for newborns only, a four-month notification period.

7. Any other important information (e.g., amending an accreditation standard).

None.

HEALTH POLICY RATE AND FORM FILING MODEL [ACT] [REGULATION]

Table of Contents

Section 1. Short Title

This [Act][regulation] may be known as the Health Policy Rate and Form Filing [Act][Regulation].

[Section 2. Purpose

The purpose of this Act is to provide a uniform standard for processing of accident and health carrier policy rate and form filings.]

Drafting Note: This option should be used if the state is adopting this model as a statute.

Drafting Note: If the state requires approval of marketing material, a reference should be added in this section.

[Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of state law establishing the commissioner's authority to issue regulations]].

Drafting Note: If the state determines it has the authority to adopt the provisions of this model by regulation, this option should be used.

Section 3. Definitions

A. "Accident and health carrier" means an entity licensed to offer accident and health insurance in this state, or subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, or any insurer that provides policies of supplemental, disability income, Medicare supplement or long term care insurance.

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

C. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

D. "Policy form" means any policy, contract, certificate, rider, endorsement, evidence of coverage or any amendments thereto that are required by law to be filed with the commissioner for approval prior to their sale or issuance for sale in this state.

E. "Supplemental documents" means documents required to be filed in support of policy forms that may or may not be subject to approval.

F. "Type of insurance" means those coverages listed on the NAIC Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix or any successor document under the headings "Continuing Care Retirement Communities," "Health," "Long Term Care" and "Medicare Supplement."

Section 4. Applicability and Scope

This [Act] [Regulation] shall apply to any individual or group policy form issued by an accident and health carrier required to be filed with the commissioner for review or approval.

Section 5. Due Diligence

All parties in the filing process shall act in good faith and with due diligence in performance of their duties pursuant to this [Act][regulation].

Section 6. Review Procedures

A. Subject to the provisions of this section, no policy form subject to this [Act] [regulation] shall be delivered or issued for delivery in this state, unless it has been filed with and approved by the commissioner.

B. (1) The commissioner shall create a document containing filing requirements for each type of insurance. The document shall contain a list of all product filing requirements contained in the statutes, regulations and published bulletins in this state having the force and effect of law, with appropriate citations to each, including the citation for the type of insurance that is required to be filed, and shall be available on the Insurance Department Internet site.

(2) The commissioner shall update the document no less frequently than annually, and within thirty (30) days of any change in law, regulation or bulletin published by the commissioner having the force and effect of law in this state requiring its amendment.

C. A filer shall submit a copy of the document with a policy form filing, indicating the location within the policy form or supplemental documents for each requirement contained in the document, and certifying that the policy form meets all requirements of state law.

D. The commissioner shall review and approve, provide notice of deficiencies or disapprove the initial filing within sixty (60) days of receipt. Any notice of deficiencies or disapproval shall be in writing and based only on the specific provisions of applicable statutes, regulations or bulletins published by the commissioner having the force and effect of law in this state and contained in the document created by the commissioner pursuant to Subsection B. The notice of deficiencies or disapproval shall provide the reasons for notice of deficiencies or disapproval and sufficient detail for the filer to bring the policy form into compliance, and shall cite the specific statutes, regulations or bulletins upon which the notice of deficiencies or disapproval is based.

E. A filer may resubmit a policy form that corrects any deficiencies or resubmit a disapproved policy form, and a revised certification, within thirty (30) days of its receipt of the commissioner's notice of deficiencies or disapproval. Any policy form not resubmitted within thirty (30) days of the notice of deficiencies shall be deemed withdrawn. Any disapproved policy form not resubmitted within thirty (30) days is disapproved.

Drafting Note: States should review statutory language with regard to the insurer's right to a hearing upon policy form disapproval to ensure consistent terminology.

F. At the end of the review period, the form is deemed approved if the commissioner has taken no action.

G. (1) The commissioner shall review the resubmitted filing and certification, and shall approve or disapprove it within thirty (30) days. Notice of deficiencies or disapproval shall be in writing and shall provide a detailed description of the reasons for the disapproval and sufficient detail for the filer to bring the policy form into compliance and shall cite the specific statutes, regulations, or bulletins upon which the disapproval is based. No further extensions of time may be taken unless the filer has introduced new provisions in the resubmission or the filer has materially modified any substantive provisions of the policy form, in which case the commissioner may extend the time for review by an additional thirty (30) days. At the end of the review period, the policy form is deemed approved if the commissioner has taken no action.

(2) (a) Subject to Subparagraph (b) of this paragraph, the commissioner may not disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to Subsection D.

(b) The commissioner may disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to Subsection D if:

(i) The filer has introduced new provisions in the resubmission;

(ii) The filer has materially modified any substantive provisions of the policy form;

(iii) There has been a change in statutes, regulations or published bulletins in this state having the force and effect of law; or

(iv) There has been reviewer error and the written disapproval fails to state a specific provision of applicable statute, regulation or bulletin published by the commissioner having the force and effect of law in this state that is necessary to have the policy form conform to the requirements of law.

H. Notwithstanding any other provision in this section, the commissioner may return a grossly inadequate filing to the filer without triggering any of the time deadlines set forth in this section. For purposes of this subsection, a "grossly inadequate filing" means a filing that fails to provide key information, including state-specific information, regarding a product, policy or rate, or that demonstrates an insufficient understanding of what is required to comply with state statutes or regulations.

OPTIONAL PROVISION

Section 7. Self-Certification Option

A. A filer may elect to self-certify its policy forms pursuant to the requirements of this section and opt out of the review procedures of Section 6 of this [Act] [regulation].

B. (1) A valid self-certification shall be made by the [appropriate company officer] and shall be on a form prescribed by the commissioner certifying that the policy form meets all requirements of state law and that the filer intends to forego the review process.

(2) A filer shall submit a copy of the document created by the commissioner pursuant to Section 6B of this [Act][regulation], with a policy form filing, indicating the location within the policy form for each requirement contained in the document.

C. (1) If the commissioner determines that there are material errors or omissions in a policy form that has been self-certified, then the commissioner may review and disapprove the policy form. The commissioner shall notify the filer in writing of the reasons for the disapproval. Any disapproval shall be based only on the specific provisions of applicable statutes, regulations or bulletins published by the commissioner having the force and effect of law in this state and contained in the document created by the commissioner pursuant to Section 6B of this [Act][regulation]. The notice shall provide a detailed description of the reasons for disapproval and sufficient detail for the filer to bring the policy form into compliance, and shall cite the specific statutes, regulations, or bulletins upon which the disapproval is based.

(2) If a self-certified filing is disapproved, the commissioner may order the filer to take appropriate actions with respect to existing policyholders.

(3) A filer may correct any deficiencies and resubmit a disapproved policy form within sixty (60) days of its receipt of the commissioner's notice of disapproval. Any disapproved policy form not resubmitted within sixty (60) days shall be deemed withdrawn.

(4) (a) The commissioner shall review the resubmitted filing and may approve or disapprove it within thirty (30) days. Notice of disapproval shall be in writing and shall provide a detailed description of the reasons for the disapproval, specific recommendations for compliance and shall cite the specific statutes, regulations or bulletins upon which the disapproval is based. No further extensions of time may be taken unless the filer has introduced new provisions in the resubmission or the filer has materially modified any substantive provisions of the policy form, in which case the commissioner mayextend the time for review by an additional thirty (30) days. At the end of the review period, the policy form is deemed approved if the commissioner has taken no action.

(b) (i) Except as provided in Item (ii), the commissioner may not disapprove a resubmitted policy form for reasons other than those initially set forth in the original disapproval letter sent pursuant to Paragraph (1) of this subsection.

(ii) The commissioner may disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of disapproval sent pursuant to Paragraph (1) of this subsection if the filer has introduced new provisions in the resubmission or if the filer has materially modified any substantive provisions of the policy form.

D. If the commissioner has made a finding pursuant to Subsection C(1), the self-certification option is no longer available to that filer for a time period to be determined by the commissioner.]

Drafting Note: States that do not want to allow a self-certification option should not adopt this section.

Section 8. Effect of Deemer Provision

Except in cases of a material error or omission in a policy form that has been approved or deemed approved pursuant to the provisions of this [Act][regulation], the commissioner shall not:

A. Retroactively disapprove that filing; or

B. With respect to those policy forms, examine the filer during a routine or targeted market conduct examination for compliance with any later-enacted policy form filing requirements.

Section 9. Effect of Subsequent Law Changes

Unless otherwise required by statute, no rules or regulations issued by the commissioner impacting product filings shall be applicable to existing approved or deemed-approved policy forms except upon policy renewal or anniversary date.

Section 10. Rate Filings and Marketing Materials

If a rate filing or marketing material is required to be filed or approved by state law for a specific policy form, the time frames for review, approval or disapproval, resubmission, and re-review of those rates or materials shall be the same as those provided for in Sections 6 and 7 of this [Act][regulation] for the review of policy forms.

Section 11. Effective Date

This [Act] [Regulation] shall be effective for health policy forms and rates filed on or after [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2006 Proc. 2nd Quarter 40, 76-82 (adopted).

HEALTH POLICY RATE AND FORM FILING MODEL [ACT] [REGULATION]

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE § 27-14-8 (all insurance policies and annuity contracts).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1691.08 (2003) (long-term care).
Arkansas			ARK. CODE ANN. §§ 23-79-109 to 23-79-110 (1959/2015).
California	NO CURRENT ACTIVITY		
Colorado			3 COLO. CODE REGS. § 702-4:4-2-11 (1992/2013).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia			D.C. CODE ANN. § 31-5107 (1998).
Florida			FLA. ADMIN. CODE ANN. 69O-149.002 to 69O-149.010 (2008/2013).

HEALTH POLICY RATE AND FORM FILING MODEL [ACT] [REGULATION]

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. § 33-24-9 (1960).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/143 (1937/2013).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. § 40-2215 (1965/2008).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. § 33-1-501 (1959).
Nebraska			NEB. REV. STAT. ANN. § 44-348 (1913).
Nevada			NEV. REV. STAT. ANN. § 687B.120 (1971).

HEALTH POLICY RATE AND FORM FILING MODEL [ACT] [REGULATION]

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. ANN. § 58-51-85 (1945).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3923.02 (1956).
Oklahoma			OKLA. STAT. tit. 36, §§ 4402 to 4403 (1957).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania			31 PA. CODE § 89B.3 (2002).
Puerto Rico			26 P.R. LAWS ANN. § 1111 (2008).
Rhode Island			R.I. GEN. LAWS ANN. § 27-18-8 (1988); 230 R.I. CODE R. 20-30-15.4 (2018).
South Carolina			S.C. CODE ANN. § 38-71-310 (1976/2001).
South Dakota	S.D. CODIFIED LAWS §§ 58-11-64 to 58-11-76 (2008).		
Tennessee	NO CURRENT ACTIVITY		
Texas			BULLETIN B-0008-13 (2013).
Utah			BULLETIN 2013-4 (2013).

HEALTH POLICY RATE AND FORM FILING MODEL [ACT] [REGULATION]

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont			VT. STAT. ANN. tit. 8, § 3541 (1967).
Virgin Islands			22 V.I. CODE § 810 (1968).
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE ANN. § 33-6-8 (1957).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2006

HEALTH PLAN RATE AND FORM FILING MODEL [ACT][REGULATION] (#165)

1. Description of the project, issues addressed, etc.

This model regulation was drafted to implement rate and form filing process standards for health insurance.

2. Name of group responsible for drafting the model:

Rate and Form Filing (B) Working Group

States Participating:

Kansas (chair), Arkansas, Florida, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Oregon, South Dakota, Texas, Utah, Wisconsin

3. Project authorized by what charge and date first given to the group:

The working group completed the following 2005 charge:

> Review issues surrounding existing rate and form filing processes with respect to regulatory modernization and determine whether national uniform processing standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. Report by Winter 2006 National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The working group drafted the model. States on the working group actively contributed comments on drafts. Trade associations, including America's Health Insurance Plans (AHIP), and the American Council of Life Insurers (ACLI), participated in the process.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

The first draft of the model regulation is dated July 21, 2005. It was reviewed by the working group in September 2005, and a new draft was issued on February 10, 2006. It was adopted by the Working Group on March 6, 2006. Comment letters were received and considered throughout the drafting process.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

Rather than being controversial, issues were discussed regarding definitions, appropriate timeframes, and the various steps of the process. A self-certification option for insurers is optional to the states.

7. Any other important information (e.g., amending an accreditation standard).

None

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this Act is to standardize and simplify the terms and coverages, to facilitate public understanding and comparison, to eliminate provisions that may be misleading or unreasonably confusing in connection either with the purchase of these coverages or with the settlement of claims and to provide for full disclosure in the sale of supplementary and short-term health insurance, as defined in this Act.

Section 2. Applicability and Scope

A. This Act shall apply to individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity insurance, accident only, specified accident, specified disease, limited benefit health, and disability income protection, referred to collectively in Section 1 of this Act and hereafter, as "supplementary health insurance." This Act also applies to short-term, limited-duration health insurance coverage, which, unless otherwise specified, is included in the definition of "short-term health insurance" under this Act.

Drafting Note: Subsection A includes short-term, limited-duration health insurance within the scope of this Act. Although, short-term, limited-duration health insurance is not an "excepted benefit," as the other listed coverages, short-term, limited-duration coverage has been included in this Act because it is not considered individual health insurance under federal law and, as such, is not subject to the individual market reforms under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the federal Affordable Care Act (ACA).

Drafting Note: The term "individual" as used in this Act corresponds to its use in the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180), thus extending the coverage of the Act to "family" policies. The term "group" as used in this Act corresponds to its use in the NAIC *Group Health Insurance Standards Model Act* (#100).

Drafting Note: States should be aware that generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as "grandfathered health plan coverage." However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHSA, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the final regulations on grandfathered plans (26 CFR 54.9815-1251, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* Nov. 18, 2015 (80 FR 72191).

B. This Act shall apply to limited scope dental coverage and limited scope vision coverage only as specified.

C. This Act shall not apply to:

(1) Medicare supplement policies subject to [insert reference to state law equivalent to the NAIC *Medicare Supplement Insurance Minimum Standards Model Act* (#650)];

(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* (#640)]; or

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* (#640) defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited long-term care insurance plans, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and the *Limited Long-Term Care Insurance Model Regulation* (#643).

(3) TRICARE formerly known as the Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10, of the United States Code) (CHAMPUS) supplement insurance policies.

Drafting Note: TRICARE supplement insurance is not subject to federal regulation. TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to TRICARE benefits. In general, states regulate TRICARE supplement insurance policies under the state group or individual insurance laws.

Section 3. Definitions

A. "Certificate" means a statement of the coverage and provisions of a policy of group supplementary and short-term health insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

C. "Direct response solicitation" means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.

D. "Form" means policies, certificates, contracts, riders, endorsements and applications as provided in [insert reference to state law regarding the filing and approval of supplementary and short-term health insurance policy forms].

Drafting Note: This definition may be unnecessary if the term "form" is appropriately defined elsewhere, but it may be helpful to include it here with an appropriate cross-reference.

E. "Hospital indemnity or other fixed indemnity insurance" refers to coverage that provides benefits on an independent, non-coordinated basis and that pays a fixed amount for specified events without regard to other insurance.

Drafting Note: "Hospital indemnity or other fixed indemnity insurance" does not include any other type or category of insurance that is listed separately as an excepted benefit in Section 2791(c) of the federal Public Health Service Act (PHSA) (e.g., disability income protection coverage, specified disease coverage, etc.) regardless of whether benefits under such coverage are paid as a fixed dollar amount.

F. "Limited scope dental coverage" means insurance that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

G. "Limited scope vision coverage" means insurance that provides coverage substantially all of which is for treatment of the eye, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

H. "Policy" means the entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.

I. "Short-term, limited-duration insurance" means health insurance coverage offered or provided within the state pursuant to a contract by a health carrier, regardless of the situs of the delivery of the contract, that has an expiration date specified in the contract that is less than [X days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X days or months] after the original effective date of the contract.

Drafting Note: Subsection I does not include a potential maximum length of coverage for short-term, limited duration insurance. States have established different terms and durations of coverage for short-term, limited-duration insurance, if such coverage can be sold. Some states have prohibited the sale of such products, while others have set the maximum duration of coverage at less than 12 months, such as establishing a three-month maximum. In addition, some states provide that such coverage may not be renewed or extended beyond the established term, or have otherwise limited total duration, while other states have no such provisions regarding renewal or extension. The current federal regulations, which were effective Oct. 2, 2018, limit short-term, limited-duration insurance contracts to less than twelve months and, taking into account renewals or extensions, to a maximum duration of no longer than 36 months in total. States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans, including whether renewability or extension of such coverage is appropriate and consistent with federal law. States should also ensure that any other definitions of

short-term limited-duration insurance that are used in statutes that provide exemptions from otherwise applicable regulatory requirements are consistent with the definition used above in order to prevent gaps in regulatory authority.

J. (1) "Supplementary and short-term health insurance" means insurance written under [insert reference to state law authorizing supplementary and short-term health insurance].

(2) "Supplementary and short-term health insurance" does not include credit accident and sickness insurance.

Drafting Note: The phrase "supplementary and short-term health" should be replaced by "accident and disability," "accident and health," or other phrase appropriate under state law.

Section 4. Standards for Policy Provisions

A. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of supplementary and short-term health insurance subject to this Act. The commissioner may issue additional regulations to establish specific standards for the sale of limited scope dental and limited scope vision coverage. This Act and any regulations issued pursuant to this Act shall be in addition to and in accordance with applicable laws of this state, including the [insert reference to state law equivalent to the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)], which may cover, but shall not be limited to:

(1) Terms of renewability or extension of coverage;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage provisions;

(4) Coverage of dependents;

(5) Preexisting conditions and pre-existing condition exclusions;

(6) Termination of insurance;

(7) Probationary periods;

(8) Limitations;

(9) Exceptions;

(10) Reductions;

(11) Elimination periods;

(12) Requirements for replacement;

(13) Recurrent conditions;

(14) The definition of terms, including but not limited to, the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, mental or nervous disorder, guaranteed renewable and noncancelable; and

(15) Any maximum duration of coverage.

Drafting Note: States may want to consider reviewing issues surrounding post-claims underwriting possibly using their state unfair practices law or regulation, or other appropriate state law or regulation, to address issues, such as policy rescissions in instances of fraud and intentional misrepresentation.

Drafting Note: This section authorizes the commissioner to establish specific standards to facilitate public understanding of policy provisions. The section does not alter the requirements of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180) or other specifically applicable state laws dealing with individual policy provisions. Regulations adopted under this section should be consistent with the UPPL and other applicable state laws relating to the subject matter. The phrase "including standards of full and fair disclosure" provides the commissioner authority to establish standards that ensure policy provisions are technically accurate, in clear language and make the significance of policy provisions fully understandable.

B. The commissioner may issue regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, a person insured under the policy, or to a beneficiary of the policy.

Section 5. Minimum Standards for Benefits

A. The commissioner shall issue regulations to establish minimum standards for benefits under specified categories of coverage of supplementary and short-term health insurance subject to this Act.

B. The regulation shall set minimum standards for benefits for the following categories of supplementary coverage:

(1) Hospital indemnity or other fixed indemnity coverage;

(2) Disability income protection coverage;

(3) Accident only coverage;

(4) Specified disease coverage;

(5) Specified accident coverage; and

Drafting Note: "Specified disease coverage" or "specified accident coverage" refers to coverage that contains exclusions, limitations, reductions, or conditions that limit the payments of benefits under the policy or contract to a specified frequency and/or amounts. Examples of a specified disease or specified accident coverage would be a cancer only policy or an automobile accident only policy.

(6) Limited benefit health coverage.

C. The regulation shall set minimum standards for benefits for short-term coverage referred to hereafter as "short-term, limited duration health insurance coverage."

D. This section does not preclude the issuance of a policy or contract that combines two (2) or more of the categories of coverage enumerated in Subsection B or C.

Drafting Note: This subsection does not restrict reasonable combinations of the coverages in Subsection B and C. For example, accident only coverage may be issued in conjunction with other categories. However, the section does not permit the combination of specified disease or specified accident coverages with other categories of coverage unless specifically permitted by a regulation adopted pursuant to this Act. In addition, it should be noted that the combination of coverages might not qualify as "excepted benefits" under HIPAA, as amended by the ACA, thus making those combination policies subject to HIPAA requirements as amended by the ACA, and ACA requirements, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. States may want to consider developing regulations on combination products and the potential for such products to confuse consumers that the combination coverage is equivalent to comprehensive, major medical coverage.

E. A policy or contract shall not be delivered or issued for delivery in this state that does not meet the prescribed minimum standards for the categories of coverage listed in Subsection B or C or does not meet the requirements set forth in [insert reference to state law authorizing the commissioner to disapprove policy forms if the benefits provided in the policy forms are unreasonable in relation to the premium charged].

F. The commissioner shall prescribe the method of identification of policies, certificates and contracts based upon coverages provided.

Section 6. Disclosure Requirements

A. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of supplementary and short-term health insurance subject to this Act and limited scope dental coverage and limited scope vision coverage delivered or issued for delivery in this state.

B. If the sale of a policy described in Subsection A occurs through an insurance producer, the outline of coverage shall be delivered to the applicant at the time of application or to the certificateholder at the time of enrollment.

C. If the sale of a policy described in Subsection A occurs through direct response advertising, the outline of coverage shall be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.

D. If the outline of coverage required in Subsections A and H, and any regulations issued by the commissioner pursuant to this Act, is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee shall contain all the information required in Subsection H and in any regulations issued by the commissioner pursuant to this Act.

E. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer shall collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer shall maintain evidence of the delivery.

F. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued shall be delivered with the policy or certificate to the applicant or enrollee.

G. An insurer shall not be required to deliver an outline of coverage for group supplementary and short-term health insurance group limited scope dental coverage, and group limited scope vision coverage to individual members of the group if the certificate contains a brief description of:

(1) Benefits;

(2) Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;

(3) Conditions under which the insurance coverage may terminate; and

(4) Notice requirements as provided in the regulation promulgated pursuant to this Act.

Drafting Note: Advertisements can fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage under Subsection H and in the regulation promulgated pursuant to this Act.

H. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. "Format" means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include:

(1) A statement identifying the applicable category or categories of coverage as prescribed in Section 5 of this Act;

(2) A description of the principal benefits and coverage provided;

(3) A statement of the exceptions, reductions and limitations;

(4) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and

(5) A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions.

Drafting Note: Any possible conflict with Section 3A(1) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180) can be avoided by enclosing and not attaching the outline at the time of policy or certificate delivery.

I. An insurer shall deliver to persons eligible for Medicare notice required under [insert reference to state law equivalent to Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)].

J. For supplementary health insurance providing hospital indemnity or other fixed indemnity coverage, an insurer shall display prominently in the application materials in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to check the policy to understand what the policy covers and does not cover (including exclusions related to pre-existing conditions and treatment limitations on health benefits outside the scope of coverage.) The notice shall also state that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

Drafting Note: States may have to alter the language in Subsection J or consider additional disclosures to reflect hybrid types of supplementary coverage subject to this Act.

K. For short-term, limited-duration coverage, an insurer shall display prominently in the application materials provided in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to review and check the policy to understand what the policy covers and does not cover and the possibility that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the language in Subsection K to ensure it accurately reflects a state's specific requirements. States also should be aware that federal regulations effective Oct. 2, 2018 (see *Federal Register*, Vol. 83, No. 150, p. 38243 for the changes to 45 CFR §144.103), include specific notice requirements for short-term, limited-duration coverage, and recognize that the notice also may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage. States also may have to consider including language to alert consumers to potential issues to consider prior to enrollment when the consumer is purchasing coverage under a policy using funds from a health reimbursement account (HRA).

Section 7. Preexisting Conditions

A. Notwithstanding the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)], if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured's health at the time of application or enrollment, but without any questions concerning the prospective insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and except as so provided, the policy or certificate shall not include wording that would permit a defense based upon preexisting conditions**.**

Drafting Note: States that have specific requirements with respect to waivers, exclusionary riders or evidence of insurability for group insurance should modify Subsection A by deleting references to "enrollment" and adding a new subsection addressing the requirements.

B. Notwithstanding the provisions of Subsection A and the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)] an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form, may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least six (6) months, unless the loss results from a preexisting condition that first manifested itself within six (6) months prior to the effective date of the policy or certificate or was diagnosed by a physician at any time prior to that date. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

Section 8. Administrative Procedures

The adoption of regulations pursuant to this Act shall be subject to the notice and hearing requirements set forth in [insert reference to state law relating to the adoption and promulgation of rules and regulations or state Administrative Procedures Act].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1974 Proc. I 12, 14, 405, 413, 414-418 (adopted).
1977 Proc. I 26, 28, 49-53, 317, 325 (amended and reprinted).
1979 Proc. I 44, 47, 373, 385, 394-396 (amended).
1980 Proc. II 22, 26, 588, 591, 594, 634 (amended).
1989 Proc. II 13, 23-24, 467-468, 518-519, 544-548 (amended to remove references to Medicare supplement insurance).
1998 Proc. 4th Quarter 16, 17, 652, 654, 655-660 (amended and reprinted).
2019 Proc. 1st Quarter (amended and title changed from Accident and Sickness Insurance Minimum Standards Model Act).

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. ADMIN. CODE 054.00.18 (1981/2003).
California			CAL. INS. CODE §§ 10600 to 10609 (1974/2019).
Colorado	NO CURRENT ACTIVITY		
Connecticut		CONN. GEN. STAT. § 38a-505 (1976/2017).	
Delaware		DEL. CODE ANN. tit. 18, §§ 3601 to 3613 (1983/2019).	
District of Columbia	NO CURRENT ACTIVITY		
Florida		FLA. STAT. § 627.643 (1982/2003).	
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii			HAW. REV. STAT. ANN. § 431:10A-605 (2018).
Idaho		IDAHO CODE ANN. §§ 41-4201 to 41-4207 (1975/2009).	
Illinois			215 ILL. COMP. STAT. 5/355a (1980/2017).
Indiana	NO CURRENT ACTIVITY		
Iowa		IOWA CODE §§ 514D.1 to 514D.9 (1980/2013).	IOWA ADMIN. CODE r. 191-36.1 to 191-36.13 (514D) (1981/2019).
Kansas		KAN. STAT. ANN. §§ 40-2216 to 40-2220 (1976/1997).	
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2694 (2001).
Maryland			MD. CODE ANN. INS. § 12-102 (1963/2017).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire		N.H. REV. STAT. ANN. §§ 415-A:1 to 415-A:7 (1975/2019).	

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey			N.J. STAT. ANN. § 17B:26-45 (1979); N.J. ADMIN. CODE §§ 11:22-5.1 to 11:22-5.11 (2006/2019).
New Mexico			N.M. STAT. ANN. §§ 59A-23G-1 to 59A-23G-7 (2019).
New York			N.Y. INS. LAW § 3217 (1984/2017).
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE ANN. § 26.1-36-49 (2019).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, § 3611 (1957/1993); OKLA. ADMIN. CODE §§ 365:10-5-1 to 365:10-5-9 (1991/2011).
Oregon			OR. REV. STAT. § 743.010 (1979/2018) (authority to adopt).
Pennsylvania		40 PA. STAT. ANN. §§ 776.1 to 776.7 (1976).	
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS §§ 27-18-1 to 27-18-84 (1956/2012).
South Carolina			S.C. CODE ANN. §§ 38-71-510 to 38-71-560 (1988/1993).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 1201.101 to 1201.154 (2005/2015); § 1202.051 (2005).

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah		UTAH CODE ANN. §§ 31A-22-605 to 31A-22-606 (1986/2019).	
Vermont			4-3 VT. CODE R. § 8 (1980).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		VA. CODE ANN. §§ 38.2-3516 to 38.2-3520 (1986/2013).	
Washington		WASH. REV. CODE ANN. §§ 48.20.450 to 48.20.480 (1975).	
West Virginia		W. VA. CODE §§ 33-28-1 to 33-28-7 (1974/1996).	
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2019

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#170)

1. Description of the Project, Issues Addressed, etc.

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing NAIC existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, the Task Force added the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) to the list of NAIC models to be considered for revision given the model's provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled *Managed Care Network Adequacy Model Act* (#74), now the *Health Benefit Plan Network Access and Adequacy Model Act* (#74), to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished its work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. In March 2016, the Subgroup began meeting every other week to review and discuss the comments received on Model #170 by the Jan. 22, 2016, public comment deadline. The Subgroup met throughout 2016 until November 2016. During its conference calls, the Subgroup discussed a myriad of issues with respect to the revisions to Model #170, including issues concerning the definition of "hospital indemnity or other fixed indemnity insurance;" short-term, limited-duration insurance; and the disclosure of certain information with respect to these coverages as reflected in federal regulations. The Subgroup also discussed initial revisions to Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA's future, given congressional proposals to repeal, replace and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. During its first meetings in 2018, the Subgroup decided to focus first on revisions to Model #170, and after those revisions were complete, the Subgroup would begin discussion of revisions to Model #171. During its meetings via conference call, the Subgroup continued its discussions of revisions to Model #170 to address issues related to hospital indemnity or other fixed indemnity insurance; and short-term, limited-duration insurance. The Subgroup also discussed what language disclosures and notices carriers must provide to consumers purchasing such coverage to alert consumers that these types of coverages are not required to comply with the requirements of the ACA because they are not considered the types of health insurance coverage subject to the ACA's requirements. The Subgroup also discussed revisions to Model #170's scope section for consistency with the types of coverage subject to the model's provisions.

The Subgroup adopted the revisions July 23, 2018. As part of its adoption, the Subgroup established a 30-day public comment period ending Aug. 27, 2018, for the Task Force to receive comments on the revised model. Following the end of the public comment period, the Task Force met Oct. 17 and Sept. 24, 2018, via conference call to discuss the comments received focusing on comments received related to Model #170's title and other clarifying suggested revisions. The Task Force adopted the revised model at the 2018 Fall National Meeting. The Health Insurance and Managed Care (B) Committee adopted the revisions Feb. 14.

The proposed revisions to Model #170 remove provisions in the model concerning the type of health insurance plans subject to the ACA's requirements, such as its guaranteed issue, guaranteed renewal, and prohibition on preexisting condition exclusion requirements. The revisions add specific provisions concerning short-term, limited-duration insurance; and hospital indemnity or other fixed indemnity insurance, including definitions of the terms and provisions requiring that certain notices and disclosures be provided to consumers purchasing such coverage.

2. Name of Group Responsible for Drafting the Model and States Participating

The Subgroup of the Task Force drafted the proposed revisions to Model #170. The members of the Subgroup were: Wisconsin, Chair; Colorado; Florida; Iowa; Louisiana; Maine; Missouri; Nebraska; Oklahoma; Oregon; Pennsylvania; South Carolina; Utah; Vermont; and Washington. The Task Force adopted additional revisions to Model #170 following the Subgroup's adoption of the proposed revisions. The members of the Task Force were: Wisconsin, Chair; Colorado, Vice Chair; Alaska; American Samoa; Arkansas; California; District of Columbia; Florida; Idaho; Iowa; Kansas; Kentucky; Maine; Maryland; Massachusetts; Minnesota; Missouri; Nebraska; New Hampshire; North Carolina; North Dakota; Oklahoma; Pennsylvania; South Dakota; Texas; Utah; Virginia; Washington; and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The Task Force established the Subgroup in February 2016 to consider revisions to Model #170 and Model #171 based on the Task Force's continuing charge to "review the model law review recommendations of NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group to revise the NAIC model(s) prioritized for revision in 2016."

Based on that charge, the Task Force's charge to the Subgroup is to"review and consider revisions to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) and its companion regulation, the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171)."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2016 and ending in July 2018, the reviewed and discussed all comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and other stakeholders. Each draft of proposed revisions was posted to the Subgroup's webpage and as appropriate, the Task Force's webpage, on the NAIC website. All comment letters received were also posted.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2016 and ending in July 2018, the Subgroup reviewed and discussed all comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and other stakeholders. Each draft of proposed revisions was posted to the Subgroup's webpage and as appropriate, the Task Force's webpage, on the NAIC website. All comment letters received were also posted.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

A few significant issues were raised and addressed during the drafting process. Those issues focused on: 1) the definition of "short-term, limited-duration insurance;" and 2) what specific information insurers must include in the notices provided to consumers purchasing hospital indemnity or other fixed indemnity insurance or short-term, limited-duration insurance. Specifically, regarding the definition of "short-term, limited-duration insurance," the Subgroup discussed whether the draft should reflect language in the final federal regulations defining the maximum duration of such coverage or whether to provide flexibility to the states to establish their own such provisions. After extended discussion, given the different requirements the states have with respect to the duration of short-term, limited-duration insurance coverage and the renewal of such coverage, the Subgroup decided to include in the revisions language in the definition of "short-term, limited-duration coverage," in proposed Section 3I, providing flexibility to the states to establish their own requirements related to such coverage. The Subgroup also added a drafting note for proposed Section 3I explaining its rationale. In its discussions related to the information insurers must include in the notices to be provided to consumers purchasing hospital indemnity or other fixed indemnity insurance or short-term, limited-duration insurance coverage, the Subgroup discussed how detailed the language should be with respect to distinguishing these types of coverage from major, medical insurance coverage and the ACA requirements. The Subgroup decided not to be too detailed in order avoid consumer confusion. The Subgroup decided to require insurers to include in the notices broad language noting these coverages are not required to comply with ACA requirements. In addition, the Subgroup decided to require that insurers include in the notice language advising consumers to check the policy to understand what it covers and does not cover as an additional measure to help ensure that consumers know what they are purchasing.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

Section-by-Section Summary of Proposed Revisions

The proposed revisions to Model #170 revise the title to "Supplementary and Short-Term Health Insurance Minimum Standards Model Act."

Section 1. Purpose

The proposed revisions to Model #170 revise this section for consistency with the substantive changes to the model, which remove provisions concerning the types of health insurance coverage subject to the requirements of the ACA.

Section 2. Applicability and Scope

The proposed revisions to Model #170 for this section clarify what types of health insurance coverage are subject to and not subject to its requirements.

Section 3. Definitions

The proposed revisions to Model #170 for this section add, revise and delete definitions to reflect the substantive changes made in the other sections of the model. The proposed revisions add new definitions for the terms: 1) hospital indemnity or other fixed indemnity insurance; 2) limited scope dental coverage; 3) limited scope vision coverage; 4) short-term, limited-duration insurance; and 5) supplementary and short-term health insurance. The proposed revisions revise and delete several definitions for consistency with the substantive changes to the model's provisions.

Section 4. Standards for Policy Provisions

The proposed revisions to Model #170 for this section make a few revisions for consistency with the substantive revisions to the model. The proposed revisions also clarify a few of the standards for policy provisions related to terms of renewability or extensions of coverage and preexisting condition exclusions.

Section 5. Minimum Standards for Benefits

The proposed revisions to Model #170 revise this section for consistency with the substantive revisions to other sections in the model. For example, the proposed revisions delete references to the health insurance coverage subject to the ACA's requirements removed from the model. The proposed revisions also make a few non-substantive changes.

Section 6. Disclosure Requirements

The proposed revisions to Model #170 revise this section for consistency with the substantive revisions to other sections in the model. The proposed revisions to this section also add new consumer notice requirements for hospital indemnity or other fixed indemnity insurance coverage and short-term, limited-duration insurance coverage.

Section 7. Preexisting Conditions

The proposed revisions to Model #170 make no changes to this section.

Section 8. Administrative Procedures

The proposed revisions to Model #170 make no changes to this section.

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC Accident and Sickness Insurance Minimum Standards Model Act] (the Act) to standardize and simplify the terms and coverages of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease. specified accident or limited benefit health coverage (hereafter referred to as "group supplemental health insurance"). This regulation is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims; and to provide for full disclosure in the marketing and sale of individual accident and sickness insurance policies and group supplemental health insurance. This regulation is also intended to assert the commissioner's jurisdiction over dental and vision plans, and to provide for disclosure in the sale of those plans.

Drafting Note: States should determine if the phrase "individual accident and sickness insurance policies" is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. "subscriber contracts" of "nonprofit hospital, medical and dental associations") to cover these plans should choose terminology conforming to state statute.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC Accident and Sickness Insurance Minimum Standards Model Act and any other appropriate section of law regarding authority of commissioner to issue regulations].

Section 3. Applicability and Scope

A. This regulation applies to all individual accident and sickness insurance policies and group supplemental health policies and certificates, delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation.

B. This Act shall apply to dental plans and vision plans only as specified.

C. This regulation shall not apply to:

(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;

(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;

(3) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act];

(4) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act]; or

(5) Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10 of the United States Code) (CHAMPUS) supplement insurance policies.

Drafting Note: CHAMPUS supplement insurance is not subject to federal regulation. CHAMPUS supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to CHAMPUS benefits. In general, states regulate CHAMPUS supplement insurance policies under the state group or individual insurance laws.

D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation].

Section 5. Policy Definitions

A. Except as providedin this regulation, an individual accident and sickness insurance policy or group supplemental health insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

B (1) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(2) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested;

(c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

(2) The definition of the home or facility may provide that the term shall not be inclusive of:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state law may be required in structuring this definition.

D. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" may state that the term shall not be inclusive of:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

(b) Facilities affording primarily custodial, educational or rehabilitory care;

(c) Facilities for the aged, drug addicts or alcoholics; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

E. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

F. "Mental or nervous disorder" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

G. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

H. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important" or "essential" duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation.

J. "Physician" may be defined by including words such as "qualified physician" or "licensed physician." The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

K. "Preexisting condition" shall not be defined more restrictively than the following: "Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the "federal fallback" provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.

L. "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

M. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person." The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section 6. Prohibited Policy Provisions

A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.

(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.

C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate**.**

Drafting Note: Where the state has enacted the NAIC Individual Accident and Sickness Insurance Minimum Standard Act Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.

D. A disability income policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addition;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7H of this regulation;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

(5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

(7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effectsof it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing "freedom of choice" statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.

(8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen's compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(9) Dental care or treatment;

(10) Eye glasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations; and

(12) Territorial limitations.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

G. This regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

Drafting Note: States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.

H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 3B of the Accident and Sickness Insurance Minimum Standards Act] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

Section 7. Accident and Sickness Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. An individual accident and sickness insurance policy or group supplemental health insurance policy shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 8L of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in [cite state law equivalent to Section 5A and B of the NAIC Accident and Sickness Insurance Minimum Standards Model Act].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual accident and sickness policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual accident and sickness policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

(c) An individual accident and sickness or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

(d) Except as provided above, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(3) In an individual accident and sickness policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA or applicable state law.

(4) When accidental death and dismemberment coverage is part of the individual accident and sickness insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(8) In individual accident and sickness insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy shall be without prejudice ~~of~~ to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

B. Basic Hospital Expense Coverage

"Basic hospital expense coverage" is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of:

(a) [80%] of the charges for semiprivate room accommodations or

(b) [$100] per day;

Drafting Note: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: "except that $[insert amount] may be reduced to $[insert amount] outside the area." Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [$3,000] or [ten] times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed,

(b) Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than [$150]; and

(c) X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [$100] if rendered to an in-patient of the hospital.

(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [$100].

C. Basic Medical-Surgical Expense Coverage

"Basic medical-surgical expense coverage" is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule].up to a maximum of at least [$1000] for a one procedure; or

(b) Not less than [80%] of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:

(a) In an amount not less than [80%] of the reasonable charges; or

(b) [15%] of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than [80%] of the reasonable charges, or [$50] per day for not less than twenty-one (21) days during one period of confinement.

Basic Hospital/Medical-Surgical Expense Coverage

"Basic hospital/medical-surgical expense coverage" is a combined coverage and must meet the requirements of both Subsections B and C.

D. Hospital Confinement Indemnity Coverage

(1) "Hospital confinement indemnity coverage" is a policy of accident and sickness insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.

(2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.

Drafting Note: Hospital confinement indemnity coverage is recognized as supplemental coverage. Any hospital confinement indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement indemnity coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts…." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement indemnity coverage purchased by the insured.

E. Individual Major Medical Expense Coverage

(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:

(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(g) Not fewer than three (3) of the following additional benefits:

(i) In-hospital private duty registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physiotherapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

(v) Artificial limbs or eyes, casts, splints, trusses or braces;

(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or

(vii) Out-of-hospital prescription drugs and medications.

(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

(3) The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

F. Individual Basic Medical Expense Coverage

(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:

(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty-one (31) days during continuous hospital confinement;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(g) Not fewer than three (3) of the following additional benefits:

(i) In-hospital private duty graduate registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physiotherapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

(v) Artificial limbs or eyes, casts, splints, trusses or braces;

(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or

(vii) Out-of-hospital prescription drugs and medications.

(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7G(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, anindividual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

G. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62);

(2) Contains an elimination period no greater than:

(a) Ninety (90) days in the case of a coverage providing a benefit of one year or less;

(b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

(c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 7F does not apply to those policies providing business buy-out coverage;

(4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

H. Accident Only Coverage

"Accident only coverage" is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least [$1,000] and a single dismemberment amount shall be at least [$500].

I. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be acceptedinstead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditionsor diseases, directly caused or aggravated by the specified diseasesor the treatment of the specified disease.

(d) Individual accident and sickness policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

(f) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(g) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.

Drafting Note: Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

(h) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(i) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges."

(j) "Preexisting condition" shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

(k) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.

(l) Hospice Care.

(i) "Hospice" means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least $50 per day; and

(III) A lifetime maximum benefit limit of at least $10,000.

(iii) Hospice care does not cover nonterminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [$250] and an overall aggregate benefit limit of no less than [$10,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a legally qualified physician or surgeon;

(iii) Private duty services of a registered nurse (R.N.);

(iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(v) Professional ambulance for local service to or from a local hospital;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

(viii) The rental of an iron lung or similar mechanical apparatus;

(ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [$25,000] payable at the rate of not less than [$50] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [$250], and an overall aggregate benefit limit of not less than [$10,000] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:

(a) Treatment by, or under the direction of, a legally qualified physician or surgeon;

(b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;

(c) Hospital room and board and any other hospital furnished medical services or supplies;

(d) Blood transfusions and their administration, including expense incurred for blood donors;

(e) Drugs and medicines prescribed by a physician;

(f) Professional ambulance for local service to or from a local hospital;

(g) Private duty services of a registered nurse provided in a hospital;

(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;

(i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;

(j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(k) (i) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:

(I) It is primarily engaged in providing home health care services;

(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;

(III) A physician or a registered nurse provides supervision of home health care services;

(IV) It maintains clinical records on all patients; and

(V) It has a full time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

(ii) Home health includes, but is not limited to:

(I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

(II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

(III) Physical, occupational or speech and hearing therapy; and

(IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.

(l) Physical, speech, hearing and occupational therapy;

(m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(n) Prosthetic devices including wigs and artificial breasts;

(o) Nursing home care for noncustodial services; and

(p) Reconstructive surgery when deemed necessary by the attending physician.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least [$100] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least $50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:

(i) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should be sensitive to this possibility in approving policies.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

J. Specified Accident Coverage

"Specified accident coverage" is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than [$1,000] for accidental death, [$1,000] for double dismemberment [$500] for single dismemberment.

K. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, C, D, E, F, G, I and K. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8L of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7J and shall not be offered for sale as a "limited coverage."

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act and Medicare Supplement Insurance Minimum Standards Model Act].

Drafting Note: The NAIC Long-Term Care Insurance Model Act defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited benefit health plans, and should be subject to the NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation.

Section 8. Required Disclosure Provisions

A. General Rules

(1) All applications for coverages specified in Sections 7B, C, D, E, G, I, J, K and L shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."

(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."

(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."

(4) Each policy of individual accident and sickness insurance and group supplemental health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(5) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificateholder also pays the insurance premium.

(6) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate.

(7) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(8) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(9) All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

"Notice to Buyer: This is an accident-only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."

Accident-only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(10) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificateholder is not satisfied for any reason.

Drafting Note: This section should be included only if the state has legislation granting authority.

(11) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage.

(12) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(13) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (Section 7E), specified disease (Section 7J), or limited benefit health coverages (Section 7L) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections F and J, the following language, which shall be printed on or attached to the first page of the outline of coverage:

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act].

(14) Insurers, except direct response insurers, shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery. Direct response insurers shall provide the Buyer's Guide upon request but not later than the time that the policy or certificate is delivered.

(15) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows:Notice to Buyer: This is a specified disease [policy] [certificate].This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide.

Drafting Note: The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.

(16) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(19) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(20) All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital/medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:

"Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."

(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This [policy] [certificate] provides dental benefits only."

(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This [policy] [certificate] provides vision benefits only."

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued."

(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(5) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

C. Basic Hospital Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC HOSPITAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE
THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days' duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital outpatient services;

(d) Surgical services;

(e) Anesthesia services;

(f) In-hospital medical services; and

(g) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

F. Hospital Confinement Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7E of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

HOSPITAL CONFINEMENT INDEMNITY COVERAGE
THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Hospital confinement indemnity coverageis designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) [A brief specific description of the benefits in the following order:

(a) Daily benefit payable during hospital confinement; and

(b) Duration of benefit described in (a).]

Drafting Note: The above description of benefits shall be stated clearly and concisely.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [Any benefits provided in addition to the daily hospital benefit.]

G. Individual Major Medical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!]

(2) Individual major medical expense voverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services,

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services,

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

H. Individual Basic Medical Expense Coverage

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services,

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services,

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

I. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) [A brief specific description of the benefits contained in this policy.]

Drafting Note: The above description of benefits shall be stated clearly and concisely.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

J. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Section 7I of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

ACCIDENT-ONLY COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) [A brief specific description of the benefits.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

K. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections 7J and K of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(2) Read Your [policy] [certificate][Outline of Coverage] Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(3) [Specified disease][Specified accident] coverageis designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [A brief specific description of the benefits, including dollar amounts.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, andshall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

L. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections 7B, C, D, E, F, G, I and K of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR[POLICY][CERTIFICATE] CAREFULLY!

(2) Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

(3) [A brief specific description of the benefits, including dollar amounts.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

(4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

M. Dental Plans (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR[POLICY][CERTIFICATE] CAREFULLY!

(2) [A brief specific description of the benefits.]

(3) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (1) above.]

(4) [A descripton of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

N. Vision Plans (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR[POLICY][CERTIFICATE] CAREFULLY!

(2) [A brief specific description of the benefits.]

(3) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (1) above.]

(4) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section 9. Requirements for Replacement of Individual Accident and Sickness Insurance

Drafting Note: Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

Section 10. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1975 Proc. I 2, 6, 573, 575, 590-605 (adopted).
1977 Proc. I 26, 28, 54-77, 317, 325 (amended).
1979 Proc. II 31, 34, 327, 333, 339-344 (amended regarding Medicare supplement insurance).
1980 Proc. II 22, 26, 588, 591, 594, 622, 634-636 (amended).
1989 Proc. II 13, 23-24, 467-468, 518-519, 548-570 (amended to remove reference to Medicare supplement insurance).
1998 Proc. 4th Quarter 16, 17, 652, 654, 660-687 (amended and reprinted).

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas		ARK. ADMIN. CODE 054.00.18-1 to 054.00.18-10 (2003).	
California		CAL. CODE REGS. tit. 10, §§ 2540 to 2540.8 (1976).	CAL. CODE REGS. tit. 10, §§ 2220.19 to 2220.31 (1972).
Colorado	NO CURRENT ACTIVITY		
Connecticut		CONN. AGENCIES REGS §§ 38a-505-1 to 38a-505-13 (1979/2013).	
Delaware			DEL. CODE ANN. tit. 18, §§ 3601 to 3613 (2013).
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-154.102 to 69O-154.107 (1975/2003) (portions of model).		

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO ADMIN. CODE r. 18.04.08.012 to 18.04.08.029 (2019).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2007.10 to 2007.100 (1978/2014) (portions of model).		
Indiana	NO CURRENT ACTIVITY		
Iowa		IOWA ADMIN. CODE r. 191-36.1 to 191-36.12 (1981/2007).	
Kansas	NO CURRENT ACTIVITY		KAN. ADMIN. REGS. §§ 40-4-22 to 40-4-33 (1975/1986).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	02-031 CODE ME. R. ch. 755 (2004).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	211 MASS. CODE REGS. 42.01 to 42.11 (1974/2003) (portions of model).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. 1902.07 (2006) (medicare).
New Jersey	N.J. ADMIN. CODE §§ 11:4-16.1 to 11:4-16.11 (1981/2012).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.1 to 52.17; §§ 52.54. to 52.63 (Regulation 62) (1983/2008) (portions of model).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-5-1 to 365:10-5-8 (1981/2005).	
Oregon	NO CURRENT ACTIVITY		
Pennsylvania		PA. CODE §§ 88.131 to 88.195 (1982/1989).	
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			230 R.I. CODE R. 20-30-1.1 to 20-30-1.15 (2001).
South Carolina		S.C. CODE ANN. REGS. 69-34 (1981)/1989).	
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas	TEX. ADMIN. CODE §§ 3.3001 to 3.3111 (1977/1997).		
Utah	UTAH ADMIN. CODE r. 590-126 (1989/2009) (also applies to long-term care and Medicare supplement policies).		
Vermont		4-3 VT. CODE R. § 8 (1980).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		14 VA. ADMIN. CODE §§ 5-140-10 to 5-140-100 (1989).	
Washington		WASH. ADMIN. CODE 284-50-300 to 284-50-435 (1977/1987).	
West Virginia	W. VA. CODE R. §§ 114-12-1 to 114-12-8 (1974/1999); §§ 114-39-1 to 114-39-10 (1994/2003) (group).		
Wisconsin			WIS. ADMIN. CODE INS. § 3.13 (1982/2009); § 3.28 (1974/1999); § 3.29 (1974/2009).
Wyoming	NO CURRENT ACTIVITY		

UNIFORM INDIVIDUAL ACCIDENT AND SICKNESS POLICY PROVISION LAW

Table of Contents

Section 1. Definition of Accident and Sickness Insurance Policy

The term "policy of accident and sickness insurance" as used herein includes any policy or contract covering the kind or kinds of insurance described in [insert here the section of law authorizing accident and sickness insurance].

Drafting Note: If the insurance law of the state in which this draft is proposed for enactment does not have a section specifically authorizing the various types of insurance which may be written, this section should be modified to define accident and sickness insurance as "insurance against loss resulting from sickness or from bodily injury or death by accident, or both."

Section 2. Form of Policy

A. No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen (19) years and any other person dependent upon the policyholder; and

Drafting Note: In states having community property systems derived from the civil law it is suggested that in the foregoing subparagraph the words "an adult member" be replaced with "the head."

(4) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); and

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 3 of this Act, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commissioner.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of the other state shall have advised the Commissioner that the policy is not subject to approval or disapproval by the official, the Commissioner may by ruling require that the policy meet the standards set forth in Subsection A of this section and in Section 3.

Section 3. Accident and Sickness Policy Provisions

A. Required Provisions.

Except as provided in Subsection C, each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision as follows:

Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Drafting Note: When enacted in states which prohibit amendment of a policy form by means other than attached printed rider upon a separate piece of paper the new law should contain (but not as a required policy provision) an added section defining "endorsement" in such a manner as to make the new law consistent with current statutes.

(2) A provision as follows:

Time Limit on Certain Defenses:

(a) After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the three-year period.

Drafting Note: The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three-year period, nor to limit the application of Sections 3B(1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.

Drafting Note: A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable:"

After this policy has been in force for a period of three (3) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three (3) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) A provision as follows:

Grace Period: A grace period of [insert a number not less than 7 for weekly premium policies, 10 for monthly premium policies and 31 for all other policies] days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

Drafting Note: A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision:

Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address, as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted;

(4) A provision as follows:

Renewal: Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision thereof or in an endorsement thereon or in a rider attached thereto, that subject to the right to terminate the policy upon non-payment of premium when due, the right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest each anniversary of the last reinstatement, and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.

(5) A provision as follows:

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking such approval, upon the forty-fifth day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after that date. In all other respects the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to the provisions of any rider which may be attached in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Drafting Note: The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue.

Drafting Note: For a statement of interpretation of this provision. See 1963 NAIC Proceedings II 514-517.

(6) A provision as follows:

Notice of Claim: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at [insert the location of such office as the insurer may designate for the purpose], or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Drafting Note: In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which notice is actually given.

(7) A provision as follows:

Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If forms are not furnished within fifteen (15) days after the giving of notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(8) A provision as follows:

Proofs of Loss: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of the loss. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within that time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(9) A provision as follows:

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid [insert period for payment which must not be less frequently than monthly] and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(10) A provision as follows:

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, the indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities will be payable to the insured.

Drafting Note: The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release; the insurer may pay such indemnity, up to an amount not exceeding $[insert an amount which shall not exceed $1000], to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of the payment.

Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(11) A provision as follows:

Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(12) A provision as follows:

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(13) A provision as follows:

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Drafting Note: The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

B. Other Provisions

Except as provided in Subsection C, no policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision as follows:

Change of Occupation: If the insured is injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows:

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows:

Overinsurance: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for [insert type of coverage or coverages] in excess of $[insert maximum limit of indemnity or indemnities] the excess shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

or, in lieu thereof:

Insurance effective at any one time on the insured under this policy and a like policy or policies in this insurer is limited to the one policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows:

Overinsurance: If, with respect to a person covered under this policy, benefits for allowable expense incurred during a claim determination period under this policy together with benefits for allowable expense during such period under all other valid coverage (without giving effect to this provision or to any "overinsurance provision" applying to such other valid coverage), exceed the total of the person's allowable expense during the period, this insurer shall be liable only for the proportionate amount of the benefits for allowable expense under this policy during the period as the total allowable expense during such period bears to the total amount of benefits payable during the period for expense under this policy and all other valid coverage (without giving effect to this provision or to any overinsurance provision applying to the other valid coverage) less any amount of benefits for allowable expense payable under other valid coverage which does not contain an overinsurance provision. In no event shall this provision operate to increase the amount of benefits for allowable expense payable under this policy with respect to a person covered under this policy above the amount which would have been paid in the absence of this provision. This insurer may pay benefits to any insurer providing other valid coverage in the event of overpayment by such insurer. Any such payment shall discharge the liability of this insurer as fully as if the payment had been made directly to the insured, his assignee or his beneficiary. In the event that this insurer pays benefits to the insured, his assignee or his beneficiary, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, this insurer shall have a right of action against the insured, his assignee or his beneficiary, to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid

coverage. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of such coverage.

For purposes of this provision:

(a) "Allowable expense" means 110 percent of any necessary, reasonable and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical or major medical expense under this policy or under any other valid coverage.

(b) "Claim determination period" with respect to any covered person means the initial period of [insert period of not less than 30 days] and each successive period of a like number of days, during which allowable expense covered under this policy is incurred on account of such person. The first period begins on the date when the first expense is incurred, and successive periods shall begin when expense is incurred after expiration of a prior period.

or, in lieu thereof:

"Claim determination period" with respect to any covered person means each [insert calendar or policy period of not less than a month] during which allowable expense covered under this policy is incurred on account of such person.

(c) "Overinsurance provision" means this provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.

Drafting Note: The foregoing policy provision may be inserted in all (guaranteed renewable and non-cancellable as well as guaranteed renewable) policies providing hospital, surgical, medical or major medical benefits. The insurer may make this provision applicable to either or both (a) other valid coverage with other insurers and, (b) except for individual policies individually underwritten, other valid coverage with the same insurer. The insurer shall include in this provision a definition of "other valid coverage" approved as to form by the Commissioner. The term may include hospital, surgical, medical or major medical benefits provided by group, blanket or franchise coverage, individual and family-type coverage, Blue Cross-Blue Shield coverage and other prepayment plans, group practice and individual practice plans, uninsured benefits provided by labor-management trusteed plans, or union welfare plans, or by employer or employee benefit organizations, benefits provided under governmental programs, workmen's compensation insurance or any coverage required or provided by any other statute, and medical payments under automobile liability and personal liability policies. Other valid coverage shall not include payments made under third party liability coverage as a result of a determination of negligence, but an insurer may at its option include a subrogation clause in its policy. The insurer may require, as part of the proof of claim, the information necessary to administer this provision.

(5) A provision as follows:

Overinsurance: After the loss-of-time benefit of this policy has been payable for ninety (90) days, the benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed [insert amount] percent of the insured's earned income; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under this policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded [insert amount] percent of the insured's earned income at the time of such application, the higher percentage will be used in place of [insert amount] percent. The adjusted loss-of-time benefit under this policy for any month shall be only such proportion of the loss-of-time benefit otherwise payable under this policy as (i) the product of the insured's earned income and [insert amount] percent (or, if higher, the alternative percentage described at the end of the first sentence of this provision) bears to (ii) the total amount of loss-of-time benefits payable for such month under this policy and all other valid loss-of-time coverage on the insured (without giving effect to the overinsurance provision in this or any other coverage) less in both (i) and (ii) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an overinsurance provision. In making the computation, all benefits and earnings shall be converted to a consistent [insert "weekly" if the loss-of-time benefit of this policy is payable weekly, "monthly" if the benefit is payable monthly, etc.] basis. If the numerator of the foregoing ratio is zero or is negative, no benefit shall be payable under this policy. In no event shall this provision operate to reduce the total combined amount of loss-of-time benefits for such month payable under this policy and all other valid loss-of-time coverage below the less of $300 and the total combined amount of loss-of-time benefits determined without giving effect to any overinsurance provision, or operate to increase

the amount of benefits payable under this policy above the amount which would have been paid in the absence of this provision, or take into account or operate to reduce any benefit other than the loss-of-time benefit.

For purposes of this provision:

(a) "Earned income," except where otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and his average monthly earnings for a period of two (2) years immediately preceding the commencement of disability, and shall not include any investment income or any other income not derived from the insured's vocational activities.

(b) "Overinsurance provision" shall include this provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings.

Drafting Note: The foregoing provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least fifty-two weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits or the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent, selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage shall be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy shall include a definition of "valid loss-of-time coverage," approved as to form by the Commissioner, which definition may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance authorities of this or any other state of the United States or of any other country or subdivision thereof, coverage provided for such insured pursuant to any disability benefits statute or any workmen's compensation or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved by the Commissioner.

(6) A provision as follows:

Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(7) A provision as follows:

Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(8) A provision as follows:

Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(9) (a) A provision as follows:

Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(b) This provision may not be used with respect to a medical expense policy.

(c) For purposes of this provision, "medical expense policy" means an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage.

Drafting Note: Paragraphs (9) and (10) are suggested for states which desire such provisions.

C. Inapplicable or Inconsistent Provisions

If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

D. Order of Certain Policy Provisions

The provisions which are the subject of Subsections A and B of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provisions may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

E. Third Party Ownership

The word "insured," as used in this Act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

F. Requirements of Other Jurisdictions

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this Act and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

G. Filing Procedure

The Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this Act as are necessary, proper or advisable to the administration of this Act. This provision shall not abridge any other authority granted the Commissioner by law.

Section 4. Conforming to Statute

A. Other Policy Provisions

No policy which is not subject to Section 3 of this Act shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this Act.

B. Policy Conflicting with this Act

A policy delivered or issued for delivery to any person in this state in violation of this Act shall be held valid but shall be construed as provided in this Act. When any provision in a policy subject to this Act is in conflict with any provision of this Act, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this Act.

Section 5. Application

A. The insured shall not be bound by any statement made in an application for a policy unless a copy of the application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of the policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen (15) days after the receipt of the request at its home office or any branch office of the insurer, deliver or mail to the person making the request, a copy of the application. If the copy shall not be so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

C. The falsity of any statement in the application for any policy covered by this Act may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Drafting Note: Section 5, or any subsection thereof, is suggested for use in states which have no comparable statutes relating to the application.

Section 6. Notice, Waiver

The acknowledgment by any insurer of the receipt of notice given under any policy covered by this Act, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Section 7. Age Limit

If any policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Section 8. Non-Application to Certain Policies

Nothing in this Act shall apply to or affect:

A. Any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or

B. Any policy or contract of reinsurance; or

C. Any blanket or group policy of insurance; or

D. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident, or as

(b Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

Drafting Note: This provision may, if desired, be modified in individual states so as to be consistent with current statutes of such states.

Section 9. Violation

Any person, partnership or corporation willfully violating any provision of this Act or order of the Commissioner made in accordance with this Act, shall forfeit to the people of the state a sum not to exceed $[insert amount] for each violation, which may be recovered by a civil action. The Commissioner may also suspend or revoke the license of an insurer or agent for any willful violation.

Drafting Note: This provision is to be used only in those states which do not have similar legislation now in effect.

Section 10. Judicial Review

Any order or decision of the Commissioner under this Act shall be subject to review by appeal (writ of certiorari) to the [insert title] Court at the instance of any party in interest. The filing of the appeal (petition for such writ) shall operate as a stay of any such order or decision until the Court directs otherwise. The Court may review all the facts and, in disposing of the issue before it, may modify, affirm or reverse the order or decision of the Commissioner in whole or in part.

Drafting Note: This provision is to be used only in those states which do not have similar legislation now in effect.

Section 11. Repeal of Inconsistent Acts

Note: This section should contain suitable language to repeal acts or parts of acts presently enacted and inconsistent with this Act. The repealing section should contain an appropriate exception with regard to Section 12 of this Act.

Section 12. Effective Date of Act

This Act shall take effect on the [insert day] of [insert month], 19 [insert year]. A policy, rider or endorsement which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before the effective date of this Act may be used or delivered or issued for delivery to any such person during five (5) years after the effective date of this Act.

APPENDIX A

PROPOSED REGULATION REGARDING OVERINSURANCE PROVISIONS

Each individual health insurance policy, delivered or issued for delivery in this State on or after [insert effective date], which contains the overinsurance provisions authorized in [insert reference to statutory section which contains Section 3B(4) of the Uniform Individual Accident and Sickness Policy Provisions Law] or [insert reference to statutory section which contains Section 3B(5) of the Uniform Individual Accident and Sickness Policy Provisions Law] or, at the option of the insurer, the application for such policy, shall contain, or have attached to or be stamped or endorsed to add, a statement to the effect that benefits under the policy are subject to reduction if the insured has benefits under any other coverage of the type described in the overinsurance provision causing overinsurance as defined in such provision. If the insurer elects to include such statement in the policy, rather than in the application, the policy shall also contain, or have attached to or be stamped or endorsed to add, an additional statement to the effect that during a period of ten (10) days from the date the policy is delivered to the policyholder, it may be surrendered to the insurer together with a written request for cancellation of the policy and in such event the insurer will refund any premium paid therefor including any policy fees or other charges.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1950 Proc. 398, 399-413, 414 (adopted).
1956 Proc. II 289-290, 315 (amended).
1964 Proc. I 91, 95, 98-101, 115 (amended).
2001 Proc. 1st Quarter 18, 97-98, 106-107, 178 (amended).

See Also:
1979 Proc. I 375 (UPPL restated in simplified language) (P. 185-1).

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What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-19-1 to 27-19-36 (1972).		
Alaska	ALASKA STAT. §§ 21.51.010 to 21.51.340 (1966/1990).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1341 to 20-1374 (1954/2014).		
Arkansas	ARK. CODE ANN. §§ 23-85-101 to 23-85-140 (1959).		
California	CAL. INS. CODE §§ 10320 to 10383 (1951).		
Colorado	COLO. REV. STAT. §§ 10-16-201 to 10-16-212 (1992); §§ 10-16-216 to 10-16-218 (1992/2013).		BULLETIN B-4.59 (2103).
Connecticut	CONN. GEN. STAT. §§ 38a-480 to 38a-506 (1951/2014).		
Delaware	DEL. CODE ANN. tit. 18, §§ 3301 to 3332 (1953/2013).		
District of Columbia	D.C. CODE § 31-4712(b) (1976).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. §§ 627.601 to 627.635 (1982/1992).		
Georgia	GA. CODE ANN. §§ 33-29-1 to 33-29-17 (1960).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:10A-105 to 431:10A-114 (1988/2004).		
Idaho	IDAHO CODE ANN. §§ 41-2101 to 41-2135 (1961).		
Illinois	215 ILL. COMP. STAT. 5/356a to 5/362a (1951/2013).		
Indiana	IND. CODE §§ 27-8-5-1 to 27-8-5-9 (1953/2013).		
Iowa	IOWA CODE §§ 514A.1 to 514A.12 (1951).		
Kansas	KAN. STAT. ANN. §§ 40-2201 to 40-2208 (1951/1989).		
Kentucky	KY. REV. STAT. ANN. §§ 304.17-010 to 304.17-260 (1970/1998).		
Louisiana	LA. REV. STAT. ANN. §§ 22:973 to 22:987 (1958/1985).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2701 to 2735 (1970).		
Maryland	MD. CODE ANN., INS. §§ 15-201 to 15-226 (1963/2002).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 108 (1973).		
Michigan	MICH. COMP. LAWS § 500.3402; §§ 500.3406 to 3474a (1957/2013) (disability only).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. §§ 62A.03 to 62A.04 (1967/2013).		
Mississippi	MISS. CODE ANN. §§ 83-9-1 to 83-9-21 (1956/2014).		
Missouri	MO. REV. STAT. §§ 376.770 to 376.777 (1959); §§ 376.780 to 376.790 (1959/2013).		
Montana	MONT. CODE ANN. §§ 33-22-201 to 33-22-232 (1959).		
Nebraska	NEB. REV. STAT. §§ 44-710.01 to 44-710.17 (1957/2013).		
Nevada	NEV. REV. STAT. §§ 689A.010 to 689A.30 (1971/2013).		
New Hampshire	N.H. REV. STAT. ANN. §§ 415:5 to 415:14 (1951/1995).		
New Jersey	N.J. STAT. ANN. §§ 17B:26-2 to17B:26-36 (1971).		
New Mexico	N.M. STAT. ANN. §§ 59A-22-2 to 59A-22-30 (1985).		
New York	N.Y. INS. LAW § 3216 (1984/2013).		
North Carolina	N.C. GEN. STAT. §§ 58-51-5 to 58-51-16 (1953/2005).		
North Dakota	N.D. CENT. CODE §§ 26.1-36-1 to 26.1-36-12 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3923.03 to 3923.09 (1948/1953).		
Oklahoma	OKLA. STAT. tit. 36, §§ 4403 to 4411 (1957).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon	OR. REV. STAT. §§ 743.405 to 743.492 (1967/2013).		
Pennsylvania	40 PA. STAT. ANN. §§ 753 to 754 (1951) (portions of model).		
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 1601 to 1636 (1957).		
Rhode Island	R.I. GEN. LAWS §§ 27-18-1 to 27-18-23 (1956/2005).		
South Carolina	S.C. CODE ANN. §§ 38-71-310 to 38-71-440 (1988).		
South Dakota	S.D. CODIFIED LAWS §§ 58-17-3 to 58-17-52 (1966/2013).		
Tennessee	TENN. CODE ANN. §§ 56-26-106 to 56-26-123 (1955).		
Texas	TEX. INS. CODE ANN. §§ 1201.201 to 1201.274 (2005).		TEX. INS. CODE ANN. §§ 1201.001 to 1201.154 (2005/2013).
Utah			UTAH CODE ANN. §§ 31A-22-607 to 31A-22-609 (1985/2004).
Vermont	VT. STAT. ANN. tit. 8, §§ 4063 to 4076 (1953).		
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 851 to 886 (1968).		
Virginia	VA. CODE ANN. §§ 38.2-3500 to 38.2-3515 (1986/2013).		
Washington	WASH. REV. CODE ANN. §§ 48.20.002 to 48.20.322 (1951/2004).		
West Virginia	W. VA. CODE §§ 33-15-1 to 33-15-9 (1957/2013).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Wisconsin	WIS. STAT. §§ 632.71 to 632.79 (1975/2013); § 632.895 (1975/1981).		
Wyoming	WYO. STAT. ANN. §§ 26-18-101 to 26-18-135 (1953/1995).		

RESTATEMENT OF THE NAIC UNIFORM INDIVIDUAL ACCIDENT AND SICKNESS POLICY PROVISION LAW IN SIMPLIFIED LANGUAGE

PURPOSE:

This restatement of the required and most often used optional provisions of the Uniform Policy Provision Law in simplified language is intended as a guideline for the submission and approval of individual accident and sickness policies written in simplified language. Although it is intended specifically for use in those states that adopt the NAIC Model Life and Health Insurance Policy Language Simplification Act, its use as a guide for approval of policies voluntarily written in simplified language is encouraged.

The restated provisions are intended to most accurately reflect the original intent of the Uniform Policy Provision Law and to duplicate its substantive requirements. The rights and obligations of both the insured and insurer or any case law interpreting the uniform provisions are not intended to be affected. They are intended as a uniform "safe harbor" for companies relying upon them. The restatements are no less favorable to the insured or beneficiary and their use is sanctioned under the authority granted by Section 3A of the Uniform Policy Provision Law.

The drafting notes accompanying these restated provisions are in addition to those found in the model law.

Although the provisions are stated in the "insured and insurer" format, rather than the personal "we and you" so as to conform more closely to the style of the model, the use of the personal pronoun format or the substitution of other descriptive terms where appropriate is encouraged. Minor grammatical changes may result from the personal pronoun format.

Section 3. Accident and Sickness Policy Provisions

A. Required Provisions.

(1) Entire Contract; Changes: This policy [with the application and attached papers] is the entire contract between the Insured and the Company. No change in this policy will be effective until approved by a company officer. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

Note: Bracketed material used when appropriate if application or other papers attached.

FLESCH SCORE without bracketed material—64.626

FLESCH SCORE with bracketed material—64.585

(2) Time Limit on Certain Defenses:

(a) Misstatements in the Application:

After three years from the issue date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the three-year period.

Drafting Note: A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision.

Incontestable:

(a) Misstatements in the Application:

After this policy has been in force for three years during the insured's lifetime (excluding any period during which the insured is disabled), the company cannot contest the statements in the application.

(b) Preexisting Conditions:

No claim for loss incurred or disability that starts after three years from the issue date will be reduced or denied because a sickness or physical condition not excluded by name or specific description before the date of loss had existed before the effective date of coverage.

Drafting Note: The restated provision used the reference to loss incurred or disability that starts. If the policy provides coverage for hospital or medical benefits only or for disability benefits only, then one or the other may be inappropriate and companies are encouraged to delete the inappropriate phrase. The three-year period is based on the model, thus, in those states that have reduced the period to a lesser time; the lesser time period should be inserted. The captions "Misstatements in the Application" and "Preexisting Conditions" are an integral part of the provision and must be read in conjunction therewith. The restatement is not intended to have any affect upon or be a bar to any other defenses under the policy.

FLESCH SCORE - Paragraphs (a) and (b)
With Required Provision—36.285
With Optional Provision—36.913

(3) Grace Period: This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. The grace period will not apply if, at least 30 days before the premium due date, the company has delivered or mailed to the insured's last address shown in the company's records written notice of the company's intent not to renew this policy. During the grace period, the policy will stay in force.

Drafting Note: The above is for those under which the insurer reserves the right to refuse renewal.

Grace Period: This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force.

Drafting Note: The above is for those under which the insurer does not reserve the right to refuse renewal. Insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies.

FLESCH SCORE where insurer reserves right to refuse renewal—62.681

FLESCH SCORE where insurer does not reserve right to refuse renewal—67.531

(4) Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the company (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If the company or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless the company has previously written the insured of its disapproval.

The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after that date. In all other respects the rights of the insured and the company will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums the company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

Drafting Note: The last paragraph of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

FLESCH SCORE—42.421

(5) Notice of Claim: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to the company at its home office, or to the company's agent. Notice should include the name of the Insured and the policy number.

FLESCH SCORE—68.536

[Optional Paragraph:] If the insured has a disability for which benefits may be payable for at least two years, at least once every six months after the insured has given notice of claim, the insured must give the company notice that the disability has continued. The insured need not do this if legally incapacitated. The first six months after any filing of proof by the insured or any payment or denial of a claim by the company will not be counted in applying this provision.

If the insured delays in giving this notice, the insured's right to any benefits for the six months before the date when the Insured gives notice will not be impaired.

FLESCH SCORE—65.644

(6) Claim Forms: When the company receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving the company a written statement of the nature and extent of the loss within the time limit stated in the proofs of loss section.

FLESCH SCORE—62.007

(7) Proofs of Loss: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the company within 90 days after the end of each period for which the company is liable. For any other loss, written proof must be given within 90 days after the loss. If it was not reasonably possible to give written proof in the time required, the company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

FLESCH SCORE—49.846

(8) Time of Payment of Claims: After receiving written proof of loss, the company will pay [monthly] all benefits then due for _____. Benefits for any other loss covered by this policy will be paid as soon as the company receives proper written proof.

Drafting Note: Delete or change "monthly" to reflect, if necessary, the period stated in the policy and insert applicable term for type of benefits.

FLESCH SCORE—66.403

(9) Payment of Claims: Benefits will be paid to the insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the insured's estate. Any other benefits unpaid at death may be paid, at the company's option, either to the insured's beneficiary or estate.

FLESCH SCORE—60.278

[Optional Paragraph:] If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, the company can pay benefits up to $1,000 to someone related to the insured or beneficiary by blood or marriage whom the company considers to be entitled to the benefits. The company will be discharged to the extent of any such payment made in good faith.

FLESCH SCORE—40.290

[Optional Paragraph:] The company may pay all or a portion of any indemnities provided for health care services to the provider, unless the insured directs otherwise in writing by the time proofs of loss are filed. The company cannot require that the services be rendered by a particular provider.

FLESCH SCORE—51.853

(10) Physical Examinations & Autopsy: The company, at its expense, has the right to have the insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

Drafting Note: If no right to an autopsy is desired or is not appropriate for the type of coverage, the second sentence of the provision and the caption reference to autopsy should be deleted.

FLESCH SCORE with the right of autopsy—42.173

FLESCH SCORE without the right of autopsy—67.333

(11) Legal Actions: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No action may be brought after three years from the time written proof of loss is required to be given.

FLESCH SCORE—60.863

(12) Change of Beneficiary: The insured can change the beneficiary at any time by giving the company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

FLESCH SCORE—38.166

B. Other Provisions.

(2) Misstatements of Age: If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

FLESCH SCORE—68.692

(3) Other Insurance In This Insurer: If the insured has more than one policy, only one policy chosen by the insured will be effective. The company will refund all premiums paid for all the other policies.

Drafting Note: Insert designation for limitation, i.e., form type.

FLESCH SCORE—64.626

Optional Paragraph: If the insured has more than one policy with this company providing a total indemnity for [ ] of more than [$] the excess insurance shall be void. The premiums paid for the excess shall be returned to the insured.

Drafting Note: Insert type of coverage or coverages and insert maximum limit of indemnity or indemnities.

FLESCH SCORE—67.672

(7) Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment

FLESCH SCORE—70.145

(8) Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of these laws.

FLESCH SCORE—45.849

(9) Illegal Occupation: The company will not be liable for any loss that results from the insured committing or attempting to commit a felony or from the insured engaging in an illegal occupation.

FLESCH SCORE—38.487

(10) Intoxicants and Narcotics: The company will not be liable for a loss resulting from the insured being drunk or under the influence of any narcotic unless taken on the advice of a physician.

Drafting Note: Appropriate language reflecting an applicable statutory definition of drunk or intoxicated may be substituted.

FLESCH SCORE—48.494

Drafting Note: The provisions were graded under the terms and conditions of the NAIC Model Life and Health Insurance Policy Language Simplification Act. As such, captions are not scored and it is assumed that the words "insured," "insurer" and "disability" are defined in the policy.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1979 Proc. I 44, 47, 372, 374, 375-379 (adopted).

REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT

Table of Contents

Section 1. Short Title

This Regulation shall be known and may be cited as the Patient Protection and Affordable Care Act Medical Loss Ratio Regulation.

Section 2. Purpose

The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized methodology for calculating the medical loss ratio, as legislated by Section 2718 (b) of the Public Health Service Act and the Patient Protection and Affordable Care Act.

Section 3. Definitions

A. As used in this Regulation and directed by PPACA to be defined by the NAIC:

(1) "Affiliate" means the statutory accounting definition for affiliate as contained in the then current NAIC Accounting Practices and Procedures Manual.

(2) "Clinical services" means "incurred claims," as defined in 3A (8).

(3) "Earned premium" means the statutory accounting definition for premium for health insurance coverage on a direct basis as contained in the then current NAIC Accounting Practices and Procedures Manual, plus or minus any portions of premium associated with group conversion privileges the issuer transfers between Group and Individual lines of business in its Annual Statement accounting, plus or minus any experience rating refunds paid or received, except as follows:

(a) For purposes of this definition, experience rating refunds shall not include any rebates paid pursuant to Sections 8 or 9 notwithstanding the definition in 3B (10).

(b) Earned premium for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct earned premium for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations.

(c) If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010), such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured earned premium as part of its medical loss ratio rebate calculations.

(4) "Expenses to improve health care quality" means those expenses as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(5) "Federal and State taxes and licensing or regulatory fees" means those taxes and licensing or regulatory fees, as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit, as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(6) "Health plan" means health insurance coverage offered by a health insurance issuer as such terms are defined in the Public Health Service Act (including a grandfathered health plan) unless such coverage is an excepted benefit as provided for in the Public Health Service Act.

(7) "Incurred loss" means "incurred claims," as defined in 3A (8).

(8) "Incurred claims" means claims for health insurance coverage on a direct basis incurred during the applicable plan year, plus unpaid claim reserves associated with claims incurred during the applicable plan year, plus the change in contract reserves, plus the claims-related portion of reserves for contingent benefits and lawsuits, plus any experience rating refunds paid or received, and reserves for experience rating refunds. This definition is consistent with the statutory accounting definition contained in the then current NAIC Accounting Practices and Procedures Manual and the definition in Appendix C derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010. If there are any group conversion charges for a health plan, the conversion charges should be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount should be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. Additionally, if the issuer transfers portions of earned premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, these amounts should be added to or subtracted from incurred claims.

(9) "Individual health plan" means a health plan offered to individuals in the individual market as such term is defined in the Public Health Service Act, but does not include short-term limited duration insurance as defined in the Public Health Service Act.

(10) "Large group health plan" means a health plan offered in the large group market as such term is defined in the Public Health Service Act.

(11) "Medical loss ratio rebate" means the quantity specified in Section 2718 (b) (1) (A) of the Public Health Service Act.

(12) "Plan year" means "calendar year" as defined in Section 3B (3).

(13) "Small group health plan" means a health plan offered in the small group market as such term is defined in state law in accordance with the Public Health Service Act.

B. As used in this Regulation:

(1) "Blended rates" means cross-subsidized rates charged for health insurance coverage provided by a single employer through two or more affiliates.

(2) "Business sold through an association" means a policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations.

(3) "Calendar year" means the period of time from January 1, YYYY to December 31, YYYY.

(4) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated coordination of benefits and subrogation.

(5) "Contract reserves" means reserves that are established which, due to the gross premium pricing structure at issue, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation net premiums at that time. Contract reserves should not include premium deficiency reserves. Contract reserves should not include reserves for expected MLR rebates.

(6) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience for smaller plans.

(7) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance except as follows: Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations. If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010), such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured claims as part of its medical loss ratio rebate calculations. Claims payments recovered through fraud reduction efforts can be added back to claims in the medical loss ratio calculation, up to the amount of expenses expended to reduce fraud.

(8) "Dual contract" means the case where a small or large group policyholder purchases in-network coverage from one issuer and out-of-network coverage from a different issuer that is an affiliate of the first issuer.

(9) "Dual option" means the case where a small or large group policyholder purchases two or more different health plans from two or more affiliates.

(10) "Experience rating refund" means retrospective premium adjustments arising from retrospectively rated contracts as determined by the Statements of Statutory Accounting Principles 66, plus any incurred state premium refunds. If the 2012 experience is not fully credible, the experience rating refund for the plan year 2012 calculation shall also include any rebate paid pursuant to Section 8. The experience rating refund for the plan year 2013 calculation shall also include any rebates paid pursuant to Sections 8 and 9.

(11) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(12) "Group conversion charges" means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

(13) "Incurred medical pool incentives and bonuses" means arrangements with providers and other risk sharing arrangements as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(14) "Life years" means the number of member months divided by 12.

(15) "Minimum medical loss ratio standard" means the percentage determined in accordance with Section 2718 (b) (1) (A) (i) or (ii) of the PHSA. In the case of minimum medical loss ratio standards that are not constant over an averaging period, the minimum standard will be the average of the standards used in each year weighted by earned premium less Federal and State taxes and licensing or regulatory fees.

(16) "Net healthcare receivables" means the healthcare receivable assets as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(17) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(18) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(19) "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(20) "PHSA" means Public Health Service Act.

(21) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(22) "Reserves for experience rating refunds" means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(23) **"**Situs of the contract" means the jurisdiction in which the contract is issued or delivered as stated in the contract.

(24) **"**State premium refund" means any rebate or refund of premium payable under state law as a result of state loss ratio requirements which need not be identical to the federal requirements in such matters as minimum percentage, definition of claim, definition of premium, aggregation, timing of calculation, etc.

(25) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(26) "Unpaid Claim Reserves" means reserves and liabilities established to account for claims unpaid.

C. All terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in Sections 8, 9, and 10. Notwithstanding the foregoing, rebates shall be reflected as specifically provided for in the instructions in Appendix A for Line 7 of the Rebate Calculation Supplemental Form.

Section 4. Applicability and Scope

The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) as provided for in Section 2718 of the PHSA for plan years 2011, 2012 and 2013.

Section 5. Levels of Aggregation for Medical Loss Ratio Rebate Calculations

A. Medical loss ratios shall be calculated at the licensed entity level within a state, with experience allocated to states based on the situs of the contract, except that for individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage and for employer business issued through a group trust, the allocation shall be based on the location of the employer. Experience shall be further subdivided into

(1) Individual health plans;

(2) Small group health plans;

(3) Large group health plans.

B. Pursuant to Section 1312(c)(3) of PPACA, a state may require the individual and small group insurance markets within a state to be merged if the State determines appropriate. In this case, rebates shall be calculated at the licensed entity level within a state, further subdivided into

(1) Individual and small group health plans;

(2) Large group health plans.

C. Plans classified as dual contract may be aggregated as follows:

(1) Experience may be treated as if it were all generated by the plan provided by the in-network issuer.

(2) An issuer that chooses this method of aggregation shall apply it for a minimum of three plan years.

(3) For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

Section 6. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments

A. Medical loss ratios shall be calculated annually by all health insurance issuers that provide coverage through one or more health plans that are subject to Section 2718 of the PHSA.

B. Medical loss ratios shall be calculated using data as of December 31 of the plan year except for incurred claims which shall be restated as of March 31 of the year following the plan year.

C. Medical loss ratios shall be reported to the applicable state(s) by May 31 of the year following the plan year using the appropriate reporting format in Appendix A.

D. Rebates shall be paid annually by June 30 of the year following the plan year.

Section 7. Credibility Adjustments to Medical Loss Ratio

A. Plan year 2011

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either non-credible or fully credible based on plan year 2011 life years.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on plan year 2011 life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using plan year 2011 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the plan year 2011 average plan deductible, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

B. Plan year 2012

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is fully credible based on plan year 2012 life years or based on the sum of life years for plan years 2011 and 2012.

(2) If the sum of life years for plan years 2011 and 2012 is non-credible for any aggregation as defined in Section 5, a credibility adjustment is not applicable.

(3) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011 and 2012 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of plan year 2011 and plan year 2012 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011 and plan year 2012 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

C. Plan year 2013

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either fully credible or non-credible based on the sum of life years for plan years 2011, 2012, and 2013.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011, 2012, and 2013 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of life years for plan years 2011, 2012, and 2013 for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011, plan year 2012 and plan year 2013 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

Section 8. Medical Loss Ratio Rebate Calculation for Plan Year 2011

A. A rebate is not payable for any aggregation that is non-credible based on plan year 2011 life years.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2011 is attributable to policies newly issued in 2011 with less than 12 months of experience in 2011, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2011. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2012. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2011, less any claims incurred in 2011 that are to be deferred to the plan year 2012 calculation.

(2) Expenses to improve health care quality are for the period from January 1, 2011 to December 31, 2011, less any expenses to improve health care quality from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2011, less any premiums earned in the 2011 plan year that are to be deferred to the plan year 2012 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2011, less any Federal and State taxes and licensing fees from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for 2011. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 9. Medical Loss Ratio Rebate Calculation for Plan Year 2012

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan years 2011 and 2012.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2012 is attributable to policies newly issued in 2012 with less than 12 months of experience in 2012, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2012. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2013. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2012 to December 31, 2012, plus any incurred claims deferred from the plan year 2011 calculation, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, incurred claims are those with incurral dates from January 1, 2011 to December 31, 2012, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2012 to December 31, 2012, plus any expenses to improve health care quality deferred from the plan year 2011 calculation, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, expenses to improve health care quality are those for the period from January 1, 2011 to December 31, 2012, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2012 to December 31, 2012, plus any earned premiums deferred from the plan year 2011 calculation, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, earned premiums are for the period from January 1, 2011 to December 31, 2012, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2012 to December 31, 2012, plus any Federal and State taxes and licensing or regulatory fees deferred from the plan year 2011 calculation, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2012, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 10. Medical Loss Ratio Rebate Calculation for Plan Year 2013

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan year 2011, plan year 2012 and plan year 2013.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2013 is attributable to policies newly issued in 2013 with less than 12 months of experience in 2013, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2013. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2014. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2013, less any claims incurred from January 1, 2013 to December 31, 2013 that are to be deferred to the plan year 2014 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2011 to December 31, 2013, less any expenses to improve quality from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2013, less any premiums earned in 2013 that are to be deferred to the plan year 2014 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2013, less any Federal and State taxes and licensing or regulatory fees from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. If both of the following conditions are met, no credibility adjustment will be applicable:

(1) Each of plan years 2011, 2012 and 2013 are partially credible based on the life years for each plan year, respectively, and;

(2) The medical loss ratio, before applying any credibility adjustments, for each of plan years 2011, 2012 and 2013 is less than the minimum medical loss ratio standard for each plan year, respectively.

(a) The plan year 2011 medical loss ratio is the quantity calculated in Section 8 G.

(b) The plan year 2012 medical loss ratio is calculated using the methodology given in Sections 9B, C, D, E, F, and G, with the exception that only experience from January 1, 2012 through December 31, 2012 is to enter into the calculation.

(c) The plan year 2013 medical loss ratio is the quantity calculated using the methodology given in Sections 10B, C, D, E, F, and G, with the exception that only experience from January 1, 2013 through December 31, 2013 is to enter into the calculation.

I. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

J. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

K. (1) If the result of J is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of J is zero or less, no rebate is to be paid.

Appendix A. Formats for Reporting Rebate Calculations

This appendix contains formats to report rebate calculations for the 2011, 2012, and 2013 plan years. Each report will require a separate supplemental information form for each experience year in the calculation.

"Line of Business" is the applicable aggregation as defined in Section 5.

"Minimum medical loss ratio" is the loss ratio as defined in Section 3B (15).

REBATE CALCULATION
FORM FOR PLAN YEAR 2011

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code_____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011
1.	Life Years	
2.	Earned Premium	
3.	Federal and State Taxes and Licensing or Regulatory Fees	
4.	Expenses to Improve Heath Care Quality	
5.	Paid Claims	
6.	Unpaid Claim Reserve	
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds	
8.	Change in Contract Reserves	
9.	Contingent Benefit and Lawsuit Reserve	
10.	Incurred Medical Pool Incentives and Bonuses	
11.	Net Healthcare Receivables	
12.	Incurred Claims	
13.	Medical Loss Ratio	
14.	Credibility Adjustment Factor	
15.	Credibility Adjusted Medical Loss Ratio	
16.	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2011

Line 1: Life Years

Rebate Supplemental Form for experience year 2011

Line 2: Earned Premium

Rebate Supplemental Form for experience year 2011

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year 2011

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year 2011

Line 5: Paid Claims

Rebate Supplemental Form for experience year 2011

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year 2011

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year 2011

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year 2011

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year 2011

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year 2011

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year 2011

Line 12: Incurred Claims as of 3/31= Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 and the methodology in Section7.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14

Line 16: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15) · (Line 2 – Line 3),where (Minimum Medical Loss Ratio - Line 15) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2012

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code _____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 Total
1.	Life Years			
2.	Earned Premium			
3.	Federal and State Taxes and Licensing or Regulatory Fees			
4.	Expenses to Improve Heath Care Quality			
5.	Paid Claims			
6.	Unpaid Claim Reserve			
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds			
8.	Change in Contract Reserves			
9.	Contingent Benefit and Lawsuit Reserve			
10.	Incurred Medical Pool Incentives and Bonuses			
11.	Net Healthcare Receivables			
12.	Incurred Claims			
13.	Medical Loss Ratio	XXX		
14.	Credibility Adjustment Factor	XXX		
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	
16.	Rebate	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2012

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 2: Earned Premium

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11.

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3) for Column 4 and Column 5.

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 4 and Column 5 and the methodology in Section 7.

Line 15: Column 5:

If Line 14 Column 4 is equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 4

If Line 14 Column 4 is not equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 5 + Line 14 Column 5

Line 16: If 2011 plus 2012 experience is non-credible as determined by Line 1 Column 5, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 5) · (Line 2 Column 4 – Line 3 Column 4), where (Minimum Medical Loss Ratio - Line 15 Column 5) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2013

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code_____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 2013	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				
13.	Medical Loss Ratio				
14.	Credibility Adjustment Factor	XXX	XXX	XXX	
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	XXX	
16.	Rebate	XXX	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2013

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 2: Earned Premiums

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 6 and the methodology in Section 7.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14 for Column 6

Line 16: If the sum of 2011, 2012 and 2013 experience is non-credible as determined by Line 1 Column 6, Rebate = 0, else

If the experience of each of plan years 2011, 2012, and 2013 are partially credible as determined by Line 1 Columns 3, 4, and 5, respectively and the medical loss ratio for each of plan years 2011, 2012 and 2013 as determined by Line 13 Columns 3, 4, and 5, respectively is less than the Minimum Medical Loss Ratio for each plan year, respectively, Rebate = (Minimum Medical Loss Ratio - Line 13 Column 6) · (Line 2 Column 5 – Line 3 Column 5), rounded to the nearer dollar, else,

If (Minimum Medical Loss Ratio - Line 15 Column 6) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 6) · (Line 2 Column 5 – Line 3 Column 5), where (Minimum Medical Loss Ratio - Line 15 Column 6) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION SUPPLEMENTAL FORM

Plan Year ____
Experience Year ____

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code_____
Line of Business _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 12/31	4 Deferred	5 Added	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				

INSTRUCTIONS
REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8B, 9B, and 10B for additional details.

Note that quantities in Lines 2 through 9 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 2, Column(s) for applicable line of business – Line 1.8 – Line 1.7, plus Part 1, Column(s) for applicable line of business – Line 1.2 + Line 1.3, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus or minus any incurred experience rating refunds.

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 1.5 + Line 1.6 + Line 1.7

Line 4: Expenses to Improve Health Care Quality

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 6.3

Line 5: Paid Claims

Amounts paid on claims incurred in the experience year as of March 31 of the year following the plan year, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus Deductible Fraud and Abuse Detection/Recovery Expenses from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4, minus any state stop loss, market stabilization and claim/census based assessments from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 2.4, plus or minus any adjustment from paragraphs D(4) and/or E(4) in Section 8, Section 9 or Section 10.

Line 6: Unpaid Claim Reserve

The reserve for amounts unpaid on claims incurred in the experience year as of March 31 of the year following the plan year.

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Experience rating refunds incurred in the experience year and paid through March 31 of the year following the plan year, plus the estimate as of March 31 of the year following the plan year for any reserves experience rating refunds incurred in the experience year, plus any state premium refunds incurred in the experience year. For the 2012 plan year, include any rebate paid pursuant to Section 8 for plan year 2011 if the 2012 experience is not fully credible on its own and 2011 experience enters into the plan year 2012 calculation. For the 2013 plan year, include any rebate paid pursuant to Section 8 for plan year 2011, plus any rebate paid pursuant to Section 9 for plan year 2012.

Line 8: Change in contract reserves

Change in contract reserves from December 31 of the year prior to the experience year to December 31 of the plan year after eliminating the effect of any valuation basis changes.

Line 9: Contingent Benefit and Lawsuit Reserve

Contingent Benefit and Lawsuit Reserve for claims incurred in the experience year as of March 31 of the year following plan year.

Line 10: Incurred Medical Pool Incentives and Bonuses

Medical Pool Incentives and Bonuses incurred in the experience year as of March 31 of the year following the plan year.

Line 11: Net Healthcare Receivables

Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 12: Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Appendix B. Credibility Tables

Table 1	
Base Credibility Additive Adjustment Factors	
Life Years	**Additive Adjustment**
< 1,000	No Credibility
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Table 2	
Plan Cost-Sharing Adjustment Factors by Deductible	
Deductible Range	**Adjustment Factor**
< $2,500	1.000
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Federal and State Taxes and Licensing or Regulatory Fees:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1:

Line 1.5 – Federal Taxes and Federal Assessments

Refer to SSAP 10R for "current income taxes incurred."

Include: All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act.

Exclude: Federal income taxes on investment income and capital gains.

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.

Guaranty fund assessments

Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State income, excise, and business taxes other than premium taxes.

State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

EITHER*:

a. Payments to a state, by not-for-profit health plans, of premium tax exemption values in lieu of state premium taxes limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group;

b. Payments by not-for-profit health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item;

OR

c. Payments made by (federal income) tax exempt health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. (NOTE: If the instruction for Line 1.5 above excludes federal income taxes, then tax exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

* These expenditures may not be double counted between this category; the federal or state assessments for similar purposes included in Lines 1.5, 1.6, or 2.4; or the Quality Improvement expenses reported in Line 6.1.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 1.7 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department.

Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Expenses to Improve Health Care Quality:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B

COLUMNS:

Column 1 – Improve Health Outcomes

> Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),
    - Programs to support shared decision making with patients, their families and the patient's representatives; and

        - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers.

    - Incorporating feedback from the insured to effectively monitor compliance;
    - Providing coaching or other support to encourage compliance with evidence based medicine;
    - Activities to identify and encourage evidence based medicine;
    - Use of the medical homes model as defined for purposes of section 3602 of PPACA);
    - Activities to prevent avoidable hospital admissions;
    - Education and participation in self management programs;
    - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance; and
    - Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1-5;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care in non-electronic format; and
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
    - Data extraction, analysis and transmission in support of the activities described above; and
    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
    - Data extraction, analysis and transmission in support of the activities described above; and
    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
    - Data extraction, analysis and transmission in support of the activities described above; and
    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;
- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
    - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: A single (not state-by-state), separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a new initiative that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New" column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes:

a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1-5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

Note: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

Direct Claims Incurred

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2 – Direct Claims Incurred:

Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below).

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

Other Professional Services

Include: Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical service.

Compensation to personnel engaged in activities in direct support of the provision of medical services.

Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.

Outside Referrals

Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

Incurred Medical Pool Incentives and Bonuses

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2.8 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

Net Healthcare Receivables

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2.9 – Net Healthcare Receivables

Report the change between prior year healthcare receivables and current year healthcare receivables. The amounts on this line are the gross healthcare receivable assets, not just the admitted portion. This amount should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2010 Proc. 3rd Quarter, Vol. I, 130, 605 (adopted).

PROJECT HISTORY - 2010

REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED REBATE CALCULATION METHODOLOGY FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT (#190)

1. Description of the Project, Issues Addressed, etc.

The Patient Protection and Affordable Care Act (PPACA) establishes a minimum loss ratio and rebate program that begins January 1, 2011. The law requires the NAIC to develop the uniform definitions and standard methodologies for calculating the medical loss ratio (MLR). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

The MLR is defined as the sum of clinical services and quality improvements divided by the earned premium minus all federal and state taxes and licensing or regulatory fees. The issues considered were 1) aggregation of the business, 2) whether the calculation would be done on a calendar year or a plan year basis, 3) credibility, 4) group conversion charges, 5) claim run out, and 6) reinsurance.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2010 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, California, Connecticut, Florida, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The initial charge was given to the Task Force in April, 2010, to consider the requirement specified in PPACA and develop a regulation to be delivered to the Secretary of Health and Human Services.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting of the model was done by the PPACA Actuarial Subgroup whose members are: Alabama (Chair), Illinois, Maine, Minnesota, New Jersey, New York, Oklahoma, Oregon, South Carolina, and Washington.

The subgroup began by identifying issues and preparing Issue Resolution Documents (IRDs) on those issues. Each IRD was discussed and posted on the NAIC's home page for comment for at least a week before begin adopted. After all IRDs were adopted by the subgroup, the regulation was written to reflect the issues decided on in the IRDs.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at 27 public conference calls on this topic from May 24, 2010, to October 4, 2010. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 400 interested parties. The drafts of the regulation were released for comment on September 23, 2010, and September 29, 2010. The subgroup voted to adopt the regulation on October 5, 2010.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Level of aggregation: The law specifies that the MLR would be calculated by each legal entity for each state for each line of business: individual, small group, and large group. There was some discussion of aggregating the large group line at the national level, but the subgroup decided to reject that concept.

Dual options: An employer may purchase two or more plans of coverage from two or more affiliated carriers, but typically it purchases an HMO product from an HMO and a more flexible product from a non-HMO. Employees are given the option of coverage through either plan (hence the term "dual option"), although the employer may require different employee contributions. The rates paid by the employer are blended rates. For example, while the rates may vary based on benefit differences, the rates do not reflect the selection between the HMO and non-HMO products. The issue is how to determine the premium and claims allocated to each carrier when there is not a contractual premium reallocation agreement in place. The subgroup decided a pre-defined adjustment may be made to the incurred claims in the calculation of the MLR.

Reinsurance: The subgroup decided to require the MLR calculation be done on a gross basis excluding reinsurance.

Credibility: The subgroup discussed making an adjustment to a MLR calculation when the amount of business involved in the calculation is not large enough to be statistically credible. The NAIC requested an actuarial consulting firm to calculate amounts to be added to the unadjusted MLR based on a 50% two-sided confidence level. The credibility factors are based on the level of life years and the average deductible of business in the calculation.

7. Any Other Important Information (e.g., amending an accreditation standard).

This regulation will be submitted to the Secretary of Health and Human Services and is not an accreditation standard.

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is issued pursuant to the authority vested in the commissioner of the State of [insert state] under [insert citation for authority].

Drafting Note: Insert title of the chief insurance regulatory official whenever the term "commissioner" appears.

Section 2. Purpose

This regulation prescribes rules for separate accounts that fund guaranteed minimum benefits under group contracts. In addition the regulation sets out the procedures for establishing and maintaining these separate accounts and the reserve requirements for these accounts.

Section 3. Scope

This regulation applies to a group life insurance contract providing survivor income benefits, a group annuity contract, or a funding agreement issued for delivery on or after the [insert prospective effective date for applicable state] if the contract is a group contract that utilizes a separate account and provides guaranteed minimum benefits. However, for contracts issued prior to [insert date 24 months after effective date of regulation] pursuant to applicable laws and regulations prior to the effective date of the regulation, the insurance company may continue to operate in accordance with the issued contract and plan of operations, if any, until such time as the applicable contract terms or provisions are substantially changed, at which time a filing complying with this regulation shall be required. This regulation shall not apply to modified guaranteed annuities or modified guaranteed life insurance or variable annuity or variable life insurance subject to Sections [insert reference] or equity index products but this regulation shall apply to index contracts as defined in Section 4.

Drafting Note: It is expected that individual regulators, where applicable, will retain the right to withdraw approval of previously filed contract forms for new issuance if they do not conform to the regulation. Therefore, no language explicitly withdrawing approval of these forms was included.

Drafting Note: This regulation shall govern solely a group contract that utilizes a separate account and provides guaranteed minimum benefits.

Drafting Note: Contracts would remain "grandfathered" until such time as the applicable contract terms or provisions are substantially changed, such as by a contract amendment modifying interest rate or withdrawal provisions. Changes that would not require the filing of a form of contract in compliance with this regulation or a change in the basis of recording asset and liability values in the annual statement would include: address changes, continued deposits, and other non-substantive changes such as these.

Section 4. Definitions

As used in this regulation, the following terms have these meanings:

A. "Account assets" means separate account assets plus any assets held in the general account or a supplemental account to meet the asset maintenance requirements.

B. "Account contracts" means the contracts providing guaranteed minimum benefits or other benefits and funded by a separate account and, if applicable, funded in part by the general account or a supplemental account to meet the asset maintenance requirements.

C. "Actuarial opinion" means the opinion of the valuation actuary required to be submitted to the commissioner pursuant to Section 10.

D. "Actuarial memorandum" means the memorandum of the valuation actuary prepared pursuant to Section 10 that supports the actuarial opinion.

E. "Affirmatively approved" means approval of an insurer's plan of operations for a class of contracts containing the form of contract under review, after the plan of operations associated with the class of contracts has been reviewed by the insurer's domiciliary insurance department, and the plan of operations has been found to be in compliance with the NAIC Model Regulation for Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts by the domiciliary insurance department. Affirmatively approved does not mean approval as a result of the deemer provision.

F. "Appointed actuary" means the qualified actuary appointed or retained either directly by or by the authority of the board of directors through an executive officer of the company to prepare the annual statement of actuarial opinion for the company as a whole pursuant to Section [insert reference to standard valuation law].

G. "Asset maintenance requirements" means the requirement to maintain assets to fund contract benefits in accordance with Sections 7, 8 and 9.

H. "Book value contract" means a fixed accumulation contract (GIC), purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, that does not participate in the investment experience of a separate account, with a fixed interest rate guarantee, including a guarantee based on an external index, and that is supported by a separate account, the plan of operations of which provides that the separate account's assets are valued as if the assets were held in the insurance company's general account.

I. "Class of contracts" means the set of all contracts to which a given plan of operations pertains.

J. "Contract" means a group life insurance policy, group annuity contract, or funding agreement that is within the scope of this regulation as set forth in Section 3.

K. "Contract benefits" means the amounts obligated to be paid by the insurance company under an account contract.

L. "Contract liabilities" means the liabilities of the insurance company under account contracts, including liabilities with respect to which guarantees as to amount are provided by the insurance company and liabilities with respect to which guarantees as to amount are not provided by the insurance company.

M. "Date of filing," with respect to a filing for approval of a form of contract under this regulation, means the date as defined by the applicable rules, regulations or statutes of the state of issue with regard to contract filings.

Drafting Note: Individual states may wish to insert a specific reference to the applicable rule, regulation or statute.

N. (1) "Derivative instrument" means an agreement, option, instrument or a series or combination of them:

(a) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(b) That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(2) Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures and any other agreements, options or substantially similar instruments or any series or combination of them and any agreements, options or other instruments permitted under [insert reference to state law equivalent to Section 18 of the NAIC Investments of Insurers Model Act (Defined Limits Version)].

O. "Duration" means, with respect to separate account or supplemental account assets or guaranteed contract liabilities, a measure of the price sensitivity of a stream of cash flows to interest rate movements, including, but not limited to, modified duration or option adjusted duration.

P. "General account" means the assets of the insurance company other than separate account and supplemental account assets, and associated reserves.

Q. "Guaranteed minimum benefits" means benefits payable under the terms of the contract that are based on either (i) the greater of Paragraph (1) or (2), or (ii) Paragraph (3) of this subsection where:

(1) Is that part of the market value of account assets that determines the contractholder's benefits, i.e., to the extent the assets are beneficially "client" assets; provided, that if asset performance does not determine the contractholder's benefit, this subparagraph equals zero;

(2) Is a fixed minimum guarantee related to all or part of the considerations received under the contract; and

(3) Is an amount based upon a publicly available interest rates series or an index of the aggregate market value of a group of publicly traded financial instruments, either of which is specified in the contract.

R. Hedging transaction means:

(1) A derivative transaction, involving use of one or more derivative instruments, that is entered into and maintained to reduce:

(a) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(b) The currency exchange risk or the degree of exposure as to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring; or

(2) Other derivative transactions specified as hedging transactions in rules adopted by the commissioner.

S. "Index contract" means a contract under which contract benefits shall be based upon a publicly available interest rate series or an index of the aggregate market value of a group of publicly traded financial instruments, either of which is specified in the contract, and that does not provide a guarantee of some or all of the consideration received plus earnings at a fixed rate specified in advance and that does not provide any secondary guarantees on elective benefits or maturity values.

T. "Market value separate account" means a separate account in which the separate account assets are valued at their market value.

U. "Plan of operations" means a written plan meeting the requirements of Section 5B.

V. "Prudent estimate" assumption means an assumption developed by applying a margin to the best estimate assumption for that risk.

W. "Qualified actuary" means an individual who is qualified to sign statements of actuarial opinion in accordance with the qualification standards set forth in [insert reference to section of the regulations related to actuarial opinions and memoranda].

X. "Separate account" means an account established pursuant to [insert reference to provision of insurance law permitting the establishment of separate accounts].

Y. "Spot rate"

(1) "Treasury-based spot rate" corresponding to a given time of benefit payment means the yield on a zero-coupon non-callable and non-prepayable United States government obligation maturing at that time, or the zero-coupon yield implied by the price of a representative sampling of coupon-bearing, non-callable and non-prepayable United States government obligations in accordance with a formula set forth in the plan of operation.

(2) "Index spot rate" corresponding to a given time of benefit payment means the zero-coupon yield implied by (x) the Barclays Short Term Corporate Index (for a given time of benefit payment under one year) or (y) the zero-coupon yield implied by the Barclays U.S. Corporate Investment Grade Bond Index (for a given time of benefit payment greater than or equal to one year).

(3) "Blended spot rate" corresponding to a given time of benefit payment means a blend of 50% of each of (i) the Treasury-based spot rate, and (ii) the index spot rate. To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country rates, in one of the two (2) highest rating categories by an independent nationally recognized United States rating agency acceptable to the commissioner and which are supported by investments denominated in the currency of the foreign country, the Treasury-based spot rate component of the blended spot rate may be determined by reference to substantially similar obligations of the government of the foreign country. For liabilities other than those described above, the blended spot rate shall be determined on a basis mutually agreed upon by the insurer and the commissioner.

Z. "Supplemental account" means a separate account established pursuant to Sections 7, 8 or 9 to which assets may be contributed by the insurance company for the purpose of complying, in whole or in part, with the asset maintenance requirement and with respect to which neither the account contracts nor applicable law shall provide that the assets of the supplemental account are not chargeable with liabilities arising out of any other business of the insurance company.

AA. "United States government obligation" means a direct obligation issued, assumed, guaranteed or insured by the United States of America or by an agency or instrumentality of the United States.

BB. "Valuation actuary" means the appointed actuary or, alternatively, a qualified actuary designated by the appointed actuary to render the actuarial opinion pursuant to Section 10. Written documentation of any such designation shall be on file at the company and available for review by the commissioner upon request.

Section 5. Plan of Operations Requirements

A contract may not be delivered or issued for delivery in this state unless the issuing insurance company is licensed as a life insurance company in this state. In addition, a domestic insurer may not deliver or issue for delivery, either in this state or outside this state, a contract belonging to a specific class of contracts unless the insurer has satisfied the requirements of Subsections A and B of this section with respect to that class.

A. A domestic insurer will satisfy the requirements of this section with respect to a class of contracts if the insurer has filed a plan of operations pertaining to the class of contracts, together with copies of forms of the contracts in the class, with the commissioner and the filing has been approved or has not been disapproved within the sixty-day period following the date of the filing, in which event the plan of operations shall be deemed approved.

B. The plan of operations for a class of contracts shall describe the financial implications for the insurer of the issuance of contracts in the class, and shall include at least the following:

(1) A description of the class of contracts to which the plan of operations pertains. This should include a description of the products, the markets to which the products will be sold, the benefits that are being offered (including whether those benefits will be paid on a market or book value basis);

(2) A statement that the plan of operations will be administered in accordance with the requirements prescribed by the commissioner pursuant to this regulation, along with a statement that the insurer will comply with the plan of operations in its administration of the contract;

(3) A statement of the investment policy for the separate account and any supplemental account, including requirements for diversification, maturity, type and quality of assets, and as applicable, target duration for matching guaranteed contract liabilities or the degree to which the investment policy is likely to match the performance of an interest rate series or index on which contract benefits are based;

(4) A description of how the value of the separate account assets and any supplemental account is to be determined, including but not limited to, a statement of procedures and rules for valuing securities and other assets that are not publicly traded;

(5) A description of how the guaranteed contract liabilities are to be valued, including, if applicable, with respect to guaranteed minimum benefits or other benefits, a description of the methodology for calculating spot rates and the rates proposed to be used to discount guaranteed contract liabilities if higher than the applicable spot rates, but the rate or rates used shall not exceed the blended spot rate, except that if the expected time of payment of a contract benefit is more than thirty (30) years, it shall be discounted from the expected time of payment to year thirty (30) at a rate of no more than eighty percent (80%) of the thirty-year blended spot rate and from year thirty (30) to the date of valuation at a rate not greater than the thirty-year blended spot rate, and shall conservatively reflect expected investment returns (taking into account foreign exchange risks);

(6) A statement of how the separate account's operations are designed to provide for payment of contract benefits as they become due, including but not limited to:

(a) A description of the method for estimating the amount and timing of benefit payments;

(b) The arrangements necessary to provide liquidity to cover contingencies;

(c) The method to be used to comply with the asset maintenance requirement;

(d) The manner in which account assets will be allocated between the separate account, any supplemental account, and the general account;

(e) If applicable, the deductions to be used in determining the market value of an asset when determining the asset maintenance requirement when the investment policy of the separate account and any supplemental accounts is not likely to match the performance of an interest rate series or index on which contract benefits are based; and

(f) For index contracts, the deductions to be used for replicated (synthetic asset) transactions in determining the market value of the separate account.

(g) For market value separate accounts supporting contracts other than index contracts:

(i) A description of the criteria used by the insurer in approving for contract issuance a pooled fund representing multiple employer-sponsored plans;

(ii) A description of risk-mitigation techniques used by the insurer in connection with contracts issued to pooled funds representing multiple employer-sponsored plans;

Drafting Note: A pooled fund is an arrangement in which multiple, unaffiliated employer -sponsored plans invest in a shared trust. Pooled funds generally allow plan sponsors the right to exit the fund at book value subject to advance notification requirements. In describing the criteria used by the insurer in evaluating the potential issuance of a contract, discuss the insurer's advance notification requirements and how any actual advance notifications will be monitored and reflected in the risk management of the contract.

(7) An unqualified opinion by a qualified actuary with expertise in such matters as to the adequacy of the consideration charged by the insurance company for the risks it has assumed with respect to the contracts in the class to which the plan of operations pertains;

(8) If hedging transactions are to be utilized in managing separate account or any supplemental account assets, a description of the instruments and techniques and an explanation of how they are intended to reduce risk of loss;

(9) If the amount of the asset maintenance requirement depends on the separate account, any supplemental account or a subportfolio of either being duration matched, a description of the method used to determine the durations of separate account and any supplemental account assets and guaranteed contract liabilities;

(10) If a part of the asset maintenance requirement is to be met by maintaining a reserve liability in the general account, a description of:

(a) The circumstances under which increases and decreases in the general account portion of the reserve liability will be made;

(b) The circumstances under which transfers will be made between the separate account and the general account; and

(c) Any arrangements needed to provide sufficient liquidity in the general account to enable the insurance company to make transfers to the separate account when due.

(11) A statement as to the extent to which the contracts in the class will provide or applicable law does provide that the separate account assets shall not be chargeable with liabilities arising out of any other business of the insurance company; and

(12) If any person other than the insurance company may authorize, approve or review the acquisition and disposition of investments for the separate account or any supplemental account, a statement of the safeguards adopted by the insurance company to assure that the actions to be taken by these persons are appropriate, including a description of the criteria used by the insurance company in selecting the person.

C. Notwithstanding the descriptions in the plan of operations, the insurance company may change the rate used pursuant to Section 7F to discount guaranteed contract liabilities and other items applicable to the separate account or any supplemental accounts, such as if the investment portfolio is different from that anticipated by the plan of operations, provided that the rates used shall not exceed the blended spot rates as prescribed in Subsection B(5) of this section. Any such change shall be disclosed and justified in the actuarial opinion submitted pursuant to Section 10.

D. A plan of operations filed pursuant to this section may provide that the separate account will fund guaranteed contract liabilities denominated in the currency of a foreign country with separate account and any supplemental account assets denominated in that currency, provided that at the time of issuance of the account contracts, the country is rated in one of the two (2) highest rating categories by an independent nationally recognized United States rating agency acceptable to the commissioner.

E. The commissioner may require an insurance company to file additional information as part of the plan of operations if the commissioner determines that the plan of operations is not sufficient.

Section 6. Required Contract Provisions and Filing Requirements

Drafting Note: Section 6 may be omitted in its entirety if the state does not require contracts to be filed for approval, and the state wishes to eliminate required contract provisions. Subsection B of this section may be omitted if a state does not require contracts to be filed for approval, but wishes to establish required contract provisions.

A contract may not be delivered or issued for delivery in this state unless the contract satisfies the requirements of Subsection A of this section and the issuing insurer has satisfied the requirements of Subsection B of this section with respect to the contract:

A. The contract shall provide:

(1) A description of any contractual safeguards to assure asset sufficiency, including termination events, discontinuance triggers or discontinuance options and corrective action procedures;

(2) A description of how any charges under the contract are computed, including, but not limited to, any risk or surrender charge; and

(3) For a book value contract, a description of how any market value adjustments under the contract are computed.

B. An insurer will satisfy the filing and approval requirements of this section with respect to a contract if the insurer has filed the form of the contract with the commissioner and it is accompanied by the items specified in Paragraphs (1), (2), and (3) of this subsection, and the form of contract has been approved or has not been disapproved within the thirty-day period following the date of filing, in which event the form of contract shall be deemed approved. Notwithstanding the foregoing, the requirement for filing and approval of the form of contract may be waived at the discretion of the commissioner.

(1) The form of the contract filed for approval shall be accompanied by a statement that the contract meets the conditions of Subsection A of this section.

(2) The form of contract filed for approval shall be accompanied by a statement:

(a) Specifying the range of variation of variable contract provisions, if any, that could have a material effect on the risk assumed by the insurer under the contract, including withdrawal methodology, crediting rate formula and termination events; and

Drafting Note: Contract forms covered by this model regulation frequently incorporate variable provisions. The statement required by Subparagraph (a) is intended to provide the information regulators need to evaluate the risks associated with such variability.

(b) Listing events, if any, that give the insurer the right to terminate the contract immediately.

(3) (a) If the plan of operations pertaining to the class of contracts to which the contract belongs has been affirmatively approved by the commissioner of the state in which the issuing insurer is domiciled, the form of a contract filed for approval shall be accompanied by a statement indicating the receipt of approval and that the approval was an affirmative approval; or

(b) If the plan of operations pertaining to the class of contracts to which the contract belongs has been deemed approved in the state in which the issuing insurer is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating that the issuing insurer has met the requirements for deemed approval; or

(c) If the plan of operations pertaining to the class of contracts to which the contract belongs has not been approved, either affirmatively or by deemer, in the state in which the issuing insurer is domiciled, the form of contract filed for approval shall be accompanied by a statement of this fact, together with a plan of operations pertaining to the contract.

Drafting Note: The state of filing may request the plan of operations for informational purposes and may take it into account in deciding whether to approve the form. It is not anticipated that the state of filing would review and approve the plan of operations, but may use it in connection with the review of the form of contract.

Drafting Note: If the plan of operations has not been approved, either affirmatively or by deemer, in the state of domicile of the issuing insurer, the state of issue, in issuing contract approvals, may wish to establish requirements to be met by the issuing insurer (e.g., a notice requirement if the plan of operations subsequently changes, or a requirement that the contract be operated in compliance with the plan of operations) in order to maintain its approval.

Section 7. Asset Maintenance Requirements for Market Value Separate Accounts Supporting Contracts other than Index Contracts

A. At all times an insurer shall hold sufficient assets as a reserve in the general account, the separate account or supplemental accounts, as appropriate, such that the:

(1) Market value of the assets held in the separate account, plus

(2) The market value of any supplemental account, plus

(3) Any assets held in the general account as a reserve for guaranteed contract liabilities (valued in accordance with [insert reference to rules governing valuation of general account assets]), less

(4) The deductions provided for in Subsection B of this section, equals or exceeds the value of guaranteed contract liabilities determined in accordance with Subsection F of this section.

B. In determining compliance with the asset maintenance requirement and the reserve for guaranteed contract liabilities in accordance Subsection A of this section, the insurance company shall deduct a percentage of the market value of the separate account or supplemental account asset or an amount attributable to a replicated (synthetic asset) transaction as follows:

(1) For debt instruments, the percentage shall be the NAIC asset valuation reserve "reserve objective factor," but the factor shall be increased fifty percent (50%) for the purpose of this calculation if the difference in durations of the assets and liabilities is more than one-half year;

(2) For assets that are not debt instruments, the percentage shall be the NAIC asset valuation reserve "maximum reserve factor"; and

(3) For replicated (synthetic asset) transactions, the market value of the separate account or supplemental account assets shall be decreased by an amount equal to the asset valuation reserve for the transaction as if the transaction were occurring in the general account, determined in accordance with [insert reference for determining asset valuation reserve]; but to the extent that the NAIC asset valuation reserve maximum reserve factor was not used in determining the amount of the deduction, the amount of the deduction shall be increased fifty percent (50%) for purposes of this calculation.

C. To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by separate account or supplemental account assets denominated in the currency of the foreign country, the percentage deduction for these assets under Subsection B of this section shall be that for a substantially similar investment denominated in the currency of the United States.

D. To the extent that guaranteed contract liabilities are denominated in the currency of the United States and are supported by separate account or supplemental account assets denominated in the currency of a foreign country, and to the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by separate account or supplemental account assets denominated in the currency of the United States, the deduction for debt instruments and replicated (synthetic assets) transactions under Subsection B of this section shall be increased by fifteen percent (15%) of its market value unless the currency exchange risk has been adequately hedged, in which case the percentage deduction under Subsection B of this section shall be increased by one-half percent (0.5%). No guaranteed contract liabilities denominated in the currency of a foreign country shall be supported by separate account or supplemental account assets denominated in the currency of another foreign country without the approval of the commissioner. For purposes of this subsection, the currency exchange rate on an asset is deemed to be adequately hedged if:

(1) It is an obligation of a jurisdiction that is rated in one of two (2) highest rating categories by an independent nationally recognized United States rating agency acceptable to the commissioner or a political subdivision or other governmental unit of the jurisdiction, or is organized under the laws of the jurisdiction; and

(2) At all times the principal amount and scheduled interest payments on the principal are hedged against the United States dollar pursuant to contracts or agreements that are:

(a) Issued by or traded on a securities exchange or board of trade regulated under the laws of the United States or Canada or a province of Canada;

(b) Entered into with a United States banking institution that has assets in excess of $5 billion and that has obligations outstanding, or has a parent corporation that has obligations, that are rated in one of the two (2) highest rating categories by an independent, nationally recognized United States rating agency, or with a broker-dealer registered with the Securities and Exchange Commission that has net capital in excess of $250 million;

(c) Entered into with any other banking institution that has assets in excess of $5 billion and that has obligations outstanding, or has a parent corporation that has obligations outstanding, that are rated in one of the two (2) highest rating categories by an independent, nationally recognized United States rating agency and that is organized under the laws of a jurisdiction that is rated in one of the two (2) highest rating categories by an independent, nationally recognized United States rating agency; or

(d) Entered into with an entity permitted under [insert reference to section of investment law enumerating permitted counterparties for currency hedging transactions].

E. All or a portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of (i) the amounts contributed (net of withdrawals) by the contractholder, and (ii) the earnings attributable to the amounts contributed (net of withdrawals) by the contractholder.

F. (1) For purposes of this section, the minimum value of guaranteed contract liabilities is defined to be the sum of the expected guaranteed contract benefits, each discounted at a rate corresponding to the expected time of payment of the contract benefit that is not greater than the rate supportable by the expected return from the separate account and any supplemental account assets provided that the rate used shall not exceed the blended spot rates as prescribed in Section 5B(5) or as described in the actuarial opinion. In calculating the minimum value of contract benefits, all guaranteed contract benefits potentially available to the contractholder shall be considered in the valuation process and analysis, and the reserve held shall be sufficient to fund the greatest present value of each independent guaranteed benefit stream, including guaranteed annuitization options available.

(2) To the extent that future cash flows are dependent upon the benefit responsiveness features of an employer-sponsored plan, a best estimate or an estimate based on the insurance company's experience shall be used in the projections of the future cash flows. In addition, the valuation actuary shall periodically review the actual experience under the contract to validate the assumptions used. In projecting cash flows for contingent benefits involving mortality, the mortality tables for these benefits prescribed or authorized in [insert appropriate section] of the insurance law shall be used.

(3) The minimum value of guaranteed contract benefits under a contract issued to a pooled fund representing multiple employer-sponsored plans shall be determined so as to reflect projected plan sponsor contract value withdrawals available to the member plans in the pooled fund.

Projections of such future cash flows shall take into account (i) known plan sponsor withdrawals, and (ii) a prudent estimate of future plan sponsor withdrawals. The prudent estimate shall be based on company experience and other relevant criteria.

Drafting Note: Other relevant criteria include, but are not limited to, the pooled fund's profile (e.g. number of employer-sponsored plans, and the minimum, maximum, and average size of such plans), the minimum notice that plan sponsors are required to give in order to effectuate a plan sponsor withdrawal, the percentage of the pooled fund that is investment-only and that is full service, and economic conditions.

A single valuation rate shall be determined equal to the lesser of: (i) the expected return from the separate account, or (ii) the blended spot rate based on the duration of the separate account.

This single valuation rate shall be used to model future market values of the separate account. Future credited interest rates shall be modeled according to the contractually defined crediting rate formula. Modeled future contract values shall reflect modeled future market values, modeled future credited interest rates, known future plan sponsor withdrawals, the prudent estimate of future plan sponsor withdrawals, future withdrawals consistent with Paragraph (2) of this subsection, and any remaining final payment at the modeled contract termination date.

All such modeled withdrawals and termination payments shall be discounted using the single valuation rate and the modeled times of those withdrawals and payments. The sum of these present values shall be deemed the minimum value of the guaranteed contract liabilities for a pooled fund contract.

Section 8. Asset Maintenance Requirements for Market Value Separate Accounts Supporting Index Contracts

A. At all times an insurance company shall hold sufficient assets as a reserve in the general account, the separate account or supplemental accounts, as appropriate, such that the:

(1) Market value of the assets held in the separate account, plus,

(2) The market value of any supplemental account, plus,

(3) Any assets held in the general account as a reserve for guaranteed contract liabilities (valued in accordance with [insert reference to rules governing valuation of general account assets]), less

(4) Any deduction provided for in Subsection B of this section, equals or exceeds the value of guaranteed contract liabilities determined in the manner set forth in the plan of operations.

B. In determining compliance with the asset maintenance requirement and the reserves for guaranteed contract liabilities in accordance with Subsection A of this section, the insurance company shall deduct a percentage of the market value of a separate account or supplemental account asset as set forth in the plan of operations, and for replication (synthetic asset) transactions, the value of the separate account or supplemental account assets shall be decreased in the manner set forth in the plan of operations.

C. All or a portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of (i) the amounts contributed (net of withdrawals) by the contractholder, and (ii) the earnings attributable to the amounts contributed (net of withdrawals) by the contractholder.

Section 9. Asset Maintenance Requirements for Separate Accounts Supporting Book Value Contracts

A. At all times an insurance company shall hold sufficient assets in the general account, the separate account or supplemental accounts, as appropriate, such that the value of the account assets, valued as if the assets were held in the insurance company's general account, equals or exceeds the reserve required for contracts supported by the separate account, determined as if the contracts were held in the general account.

B. All or any portion of the amount needed to comply with the asset maintenance requirement may be allocated to one or more supplemental accounts. If the account contract or applicable law provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurance company, the insurance company shall maintain in a supplemental account or the general account the amount of any account assets in excess of the sum of (i) the amounts contributed (net of withdrawals) by the contractholder, and (ii) the earnings attributable to the amounts contributed (net of withdrawals) by the contractholder.

Section 10. Actuarial Opinion and Memorandum

A. An insurance company that maintains any separate accounts governed by this regulation shall submit an actuarial opinion rendered by the valuation actuary to the commissioner annually by March 1 showing the status of the accounts as of the preceding December 31. The actuarial opinion shall be supported by a confidential actuarial memorandum prepared by the valuation actuary rendering the opinion. The valuation actuary may be either the appointed actuary of the company or, alternatively, a qualified actuary designated by the appointed actuary to be the valuation actuary for the purpose of this regulation.

B. The memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, are deemed to be confidential to the same extent, and under the same conditions, as the actuarial memorandum required by [insert reference to state law equivalent to Section 3 of the NAIC Model Standard Valuation Law].

C. The memorandum shall be made available for examination by the commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the commissioner.

Drafting Note: Each state should review its laws regarding confidentiality of industry provided information and conform those provisions accordingly.

D. Except in cases of fraud or willful misconduct, the valuation actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

E. The statement of actuarial opinion submitted in accordance with Section 10A shall cover the applicable points set forth in Section [insert reference to regulation governing content of actuarial opinion] and at a minimum consist of:

(1) A paragraph identifying the valuation actuary and his or her qualifications;

(2) A scope paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the valuation actuary's work;

(3) A reliance paragraph describing those areas, if any, where the valuation actuary has deferred to other experts in developing data, procedures or assumptions (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios [insert reference to regulation governing content of actuarial opinion with respect to reliance], supported by a statement of each expert in the form prescribed by [insert reference to regulation governing content of actuarial opinion with respect to reliance]); and

(4) An opinion paragraph expressing the valuation actuary's opinion that, after taking into account any risk charge payable from the separate account assets and the amount of any reserve liability of the general account and amounts held in any supplemental account with respect to the asset maintenance requirement, the account assets make adequate provision for the contract liabilities.

(5) The opinion shall also state:

(a) That the level of risk charges, if any, payable to the general account was appropriate in view of such factors as the nature of the guaranteed contract liabilities and losses experienced in connection with account contracts, and other pricing factors;

(b) That after taking account of any reserve liability of the general account and amounts held in any supplemental account with respect to the asset maintenance requirement, the amount of the account assets satisfied the asset maintenance requirement;

(c) That the fixed-income asset portfolio conformed to, and justified, the rates used to discount contract liabilities for valuation pursuant to Section 7F, if applicable; and

(d) Whether any rates used pursuant to Section 7F to discount guaranteed contract liabilities and other items applicable to the separate account or any supplemental account were modified from the rate or rates described in the plan of operations filed pursuant to Section 5.

(6) One or more additional paragraphs may be needed in individual company cases as follows:

(a) If the valuation actuary considers it necessary to state a qualification of his or her opinion;

(b) If the valuation actuary must disclose an inconsistency in the method of analysis used at the prior opinion date with that used for this opinion; or

(c) If the valuation actuary chooses to add a paragraph briefly describing the assumptions which form the basis of the actuarial opinion.

F. The opinion shall be accompanied by a certificate of an officer of the insurance company responsible for monitoring compliance with the asset maintenance requirements for the separate accounts, describing the extent to and manner in which during the preceding year:

(1) Actual benefit payments conformed to the benefit payment estimated to be made as described in the plan of operations;

(2) The determination of the value of the separate account and any supplemental account conformed to the valuation procedures described in the plan of operations, including, but not limited to, a statement of the procedures and sources of information used during the year; and

(3) Any assets were transferred to or from the insurance company's general account, or any amounts were paid to the insurance company by any contractholder to support the insurance company's guarantee.

G. The actuarial memorandum shall:

(1) Substantially conform with those portions of Section [insert reference to section of the regulations related to actuarial memoranda] of these regulations that are applicable to asset adequacy testing and either:

(a) Demonstrate the adequacy of account assets based upon cash flow analysis; or

(b) Explain why cash flow analysis is not appropriate, describe the alternative methodology of asset adequacy testing used, and demonstrate the adequacy of account assets under such methodology.

(2) Clearly describe the assumptions the valuation actuary used in support of the actuarial opinion, including any assumptions made in projecting cash flows under each class of assets, and any dynamic portfolio hedging techniques utilized and the tests performed on the utilization of the techniques;

(3) Clearly describe how the valuation actuary reflected the risk of default on obligations and mortgage loans, including obligations and mortgage loans that are not investment grade;

(4) Clearly describe how the valuation actuary has reflected withdrawal risks, if applicable, including a discussion of the positioning of the contracts within the benefit withdrawal priority order pertaining to the contracts, the impact of any dynamic lapse assumption and the results of sensitivity testing the prudent estimate of future plan sponsor withdrawals pursuant to Section 7F(3);

(5) If the plan of operations provides for investments in separate account or supplemental account assets other than United States government obligations, demonstrate that the rates used to discount contract liabilities pursuant to Section 7F conservatively reflect expected investment returns (taking into account any foreign exchange risks);

(6) If the contracts provide that in certain circumstances they would cease to be funded by a separate account and, instead, would become contracts funded by the general account, clearly describe how any increased reserves would be provided for if and to the extent these circumstances occurred;

(7) State the amount of separate account assets that are not chargeable with liabilities arising out of any other business of the insurance company;

(8) State the amount of reserves and supporting assets as of December 31 and where the reserves and assets are shown in the annual statement;

(9) State the amount of any contingency reserve carried as part of surplus;

(10) For book value contracts, state the market value of supporting assets; and

(11) Where separate account assets are not chargeable with liabilities arising out of any other business of the insurance company, describe how the level of risk charges payable to the general account provider are appropriate compensation for the risk taken by the general account.

Section 11. Asset Valuation Reserve

When the insurance company values separate account or supplemental account assets at market and complies with the asset maintenance requirements of Section 7 or 8, it need not maintain an asset valuation reserve with respect to these assets.

Section 12. Reserve Valuation

A. Reserves for contracts funded by a market value separate account supporting contracts other than index contracts shall be an amount equal to the following:

(1) The total reserve required to be maintained on the valuation date under Section 7;

(2) Plus the excess, if any, of the market value of separate account assets (to the extent that the market value of the assets determines the contractholder's benefits, i.e., to the extent the assets are beneficially "client" assets) over the amount determined in accordance with Paragraph (1) of this subsection;

(3) Plus any additional amount determined by the valuation actuary as necessary to make adequate provision for all of the contract liabilities;

(4) Plus any additional amount determined as necessary by the commissioner due to the nature of the benefits.

B. Reserves for index contracts funded by a market value separate account shall be an amount equal to the following:

(1) The total reserve required to be maintained on the valuation date under Section 8;

(2) Plus the excess, if any, of the market value of separate account assets (to the extent that the market value of the assets determines the contractholder's benefits, i.e., to the extent the assets are beneficially "client" assets) over the amount determined in accordance with Paragraph (1) of this subsection;

(3) Plus any additional amounts determined by the valuation actuary as necessary to make adequate provision for all of the contract liabilities;

(4) Plus any additional amount determined as necessary by the commissioner due to the nature of the benefits.

C. Reserves for book value contracts shall be determined as if the contracts were held in the general account.

D. The amount of any reserves required by Subsections A(3) and (4) or Subsections B(3) and (4) of this section may be established by either:

(1) Allocating sufficient assets to the separate account or a supplemental account to satisfy the requirement; or
(2) Setting up the additional reserves in the general account.

Section 13. Severability

If any provision of this regulation or its application to any person or circumstance is held invalid by a court of competent jurisdiction, that judgment shall not affect or impair the validity of the other provisions of this regulation.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1998 Proc. 4th Quarter 15, 17, 243, 285-286, 288, 289-299 (adopted).
1999 Proc. 3rd Quarter 25, 26, 340, 343, 367-369 (amended).
2016 Fall National Meeting (amended)

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. INS. CODE § 10506.4 (1996/2004); BULLETIN 95-8 (1995).
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. AGENCIES REGS. §§ 38a-459-10 to 38a.459-20 (2002/2019).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. §§ 33-11-65 to 33-11-67 (1999).

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-96.1 to 191-96.12 (2011/2017).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska			210 NEB. ADMIN. CODE 80 §§ 001 to 011 (2005/2018).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 97.1 to 97.9 (Regulation 128) (1990/2014).	
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2016

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFITS UNDER GROUP CONTRACTS MODEL REGULATION (#200)

1. Description of the Project, Issues Addressed, etc.

Revisions were made to the *Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts Model Regulation* (#200) to modify the valuation methodology. Definitions were added for the following terms: "Treasury-based spot rate"; "index spot rate"; "blended spot rate"; and "prudent estimate." Section 5B(5) and Section 5C were revised to provide further definition. Section 5B(6)(g) was added to expand the plan of operations requirements for pooled funds contracts and to provide further guidance. The modification to Section 7F(1) and the addition of Section 7F(3) clarify and strengthen the valuation requirements for pooled fund contracts. Section 10G(4) was revised to expand the actuarial memorandum requirements related to withdrawal risks.

2. Name of Group Responsible for Drafting the Model and States Participating

The Life Actuarial (A) Task Force was responsible for the revisions to the text.

States Participating:

David Mattax, Chair (*represented by Mike Boerner*)	Texas	Bruce R. Ramge (*represented by Rhonda Ahrens*)	Nebraska
Mary Taylor, Vice Chair (*represented by Pete Weber*)	Ohio	Richard J. Badolato (*represented by Felix Schirripa*)	New Jersey
Dave Jones (*represented by Perry Kupferman*)	California	Maria T. Vullo (*represented by William Carmello*)	New York
Katharine L. Wade (*represented by Tricia Dave*)	Connecticut	John D. Doak (*represented by Frank Stone*)	Oklahoma
Nick Gerhart *(represented by Mike Yanacheak*)	Iowa	Todd E. Kiser (*represented by Tomasz Serbinowski*)	Utah
Mike Rothman (*represented by Fred Andersen*)	Minnesota	Jacqueline K. Cunningham (*represented by Ern Johnson*)	Virginia
John M. Huff (*represented by William Leung*)	Missouri		

3. Project Authorized by What Charge and Date First Given to the Group

The revisions to the model were authorized in 2016 by the following charge to the Task Force: "Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The revisions to Model #200 were drafted by the American Academy of Actuaries (Academy) at the request of the Task Force. After reviewing the proposed revisions, the Task Force exposed the revisions for a public comment period. No comments were received. The Task Force adopted the proposed revisions on its Oct. 13, 2016, conference call. The revised model was then forwarded to the Life Insurance and Annuities (A) Committee. The Committee adopted the revisions on its Oct. 19, 2016, conference call.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated in the drafting process, including the American Council of Life Insurers (ACLI) and the Academy.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force met at each national meeting and held interim meetings and conference calls starting in December 2015 until adopting the revisions on its Oct. 13, 2016, conference call. Prior to adoption, the revisions were exposed for a public comment period. No comments were received.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

The revisions to Model #200 were necessitated by the 2015 adoption of similar revisions to the *Synthetic Guaranteed Investment Contracts Model Regulation* (#695). The products subject to the two regulations differ only in that, under Model #695, the group annuity contract or other agreement establishes the insurer's obligations by reference to a segregated portfolio of assets that is not owned by the insurer.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

ANNUAL FINANCIAL REPORTING MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to Sections [insert applicable sections] of the [insert state] insurance law.

Section 2. Purpose and Scope

The purpose of this regulation is to improve the [insert state] Insurance Department's surveillance of the financial condition of insurers by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management's Report of Internal Control over Financial Reporting.

Every insurer (as defined in Section 3) shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

A. A copy of the audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the commissioner in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

B. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the commissioner within the time specified in Section 10.

Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

This regulation shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers under the rules and regulations of the [insert state] Department of Insurance and the practices and procedures of the [insert state] Department of Insurance.

Section 3. Definitions

The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

A. "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

B. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

C. "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers (if applicable), and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14F for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

D. "Audited financial report" means and includes those items specified in Section 5 of this regulation.

E. "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

F. "Independent board member" has the same meaning as described in Section 14C.

G. "Insurer" means a licensed insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law or an authorized insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law.

H. "Group of insurers" means those licensed insurers included in the reporting requirements of [insert state law equivalent of the model Insurance Holding Company System Regulatory Act], or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting.

I. "Internal audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

J. "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and includes those policies and procedures that:

(1) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(2) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(3) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5B through 5G of this regulation.

K. "SEC" means the United States Securities and Exchange Commission.

L. "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

M. "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A.

N. "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in Section 4B, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual audited financial report pursuant to this regulation shall designate a group of individuals as constituting its audit committee, as defined in Section 3. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this regulation at the election of the controlling person.

Section 5. Contents of Annual Audited Financial Report

The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

The annual Audited financial report shall include the following:

A. Report of independent certified public accountant.

B. Balance sheet reporting admitted assets, liabilities, capital and surplus.

C. Statement of operations.

D. Statement of cash flow.

E. Statement of changes in capital and surplus.

F. Notes to financial statements. These notes shall be those required by the appropriate NAIC *Annual Statement Instructions* and the NAIC *Accounting Practices and Procedures Manual*. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section [insert applicable section] of the [insert state] insurance law with a written description of the nature of these differences.

G. The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted).

Section 6. Designation of Independent Certified Public Accountant

A. Each insurer required by this regulation to file an annual audited financial report must within sixty (60) days after becoming subject to the requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

B. The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Insurance Department, specifying such exceptions as he or she may believe appropriate.

C. If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the commissioner of this event. The insurer shall also furnish the commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the commissioner together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

A. The commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as *indemnification*) with respect to the audit of the insurer.

B. Except as otherwise provided in this regulation, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the [insert state] Board of Public Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under [cite applicable receivership statute], the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. (1) The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

(a) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(b) Premium volume of the insurer; or

(c) Number of jurisdictions in which the insurer transacts business.

(2) The insurer shall file, with its annual statement filing, the approval for relief from Subsection D(1) with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

E. The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by, a natural person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

F. The commissioner of insurance, as provided in Section [insert applicable section] of the insurance code, may, as provided in [insert applicable citation], hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

G. (1) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(a) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(b) Financial information systems design and implementation;

(c) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(d) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(i) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(ii) The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and

(iii) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(e) Internal audit outsourcing services;

(f) Management functions or human resources;

(g) Broker or dealer, investment adviser, or investment banking services;

(h) Legal services or expert services unrelated to the audit; or

(i) Any other services that the commissioner determines, by regulation, are impermissible.

Drafting Note: Any additions or deletions from the list of prohibited services by a state must be carefully considered as uniformity among states is essential in this section. In determining whether other services are impermissible, the commissioner shall consider utilizing the guidance provided in the SEC's Final Rule No. 33-8183, *Strengthening the Commission's Requirements Regarding Auditor Independence* adopted January 28, 2003, in order to evaluate whether the provision of such services impairs the independence of the accountant.

(2) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

H. Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection G(1). The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

I. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection G(1) or that do not conflict with Subsection G(2), only if the activity is approved in advance by the Audit committee, in accordance with Subsection J.

Drafting Note: A qualified independent certified public accountant who performs the audit may also engage in other non-audit services for an insurer, including tax services, that are not described in Subsection G(1) or that do not conflict with Subsection G(2) if the audit committee is in compliance with the SEC's Final Rule No. 33-8183, *Strengthening the Commission's Requirements Regarding Auditor Independence* adopted January 28, 2003, and has approved such activity.

J. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

K. The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by Subsection J. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

L. (1) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief from Subsection L(1) with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 8. Consolidated or Combined Audits

An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

A. Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;

B. Amounts for each insurer subject to this section shall be stated separately;

C. Noninsurance operations may be shown on the worksheet on a combined or individual basis;

D. Explanations of consolidating and eliminating entries shall be included; and

E. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, *Consideration of Internal Control in a Financial Statement Audit*, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 17, the independent certified public accountant should consider (as that term is defined in Statement on Auditing Standards (SAS) No. 102, *Defining Professional Requirements in Statements on Auditing Standards* or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the *Financial Condition Examiners Handbook* promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five (5) business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the [insert state] insurance code as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive the evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five (5) business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.

C. If the accountant, subsequent to the date of the audited financial report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by Statement on Auditing Standard 60, *Communication of Internal Control Related Matters Noted in an Audit*, or its replacement) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in Section 4(A)) in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication

should so state.

Drafting Note: The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. Such information should be made available to the examiner conducting a financial condition examination for review and kept in such a manner as to remain confidential.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

Section 12. Accountant's Letter of Qualifications

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

A. That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the [insert state] Board of Public Accountancy, or similar code;

B. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

C. That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this regulation and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

D. That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the commissioner, or the commissioner's designee or appointed agent, the workpapers, as defined in Section 13;

E. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

F. A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Work Papers

A. Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

B. Every insurer required to file an audited financial report pursuant to this regulation, shall require the accountant to make available for review by Insurance Department examiners, all work papers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Insurance Department or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Insurance Department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Insurance Department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.

Section 14. Requirements for Audit Committees

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

A. The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this regulation. Each accountant shall report directly to the audit committee.

B. The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this regulation.

C. Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection F and Section 3C.

D. In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

E. If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

Drafting Note: In determining independence, the commissioner shall consider utilizing guidance provided in the SEC's Final Rule No. 33-8220, *Standards Relating to Listed Company Audit Committees* adopted April 9, 2003.

F. To exercise the election of the controlling person to designate the audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

G. (1) The audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the audit committee in accordance with the requirements of SAS 61, *Communication with Audit Committees*, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by Subsection G(1) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

H. The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	**Over $300,000,000 - $500,000,000**	**Over $500,000,000**
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The commissioner has authority afforded by state law to require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

I. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the commissioner for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Internal Audit Function Requirements

A. Exemption – An insurer is exempt from the requirements of this section if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(2) If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

Drafting Note: An insurer or group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

B. Function – The insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

C. Independence – In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting – The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements – If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

Section 16. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's audit committee.

Drafting Note: In determining what types of sanctions or penalties could be assessed for violations of items included in Subsections A through C, each state should refer to its individual authority provided by state statutes.

Section 17. Management's Report of Internal Control over Financial Reporting

A. Every insurer required to file an audited financial report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in Section 3. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 11. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in Subsection A, the commissioner may require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in (include reference to Corrective Action statute).

C. An insurer or a group of insurers that is:

(1) Directly subject to Section 404;

(2) Part of a holding company system whose parent is directly subject to Section 404;

(3) Not directly subject to Section 404 but is a SOX Compliant Entity; or

(4) A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity;

may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section 17 requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5B through 5G of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5B through 5G of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 17 report, or (ii) the Section 404 Report and a Section 17 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting; and

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by Subsection A above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the State Insurance Department.

Drafting Note: It is the recommendation that the company officer responsible for financial reporting would not be a member of the audit committee and that the independent committee members would meet periodically, with no management present, with the independent certified public accountant to discuss the strengths and weaknesses of the insurer's or group of insurers' internal control environments.

Section 18. Exemptions and Effective Dates

A. Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of this regulation if the commissioner finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the regulations of the [insert state] Department of Insurance pertaining to administrative hearing procedures.

B. Domestic insurers retaining a certified public accountant on the effective date of this regulation who qualify as independent shall comply with this regulation for the year ending December 31, 20[ ], and each year thereafter unless the commissioner permits otherwise.

C. Domestic insurers not retaining a certified public accountant on the effective date of this regulation who qualifies as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(1) As of December 31, 20[ ], file with the commissioner an audited financial report

(2) For the year ending December 31, 20[ ], and each year thereafter, such insurers shall file with the commissioner all reports and communication required by this regulation.

D. Foreign insurers shall comply with this regulation for the year ending December 31, 20[ ], and each year thereafter, unless the commissioner permits otherwise.

E. The requirements of Section 7D shall be in effect for audits of the year beginning January 1, 2010, and thereafter.

F. The requirements of Section 14 are to be in effect January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

Drafting Note: Adoption of Section 14 is assumed to occur one year prior to the effective date of Section 17.

G. The requirements of Section 17 and other modified sections [identify modified sections], except for Section 14 covered above, are effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following

the date of acquisition or combination to comply with the reporting requirements.

H. The requirements of Section 15 are to be in effect January 1, 2016. If an insurer or group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

Section 19. Canadian and British Companies

A. In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 20. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. I 29, 37, 212, 262, 266-272 (adopted).
1991 Proc. I 9, 17, 225-226, 426, 428, 429-434 (amended and reprinted).
1998 Proc. 2nd Quarter 12, 13, 158, 226, 230, 231-232 (amended).
2001 Proc. 4th Quarter 6, 13-14, 531, 551, 561-563 (amended).
2003 Proc. 2nd Quarter 473, 489, 491 (amended and adopted by parent committee).
2003 Proc. 3rd Quarter 15 (adopted by Plenary).
2006 Proc. 2nd Quarter 779-793 (amended and adopted by Plenary).
2014 Proc. 2nd Quarter, Vol. I 115, 129-134, 173, 194, 216 (amended).
2015 Proc. 2nd Quarter, Vol. I 126, 141, 147, 156-157 (editorial changes adopted).

ANNUAL FINANCIAL REPORTING MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ANNUAL FINANCIAL REPORTING MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-141 (2008/2018).		BULLETIN 10-1-2012 (#1) (2012).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.700 to 21.799 (2008/2019).		ALASKA ADMIN. CODE tit. 3, § 21.09.200 (2007/2011); BULLETIN B 02-05 (2002).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-223 (1954/2009); §§ 20-698 to 20-698.01 (2009/2011); BULLETIN 2009-3 (2009).
Arkansas	ARK. ADMIN. CODE 054.00.25 (RULE 25) (2009/2020).		
California	A.B. No. 1813 (2019).	CAL. CODE REGS. tit. 10, §§ 2309.2 to 2309.20 (2009).	CAL. CODE REGS. tit. 10, §§ 2308.1 to 2308.3 (2009); CAL. INS. CODE § 900.2 (1991/2009).
Colorado	3 COLO. CODE REGS. § 702-3:3-1-4 (2016).		
Connecticut	CONN. AGENCIES REGS. §§ 38a.54-1 to 38a.54-14 (1991/2016).		CONN. GEN. STAT. § 38a-54 (1990/2016); BULLETIN FS-4-2009 (2009); BULLETIN FS-4-2013 (2013).

ANNUAL FINANCIAL REPORTING MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	DEL. ADMIN. CODE tit. 18, § 301 (1987/2017).		
District of Columbia	D.C. CODE §§ 31-301 to 31-314 (1993/2019).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-137.001 to 69O-137.002 (1992/2019).		FLA. STAT. § 624.424 (1985/2017).
Georgia	GA. COMP. R. & REGS. 120-2-60 (1994/2015).		GA. CODE ANN. § 33-50-5 (1992/2019).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-185-101 to 16-185-118 (2010/2019).		HAW. REV. STAT. § 431:3-302.5 (1991/2009).
Idaho	IDAHO ADMIN. CODE r. 18.07.04.000 to 18.07.04.026 (1992/2019).		BULLETIN 2014-3 (2014).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 925.20 to 925.200 (1975/2014/2019).		BULLETIN 2009-10 (2009).
Indiana	IND. CODE §§ 27-1-3.5-0.5 to 27-1-3.5-18 (1989/2018); 760 IND. ADMIN. CODE 1-78-1 to 1-78-18 (2015).		
Iowa	IOWA ADMIN. CODE r. 98.1 to 98.21 (2008/2017).		
Kansas	KAN. ADMIN. REGS. § 40-1-37 (1989/2017) (adopted by reference).		
Kentucky		806 KY. ADMIN. REGS. 3:170 (1991/2011).	
Louisiana	LA. ADMIN. CODE tit. 37, Pt. XIII §§ 13701 to 13739 (2009/2019).		LA. REV. STAT. ANN. §§ 22:671 to 22:675 (1990/1995); § 22:366 (2008/2009); § 22:386 (2008/2009).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine	02-031 ME. CODE R. § 235 (2005/2010/2019).	ME. REV. STAT. ANN. tit. 24-A, § 221-A (1985/2010).	
Maryland	MD. CODE ANN. INS. § 4-118 (1995/2010); MD. CODE REGS. 31.05.11.01 to 31.05.11.18 (2009/2018).		MD. CODE ANN. INS. § 4-116 (1987/2010).
Massachusetts	211 MASS. CODE REGS. §§ 26.01 to 26.20 (1976/2020).		
Michigan	P.A. No. 17 (2020).	MICH. COMP. LAWS §§ 500.1001 to 500.1033 (1992/2016).	
Minnesota	MINN. STAT. § 60A.1291 (2009/2019).		
Mississippi	MISS. CODE ANN. §§ 83-5-101 to 83-5-125 (1991/2019).		
Missouri	MO. REV. STAT. §§ 375.1025 to 375.1062 (1991/2019).		
Montana	MONT. ADMIN. R. 6.6.3501 to 6.6.3520 (1993/2019).		
Nebraska	210 NEB. ADMIN. CODE §§ 56-001 to 56-020 (1990/2018).		NOTICE 3-9-2009 (2009).
Nevada	NEV. ADMIN. CODE §§ 680A.172 to 680A.211 (1996/2017).		NEV. REV. STAT. § 680A.265 (1991/1995); NEV. ADMIN. CODE §§ 680A.002 to 680A.005 (2017).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. §§ 4501.01 to 4501.18 (2016).		BULLETIN 12-016-AB (2012).
New Jersey	ORDER No. A20-01 (2020).	N.J. ADMIN. CODE §§ 11:2-26.1 to 11:2-26.21 (1989/2014).	N.J. ADMIN. CODE §§ 11:19-1.1 to 11:19-1.4 (2009).
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 89.1 to 89.16 (Regulation 118) (2009/2014).	N.Y. INS. LAW § 307 (1984/2013); CIRCULAR LETTER 2010-10 (2010).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	N.C. GEN. STAT. 58-10-185 to 58-10-265 (2009/2019).		
North Dakota	N.D. ADMIN. CODE §§ 45-03-20-01 to 45-03-20-15 (2014/2016).		
Northern Marianas			20 N. MAR. I. ADMIN. CODE §§ 40.1-101 to 40.1-150 (1994).
Ohio	OHIO ADMIN. CODE § 3901-1-50 (1990/2015).		OHIO REV. CODE ANN. § 3901.48 (1990/2006).
Oklahoma	OKLA. STAT. tit. 36, §§ 311A.1 to 311A.18 (2009/2019); OKLA. STAT. tit. 36, § 311.4 (2009/2014).		
Oregon	OR. ADMIN. R. 836-011-0000 to 836-011-0230 (1992/2018).		
Pennsylvania	31 PA CODE 147.1 to 147.15 (2017).		
Puerto Rico		P.R.Regs. RULE XIV-A (1980/2011).	
Rhode Island	230-20 R.I. CODE R. §§ 7.1 to 7.20 (2016).		
South Carolina	S.C. CODE ANN. REGS. 69-70 §§ 1 to 21 (2009/2019).		BULLETIN 6-2009 (2009); BULLETIN 19-2009 (2009).
South Dakota	S.D. CODIFIED LAWS §§ 58-43-1 to 58-43-26 (1992/2018).		S.D. ADMIN. R. §§ 20:06:25:01 to 20:06:25:02 (1997/2019).
Tennessee	TENN. COMP. R. & REGS. 0780-1-65 (1995/2018).		TENN. CODE ANN. § 56-8-107 (2011).
Texas		28 TEX. ADMIN. CODE § 7.85 (1995/2014); § 7.88 (2010); TEX. INS. CODE ANN. §§ 401.001 to 401.021 (2007).	BULLETIN B-0038-10 (2010).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah		UTAH ADMIN. CODE r. 590-254-1 to 590-254-21 (2009).	UTAH ADMIN. CODE r. 590-225-1 to 590-225-16 (2009/2019); UTAH CODE ANN. § 31A-5-412 (2019).
Vermont	VT. ADMIN. CODE §§ 4-3-52:1 to 4-3-52:21 (Regulation I-2009-06) (2009/2019).		VT. STAT. ANN. tit. 8, § 3578a (1992/2013); VT. STAT. ANN. tit. 8, § 3561 (2009).
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 621-640 (2018).		
Virginia	14 VA. ADMIN. CODE §§ 5-270-10 to 5-270-180 (1991/2015).		ADMIN. LETTER 2009-7 (2009).
Washington	WASH. ADMIN. CODE §§ 284-07-100 to 284-07-220 (1992/2020)		WASH. ADMIN. CODE §§ 284-07-500 to 284-07-540 (2008/2013).
West Virginia	W. VA. CODE §§ 33-33-1 to 33-33-16 (1989/2019).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 50.01 to 50.19 (1993/2017).		
Wyoming	WYO. STAT. ANN. §§ 26-3-301 to 26-3-317 (1994/2019).		

PROJECT HISTORY - 2014

ANNUAL FINANCIAL REPORTING MODEL REGULATION (#205)

1. Project Description

U.S. insurance regulators concluded that a greater regulatory focus on corporate governance is required and formed the Corporate Governance (E) Working Group in September 2009. The Working Group received a charge to outline high-level corporate governance principles for use in U.S. insurance regulation. To do so, regulators analyzed the statutory and regulatory requirements and initiatives and best practices of the states, other countries, other regulators, and the insurance industry. The Working Group was also asked to determine the appropriate method to ensure adherence with such principles, giving due consideration to development of a model law and to development of additional regulatory guidance, including detailed best practices for the corporate governance of insurers.

In completing work on this charge, regulators developed a summary of existing corporate governance requirements found within NAIC/insurance-specific sources—as well as more general, broadly based sources—to identify potential changes in the existing insurance regulatory structure that could be affected through the NAIC Solvency Modernization Initiative (SMI). The Working Group then compared those existing U.S. requirements to regulatory needs, best practices and principles outlined in the Insurance Core Principles adopted by the International Association of Insurance Supervisors (IAIS). The results of this comparative analysis indicated the need to require large insurers to maintain an effective internal audit function capable of providing the insurer's audit committee with independent assurance regarding the insurer's governance, risk management and internal controls.

The Working Group determined that the best way to implement an internal audit requirement would be to place the requirement within the NAIC's existing *Annual Financial Reporting Model Regulation* (#205). This model regulation currently includes a requirement for insurers to receive an annual financial statement audit, as well as requirements related to the establishment of audit committees and maintenance of effective internal controls over financial reporting.

2. Group Responsible for Drafting the Revisions

The project to review and produce revisions to Model #205 to incorporate an internal audit function requirement was given to the Corporate Governance (E) Working Group. The Working Group created an Internal Audit (E) Subgroup to develop an initial draft of the proposed revisions for the Working Group to consider. Members of the Subgroup included Virginia (chair), Connecticut, New York, Ohio and Oklahoma. After the initial draft was developed by the Subgroup, it was reviewed and revised by the Working Group, whose members included Vermont (chair), New York (vice chair), Alabama, California, Connecticut, Florida, Iowa, Indiana, Louisiana, New Hampshire, Ohio, Oklahoma, Pennsylvania, Virginia, and Washington.

3. Charge Authorizing the Project

On April 8, 2013, the Financial Condition (E) Committee adopted a request for model law development to develop an internal audit function requirement as an addition to the existing Model #205. The Executive (EX) Committee and Plenary adopted this request July 26, 2013. The Financial Condition (E) Committee delegated the assignment of developing revisions to Model #205 to the Corporate Governance (E) Working Group, and drafting work began soon after the 2013 Summer National Meeting.

4. General Description of the Drafting Process and Due Process

- During September and October 2013, the Internal Audit (E) Subgroup held regulator-to-regulator conference calls to develop the initial draft of proposed revisions to Model #205.
- After finalizing an initial draft of revisions, the Subgroup referred the draft to the Corporate Governance (E) Working Group for review on a Nov. 8, 2013, conference call.
- The Working Group voted to expose the draft for a 30-day public comment period ending Dec. 6, 2013. Several comment letters were received during the exposure period suggesting a number of changes to the draft.
- The comment letters were reviewed and discussed during a meeting of the Corporate Governance (E) Working Group held Dec. 16, 2013. As a result of its discussions, the Working Group agreed to make a number of amendments to the proposed draft and voted to re-expose the updated draft for a 45-day public comment period ending Jan. 31, 2014.
- One comment letter was received from the Pennsylvania Insurance Department during the second exposure period. Members of the Working Group discussed and agreed to accept the amendments proposed by

Pennsylvania before adopting the proposed revisions as final at its March 30, 2014, meeting.

5. Discussion of Key Issues

Revisions were made to several sections of the existing model regulation to incorporate an internal audit function requirement for large insurers. A summary of the revisions is provided below.

i. A definition of "internal audit function" was added to the model as follows:

Section 3 – Definitions

I. "Internal audit function" means a person or persons that provide independent, objective, and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

ii. Responsibilities and instructions for audit committees to follow in overseeing the internal audit function were added as follows:

Section 14 – Requirements for Audit Committees

B. The Audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this Regulation.

iii. A new section was added to the model regulation to outline the specific requirements and expectations related to the internal audit function employed by large insurers as follows:

Section 15 – Internal Audit Function Requirements

A. Exemption – An insurer is exempt from the requirements of this section if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; or,

(2) If the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(3) An insurer or Group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

B. Function – The insurer or Group of insurers shall establish an Internal audit function providing independent, objective, and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

C. Independence – In order to ensure that internal auditors remain objective, the Internal audit function must be organizationally independent. Specifically, the Internal audit function will not subordinate ultimate judgment on audit matters to others and shall appoint an individual to head the Internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting – The head of the Internal audit function shall report to the Audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the Internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements – If an insurer is a member of an insurance holding company system or included in a Group of insurers, the insurer may satisfy the Internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

iv. An effective date for the new internal audit function requirement was added to the model as follows:

Section 18 – Exemptions and Effective Dates

H. The requirements of Section 15 are to be in effect January 1, 2016. If an insurer or Group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

6. Any Other Important Information

No other items identified at this time.

PROJECT HISTORY - 2006

ANNUAL FINANCIAL REPORTING MODEL REGULATION (#205)

1. Description of the Project, Issues Addressed, etc.

The purpose of this regulation is to improve a state's surveillance of the financial condition of insurers by requiring an annual audit by independent certified public accountants (CPA) of the financial statements reporting the financial position and the results of operations. The proposed amendments strengthen requirements related to CPA independence. In addition, the proposed amendments include new corporate governance standards, primarily requiring that an insurer have an audit committee that is responsible for the appointment, oversight and compensation of the CPA. The proposed amendments also indicate that management of insurers that meet a minimum premium threshold shall provide the regulator with an assessment of its internal control over financial reporting.

2. Name of Group Responsible for Drafting the Model and States Participating

The NAIC/AICPA Working Group (the Working Group) of the Financial Condition (E) Committee drafted the revisions to the model. Virginia is the chair of the Working Group, and its members include California, Delaware, Illinois, Iowa, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New York, Ohio, Oregon, Pennsylvania, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The following charge was given to the Working Group in 2003: "Monitor the Sarbanes-Oxley Bill and additional rules and regulations promulgated by the newly formed Public Accounting Oversight Board."

In 2005, the charge was expanded to the following: "Based on the study of the Sarbanes-Oxley Act, the NAIC/AICPA Working Group will propose revisions to the NAIC's Model Regulation Requiring Annual Audited Financial Reports for best practices regarding Title II Auditor Independence, Title III Corporate Responsibility and Title IV Enhanced Financial Disclosures of the Sarbanes-Oxley Act.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process began in conjunction with a review of the Sarbanes-Oxley Act of 2002. During that review process, it was noted that the model did not contain requirements related to corporate governance and did not require positive assurance regarding the effectiveness of an insurer's internal control over financial reporting. In addition, the model did not specifically discuss what services a CPA may not provide to an insurer if it also performs the audit of that insurer.

Proposed amendments to the model were first drafted in early 2004 and a public hearing was held at the 2004 Summer National Meeting. Based on comments received, three (3) subgroups were formed to handle the three (3) main topics addressed by the revisions: auditor independence, corporate governance and internal control over financial reporting. These subgroups consisted of regulators, members of industry and representatives from CPA firms. The subgroups related to auditor independence and corporate governance held numerous conference calls during 2004 and 2005. Revisions related to these topics were adopted by the Working Group in mid-2005.

The subgroup formed to discuss internal control over financial reporting met during four (4) separate interim meetings in 2005. During this process, members of the interested parties provided the subgroup with an alternative proposal, and the revisions eventually adopted by the Working Group were based on this alternative proposal rather than the original draft revisions.

Once each of the three (3) subgroups finalized its revisions, the "collective" revisions were exposed by the Working Group for a forty-five (45) day comment period, and comments received were discussed during a series of three (3) conference calls.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Widespread input was solicited on many occasions as all conference calls and meetings were held in open session. Approximately seventeen (17) conference calls and six (6) interim meetings were held in addition to any meetings held during national meetings. Both written and oral comments were accepted at any time throughout this process, and the

revisions were officially exposed for comment on at least five (5) different occasions. Members of industry and representatives from trade associations actively participated throughout the drafting process.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Auditor independence requirements – Representatives from CPA firms were concerned that the new requirements regarding prohibited non-audit services would be burdensome for smaller insurers or those insurers in rural areas where there is a limited number of CPA firms. Based on this concern, the Working Group agreed that insurers with less than $100 million in direct and assumed premium may request an exemption from this requirement.

Recruiting and retaining qualified, independent audit committee members – Certain industry representatives were concerned that smaller insurance companies may not be able to recruit or retain individuals independent from management that would be qualified to serve on the insurer's audit committee. As such, the Working Group agreed that insurers with less than $500 million in direct and assumed premium may apply for a waiver from the audit committee requirements. In addition, the Working Group revised the independence requirements for audit committee members, so that only a percentage of audit committee members, if any, are required to be independent. This is also based on an insurer's premium level.

Audit committee membership contemplated in state law – Concern was raised that state corporation law may include requirements related to audit committee membership that would conflict with requirements set forth in the model. The Working Group drafted language indicating that if state law requires board participation by otherwise non-independent members, that law shall prevail and members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

Cost of internal control over financial reporting requirements – To address the issue of whether the reporting requirements would be overly burdensome to smaller companies, the Working Group agreed that only those insurers with direct and assumed premium of more than $500 million would be subject to the management assessment requirement. To address expense issues, the Working Group agreed to remove a requirement that the insurer's CPA perform an annual attestation of management's assessment of internal control over financial reporting. In an industry study, this CPA attestation accounted for approximately 74% of the external costs. In addition, the Working Group agreed that an adequate implementation period and implementation guidance would be provided. This was based on a 2005 SEC roundtable discussion during which SEC filers noted that a short implementation period and insufficient guidance were the main cost drivers in compliance with the SEC's requirements related to internal control over financial reporting.

Insurers currently filing internal control reports for SEC purposes – Concern was raised that redundant reporting of internal control over financial reporting would be required for those insurers that are already required to file a management assessment of internal control over financial reporting for SEC purposes. The Working Group agreed that the SEC reports filed in accordance with Section 404 of Sarbanes-Oxley would be sufficient for regulator purposes. However, if there are internal controls of the insurer that have a material impact on the preparation of the insurer's statutory financial statements and those internal controls were not included in the scope of the Section 404 report, the insurer would need to provide an additional report for those internal controls.

How states have adopted the model – Currently, eleven (11) states have adopted the model via law, twenty-eight (28) via regulation and twelve (12) have adopted it by reference through adoption of the Annual Statement Instructions. The model is required for accreditation purposes, although historically a state that has not adopted the model but has adopted the Annual Statement Instructions has been found to be in compliance with the accreditation standard. This is because the Annual Statement Instructions include, verbatim, the significant elements of the model. Some have raised concern that allowing this process to continue may usurp the legislative process. As such, the Working Group has strongly encouraged those twelve (12) states to adopt the model through either law or regulation.

7. Any Other Important Information (e.g., amending an accreditation standard).

The model is currently a Part A: Laws and Regulations accreditation standard of the Financial Regulation Standards and Accreditation Program. If adopted by the NAIC membership, the Financial Regulation Standards and Accreditation (F) Committee would need to consider the revisions to the model. This process would begin at the Spring National Meeting after approval by Executive and Plenary and would include a combined exposure and seasoning period of four (4) years. In order to hear testimony from industry and legislators, and a minimum of two (2) public hearings would be held at the Committee level. In addition, actions taken by the Committee would be subject to approval by Executive and Plenary.

A group of the collective interested parties is currently drafting an implementation guide to assist in application of and compliance with the new requirements. The implementation guide is not intended to create additional requirements, but to explain and clarify the requirements in the model. The Working Group is holding an interim meeting on May 23, 2006, to discuss the first draft of the implementation guide.

PROJECT HISTORY - 2003

ANNUAL FINANCIAL REPORTING MODEL REGULATION (#205)

1. Project Description

The Model Rule Requiring Annual Audited Financial Reports has been revised to address the independent certified public accountant's consideration of the *NAIC Financial Condition Examiners Handbook*. The intention of the revision is to place more onus on the independent certified public accountant to consider the Examiners Handbook in completing financial statement audits of insurers. The revision affects only Section 9. *Scope of Examination and Report of Independent Certified Public Accountant* of the Model.

2. Group Responsible for Drafting Model and States Participating

The NAIC/AICPA Working Group of the Financial Condition (E) Committee originally developed and adopted this revision. The working group includes: Virginia (Chair), California, Delaware, Illinois, Iowa, Minnesota, Missouri, Nebraska, New Hampshire, New York, Ohio, Oregon, Pennsylvania and Texas.

3. Charge Authorizing Project

One of the 2003 charges of the working group is, "The NAIC/AICPA Working Group will establish subgroups for the specific areas of concern noted in the Use of CPA Workpapers Survey." One of the items noted in this survey was regulator concern regarding the independent certified public accountant's consideration of the Examiners Handbook.

4. General Description of Drafting Process

The drafting process was open as the NAIC/AICPA Working Group solicited comments from all interested parties, including interested regulators and industry representatives. The revision to the model was first discussed at an open meeting of the working group on March 9, 2003. At that time, the working group voted to expose the proposed revisions for comment. Only one comment letter was received during the exposure period. The revision to the model was adopted at an open meeting of the working group on June 23, 2003.

5. Significant Issues Raised

No significant issues were raised or discussed by the working group and/or interested parties. A representative from the American Institute of Certified Public Accountants (AICPA) provided testimony during the June 23, 2003, meeting stating that the AICPA is supportive of initiatives to improve communication and understanding between auditors and financial examiners and that the AICPA is supportive of this revision.

6. Other Pertinent Information

The model is currently required as a Part A: Laws and Regulation standard of the Financial Regulation Standards and Accreditation Program. If adopted by the NAIC membership, the Financial Regulation Standards and Accreditation (F) Committee will consider the revision during the Spring 2004 National Meeting.

PROJECT HISTORY - 2001

ANNUAL FINANCIAL REPORTING MODEL REGULATION (#205)

1. Project Description

The purpose of this regulation is to improve a state's surveillance of the financial condition of insurers by requiring an annual examination by independent certified public accountants (CPA) of the financial statements reporting the financial position and the results of operations of insurers. This amendment prohibits a commissioner from recognizing a person or firm as a qualified independent certified public accountant that if the person or firm has either directly or indirectly entered into an agreement of indemnity or release from liability with respect to the audit of the insurer.

2. Group Responsible for Drafting the Act

The project was assigned to the NAIC/AICPA Working Group of the Financial Condition (E) Committee (working group). The members of the working group are: Doug Stolte, Chair (VA); Ramon Calderon (CA); Darryl Reese (DE); James Hanson (IL); Jim Armstrong (IA); Jaki Gardner (MN); J. Douglas Conley (MO); David Krumm (NE); Thomas Burke (NH); Jeff Angelo (NY); Mike Motil (OH); Neeraj Gupta (OR); Steve Johnson (PA) and Betty Patterson (TX).

3. Charge Authorizing the Project

2001 Charge: "The NAIC/AICPA working group will address financial solvency issues and respond to the American Institute of Certified Public Accountants (AICPA) exposure drafts. This charge is ongoing."

4. General Description of the Drafting Process and Due Process

William Boyd of the National Association of Mutual Companies first raised the issue of CPAs including indemnification clauses in the engagement letters with insurers with the working group on December 4, 2000. The working group spent the first part of 2001 conducting an investigative review of engagement letters on file with different states and found many cases where CPAs were in fact including the clauses. In general, "indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing or other misrepresentations made by the insurer or its representatives.

The working group also discovered that the Securities and Exchange Commission (SEC) has specifically addressed the issue of indemnification and concluded that such clauses would lead the SEC to declare that the accountant could not be recognized as independent for the purpose of certifying the financial statements of public entities. The following is excerpted from SEC Financial Reporting Release § 602.02.i.i - Indemnification by Client:

> Inquiry was made as to whether an accountant who certifies financial statements included in a registration statement or annual report filed with the Commission under the Securities Act of the Exchange Act would be considered independent if he had entered into an indemnity agreement with the registrant. In the particular illustration cited, the board of directors of the registrant formally approved the filing of a registration statement with the Commission and agreed to indemnify and save harmless each and every accountant who certified any part of such statement "from any and all losses, claims, damages or liabilities arising out of such act or acts to which they or any of them may be subject under the Securities Act, as amended, or at "common law" other than for their willful misstatements or omissions".
>
> When an accountant and its client, directly or through an affiliate, have entered into an agreement of indemnity which seeks to assure to the accountant immunity from liability for its own negligent acts, whether of omission or commission, one of the major stimuli to objective and unbiased consideration of the problems encountered in a particular engagement is removed and greatly weakened. Such condition must frequently induce a departure from the standards of objectivity and impartiality which the concept of independence implies. In such difficult matters, for example, as the determination of the scope of audit necessary, existence of such an agreement may easily lead to the use of less extensive or thorough procedures than would otherwise be followed. In other cases, it may result in a failure to appraise with professional acumen the information disclosed by the examination. Consequently, the accountant cannot be recognized as independent for the purpose of certifying the financial statements of the corporation.

The working group released the proposed amendments to the model audit rule for comment on June 28, 2001. The working group held a hearing on December 10, 2001 and unanimously adopted the amendment. On December 11, 2001, the Financial Condition (E) Committee also unanimously adopted the amendments.

5. Discussion of Key Issues

The AICPA is in opposition to this change. The AICPA first voiced its resistance in 2000 and reinforced their position at the working group hearing as well as the Financial Condition (E) Committee meeting in December 2001. The AICPA's primary objection is based upon (1) the broad limitation on indemnification, (2) the concern that the NAIC/AICPA Working Group does not fully understand the relationship of indemnification for knowing management misrepresentations, the performance of an audit in accordance with Generally Accepted Auditing Standards (GAAS) and the liability of auditors when there has been knowing management misrepresentations, stating that such indemnification does not relieve the auditor of conducting and audit in accordance with GAAS, and (3) the fact that the provision for arbitration and mediation appear to be contrary to the intent of state legislators when arbitration laws were adopted.

The working group has studied this issue for one year and received an opinion from the NAIC Insolvency Counsel that such indemnification provisions would potentially negatively impact the statutory successor's position in litigation against the independent auditor. The working group also was unable to reconcile the SEC's official position on the issue with the AICPA's opposition. The working group is of the opinion that the regulations governing insurance companies should be at least as strong as those that govern public entities.

PRODUCER LICENSING MODEL ACT

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Section 1. Purpose and Scope

This Act governs the qualifications and procedures for the licensing of insurance producers. It simplifies and organizes some statutory language to improve efficiency, permits the use of new technology and reduces costs associated with issuing and renewing insurance licenses.

This Act does not apply to excess and surplus lines agents and brokers licensed pursuant to Section [refer to state excess and surplus lines statutes] except as provided in Section 8 and Section 16B of this Act.

Drafting Note: It is recommended that any statute or regulation inconsistent with this Act be repealed or amended.

Drafting Note: This Act also requires a report to the insurance commissioner of the termination of a producer by an insurer, whether with or without cause.

Section 2. Definitions

A. "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

B. "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

C. "Insurance" means any of the lines of authority in [insert reference to appropriate section of state law].

D. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

E. "Insurer" means [insert reference to appropriate section of state law].

F. "License" means a document issued by this state's insurance commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

G. "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the insurance commissioner determines should be designated a form of limited line credit insurance.

H. "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy.

I. "Limited lines insurance" means those lines of insurance defined in [insert reference to state specific limited line statute] or any other line of insurance that the insurance commissioner deems necessary to recognize for the purposes of complying with Section 8E.

J. "Limited lines producer" means a person authorized by the insurance commissioner to sell, solicit or negotiate limited lines insurance.

K. "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

L. "Person" means an individual or a business entity.

M. "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

N. "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

O. "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

P. "Uniform Business Entity Application" means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

Q. "Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

Section 3. License Required

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this Act.

Section 4. Exceptions to Licensing

A. Nothing in this Act shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

B. A license as an insurance producer shall not be required of the following:

(1) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(a) The officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or

(b) The officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(c) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans; issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass marketed property and casualty insurance; where no commission is paid to the person for the service;

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(5) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(6) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

Drafting Note: Persons who provide general insurance advice in connection with providing other professional services such as legal services, trust services, tax and accounting services, financial planning and investment advisory services are not deemed to be soliciting the sale of insurance under this Act. Sections 3 and 4 of this Act are intended to address all persons meeting the definition of "insurance producer" as defined in Title III, Section 336, of Public Law No. 106-102 (the "Gramm-Leach-Bliley Act").

Section 5. Application for Examination

A. A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to Section 9. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the insurance commissioner.

B. The insurance commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in [insert appropriate reference to state law or regulation].

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the insurance commissioner as set forth in [insert appropriate reference to state law or regulation].

D. An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

Drafting Note: A state may wish to prescribe by regulation limitations on the frequency of application for examination in addition to other prelicensing requirements.

Section 6. Application for License

A. A person applying for a resident insurance producer license shall make application to the insurance commissioner on the Uniform Application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the insurance commissioner shall find that the individual:

(1) Is at least eighteen (18) years of age;

(2) Has not committed any act that is a ground for denial, suspension or revocation set forth in Section 12;

(3) Where required by the insurance commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied;

Drafting Note: Paragraph (3) would apply only to those states that have prelicensing education requirements.

(4) Has paid the fees set forth in [insert appropriate reference to state law or regulation]; and

(5) Has successfully passed the examinations for the lines of authority for which the person has applied.

B. A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the insurance commissioner shall find that:

(1) The business entity has paid the fees set forth in [insert appropriate reference to state law or regulation; and

(2) The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

Drafting Note: Subsection B is optional and would apply only to those states that have a business entity license requirement.

C. The insurance commissioner may require any documents reasonably necessary to verify the information contained in an application.

D. Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited line credit insurance a program of instruction that may be approved by the insurance commissioner.

Section 7. License

A. Unless denied licensure pursuant to Section 12, persons who have met the requirements of Sections 5 and 6 shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

(1) Life—insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

(2) Accident and health or sickness—insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income.

(3) Property—insurance coverage for the direct or consequential loss or damage to property of every kind.

(4) Casualty—insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property.

(5) Variable life and variable annuity products—insurance coverage provided under variable life insurance contracts and variable annuities.

(6) Personal lines—property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(7) Credit—limited line credit insurance.

(8) Any other line of insurance permitted under state laws or regulations.

B. An insurance producer license shall remain in effect unless revoked or suspended as long as the fee set forth in [insert appropriate reference to state law or regulation] is paid and education requirements for resident individual producers are met by the due date.

C. An individual insurance producer who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.

D. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance (e.g., a long-term medical disability) may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

Drafting Note: References to license "renewal" should be deleted in those states that do not require license renewal.

E. The license shall contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date and any other information the insurance commissioner deems necessary.

F. Licensees shall inform the insurance commissioner by any means acceptable to the insurance commissioner of a change of address within thirty (30) days of the change. Failure to timely inform the insurance commissioner of a change in legal name or address shall result in a penalty pursuant to [insert appropriate reference to state law].

G. In order to assist in the performance of the insurance commissioner's duties, the insurance commissioner may contract with non-governmental entities, including the National Association of Insurance Commissioner (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the insurance commissioner and the non-governmental entity may deem appropriate.

Section 8. Nonresident Licensing

A. Unless denied licensure pursuant to Section 12, a nonresident person shall receive a nonresident producer license if:

(1) The person is currently licensed as a resident and in good standing in his or her home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];

(3) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and

(4) The person's home state awards non-resident producer licenses to residents of this state on the same basis.

Drafting Note: In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

B. The insurance commissioner may verify the producer's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

C. A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

D. Notwithstanding any other provision of this Act, a person licensed as a surplus lines producer in his or her home state shall receive a nonresident surplus lines producer license pursuant to Subsection A of this section. Except as to Subsection A, nothing in this section otherwise amends or supercedes any provision of [refer to state excess and surplus lines statutes].

E. Notwithstanding any other provision of this Act, a person licensed as a limited line credit insurance or other type of limited lines producer in his or her home state shall receive a nonresident limited lines producer license, pursuant to Subsection A of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of Section 8E, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to Section 7A(1) through (6).

Section 9. Exemption from Examination

A. An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety (90) days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's Producer Database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

B. A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to Section 6. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the insurance commissioner determines otherwise by regulation.

Section 10. Assumed Names

An insurance producer doing business under any name other than the producer's legal name is required to notify the insurance commissioner prior to using the assumed name.

Section 11. Temporary Licensing

A. The insurance commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the insurance commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or

(4) In any other circumstance where the insurance commissioner deems that the public interest will best be served by the issuance of this license.

B. The insurance commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The insurance commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The insurance commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

Section 12. License Denial, Nonrenewal or Revocation

A. The insurance commissioner may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in accordance with [insert appropriate reference to state law] or any combination of actions, for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) Violating any insurance laws, or violating any regulation, subpoena or order of the insurance commissioner or of another state's insurance commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(9) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(11) Improperly using notes or any other reference material to complete an examination for an insurance license;

(12) Knowingly accepting insurance business from an individual who is not licensed;

(13) Failing to comply with an administrative or court order imposing a child support obligation; or

(14) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

Drafting Note: Paragraph (14) is for those states that have a state income tax.

B. In the event that the action by the insurance commissioner is to nonrenew or to deny an application for a license, the insurance commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the insurance commissioner within [insert appropriate time period from state's administrative procedure act] for a hearing before the insurance commissioner to determine the reasonableness of the insurance commissioner's action. The hearing shall be held within [insert time period from state law] and shall be held pursuant to [insert appropriate reference to state law].

C. The license of a business entity may be suspended, revoked or refused if the insurance commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the insurance commissioner nor corrective action taken.

D. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine according to [insert appropriate reference to state law].

E. The insurance commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this Act and Title [insert appropriate reference to state law] against any person who is under investigation for or charged with a violation of this Act or Title [insert appropriate reference to state law] even if the person's license or registration has been surrendered or has lapsed by operation of law.

Section 13. Commissions

A. An insurance company or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this Act and is not so licensed.

B. A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this Act and is not so licensed.

C. Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under this Act at the time of the sale, solicitation or negotiation and was so licensed at that time.

D. An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state, unless the payment would violate [insert appropriate reference to state law, i.e. citation to anti-rebating statute, if applicable].

Section 14. Appointments [Optional]

A. An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

B. To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

Drafting Note: The group appointment provision of Subsection B is only applicable in jurisdictions that have implemented an electronic appointment process.

C. [Optional] Upon receipt of the notice of appointment, the insurance commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the insurance commissioner shall notify the insurer within five (5) days of its determination.

D. An insurer shall pay an appointment fee, in the amount and method of payment set forth in [insert appropriate reference to state law or regulation], for each insurance producer appointed by the insurer.

E. [Optional] An insurer shall remit, in a manner prescribed by the insurance commissioner, a renewal appointment fee in the amount set forth in [insert appropriate reference to state law or regulation].

Drafting Note: This act designates as optional the section on appointments of producers by insurers. That designation recognizes that some states do not require the formal appointment of a producer before business can be conducted with an insurer or multiple insurers.

Section 15. Notification to Insurance Commissioner of Termination

A. Termination for Cause. An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the insurance commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the insurance commissioner, if the reason for termination is one of the reasons set forth in Section 12 or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in Section 12. Upon the written request of the insurance commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

B. Termination Without Cause. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in Section 12, shall notify the insurance commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the insurance commissioner. Upon written request of the insurance commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

Drafting Note: Those states that do not require formal appointments may delete any reference to appointments in Subsections A and B above.

C. Ongoing Notification Requirement. The insurer or the authorized representative of the insurer shall promptly notify the insurance commissioner in a format acceptable to the insurance commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the insurance commissioner in accordance with Subsection A had the insurer then known of its existence.

D. Copy of Notification to be Provided to Producer.

(1) Within fifteen (15) days after making the notification required by Subsections A, B and C, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in Section 12, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the insurance commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the insurance commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under Subsection F.

E. Immunities

(1) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the insurance commissioner, or an organization of which the insurance commissioner is a member and that compiles the information and makes it available to other insurance commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the insurance commissioner, from an insurer or producer; or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under Subsection A was reported to the insurance commissioner, provided that the propriety of any termination for cause under Subsection A is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person that may have immunity under Paragraph (1) for making any statement required by this section or providing any information relating to any statement that may be requested by the insurance commissioner, the party bringing the action shall plead specifically in any allegation that Paragraph (1) does not apply because the person making the statement or providing the information did so with actual malice.

(3) Paragraph (1) or (2) shall not abrogate or modify any existing statutory or common law privileges or immunities.

F. Confidentiality

(1) Any documents, materials or other information in the control or possession of the department of insurance that is furnished by an insurer, producer or an employee or agent thereof acting on behalf of the insurer or producer, or obtained by the insurance commissioner in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the insurance commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the insurance commissioner's duties.

(2) Neither the insurance commissioner nor any person who received documents, materials or other information while acting under the authority of the insurance commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Paragraph (1).

(3) In order to assist in the performance of the insurance commissioner's duties under this Act, the insurance commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Paragraph (1), with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(b) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) **[OPTIONAL]** May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Paragraph 3(a) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Paragraph (3).

(5) Nothing in this Act shall prohibit the insurance commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries of the National Association of Insurance Commissioners.

G. Penalties for Failing to Report. An insurer, the authorized representative of the insurer, or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with [insert appropriate reference to state law].

Section 16. Reciprocity

A. The insurance commissioner shall waive any requirements for a nonresident license applicant with a valid license from his or her home state, except the requirements imposed by Section 8 of this Act, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

B. A nonresident producer's satisfaction of his or her home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the non-resident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

Drafting Note: States are encouraged to eliminate any licensing and appointment retaliatory fees. In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require non-resident fees that are so disparate from the resident fees that they impose a barrier to entry. Such fees would be prohibited under Public Law 106-102.

Section 17. Reporting of Actions

A. A producer shall report to the insurance commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

B. Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the insurance commissioner any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

Section 18. Compensation Disclosure

A. (1) Where any insurance producer or any affiliate of the producer receives any compensation from the customer for the placement of insurance or represents the customer with respect to that placement, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for that placement of insurance unless the producer has, prior to the customer's purchase of insurance:

(a) Obtained the customer's documented acknowledgment that such compensation will be received by the producer or affiliate; and

(b) Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

(2) Paragraph (1) shall not apply to an insurance producer who:

(a) Does not receive compensation from the customer for the placement of insurance; and

(b) In connection with that placement of insurance represents an insurer that has appointed the producer; and

(c) Discloses to the customer prior to the purchase of insurance:

(i) That the insurance producer will receive compensation from an insurer in connection with that placement; or

(ii) That, in connection with that placement of insurance, the insurance producer represents the insurer and that the producer may provide services to the customer for the insurer.

Drafting Note: In states where no appointment is required, the phrase "that has contractually authorized the producer to act as its legal agent" may be substituted for "that has appointed the producer."

B. A person shall not be considered a "customer" for purposes of this section if the person is merely:

(1) A participant or beneficiary of an employee benefit plan; or

(2) Covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the insurance producer or affiliate.

C. This section shall not apply to:

(1) A person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's producer, for example a managing general agent, a sales manager, or wholesale broker; or

(2) A reinsurance intermediary.

D. For purposes of this section:

(1) "Affiliate" means a person that controls, is controlled by, or is under common control with the producer.

(2) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(3) "Compensation from the customer" shall not include any fee or similar expense as provided in [insert reference to statutory provisions or regulations] or any fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner.

(4) "Documented acknowledgement" means the customer's written consent obtained prior to the customer's purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, consent documented by the producer shall be acceptable.

E. This section shall take effect [insert date].

Drafting Note*:* States that are considering the licensing of business entities should reference Section 6B of the NAIC's Producer Licensing Model Act and the Uniform Application for Business Entity License/Registration, which address the licensing of a business entity acting as an insurance producer.

Section 19. Regulations

The insurance commissioner may, in accordance with [insert appropriate reference to state law], promulgate reasonable regulations as are necessary or proper to carry out the purposes of this Act.

Section 20. Severability

If any provisions of this Act, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 21. Effective Date

This Act shall take effect [insert date].

Note: A minimum of six months to one year implementation time for proper notice of changes, fees and procedures is recommended.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1988 Proc. I 9, 18, 91, 101-102, 106-109 (adopted).
1989 Proc. I 9, 21, 125, 129, 135-142 (amended and reprinted).
1989 Proc. II 13, 22-23, 161, 166-167, 178-184, 189-190 (amended and reprinted).
1990 Proc. II 7, 13-14, 159-160, 192, 195 (amended).
1997 Proc. 3rd Quarter 25, 26, 1148, 1166-1168 (amended).
1999 Proc. 3rd Quarter 121, 123-136 (model adopted by parent committee).
2000 Proc. 1st Quarter 9-23, 33 (amended and reprinted).
2000 Proc. 3rd Quarter 7, 11, 36-45, 386, 403 (amended and reprinted).
2005 Proc. 1st Quarter 55, 56-57 (amended).

PRODUCER LICENSING MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PRODUCER LICENSING MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-7-1 to 27-7-40 (1957/2014).	ALA. ADMIN. CODE r. 482-1-109-.01 to 482-1-109-.06 (1994/2009); 482-1-110-.01 to 482-1-110-.09 (1994/2012); 482-1-146-.01 to 482-1-146-.14 (2009/2010); 482-1-147-.01 to 482-1-147-.13 (2012/2014).
Alaska		ALASKA STAT. §§ 21.27.010 to 21.27.570 (1966/2014).	ALASKA STAT. § 21.97.900 (2006/2010); ALASKA ADMIN. CODE tit. 3, §§ 23.100 to 23.208 (1996/2013); BULLETIN 2004-14 (2004); BULLETIN 2006-11; BULLETIN 2009-8 (2009); BULLETIN 2015-3 (2015).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-281 to 20-302 (2002/2015).	ARIZ. REV. STAT. ANN. §§ 20-2901 to 20-2904 (1998/2014); BULLETIN 2009-4 (2009).
Arkansas	ARK. CODE ANN. §§ 23-64-501 to 23-64-520 (2001/2005).		ARK. CODE ANN. §§ 23-64-101 to 23-64-227 (1959/2011); § 23-64-301 (2008/2013); BULLETIN 2-2000 (2000); BULLETIN 3-2006 (2006).

PRODUCER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
California			CAL. INS. CODE §§ 1621 to 1758.993 (1959/2016); CAL. CODE REGS. tit. 10, §§ 2186 to 2188.8 (2006/2014); § 260.204.9 (2012).
Colorado		COLO. REV. STAT. §§ 10-2-101 to 10-2-804 (1995/2014).	COLO. REV. STAT. § 18-5-211 (2014); 3 COLO. CODE REGS. §§ 702-1:1-2-4 to 702-1:1-2-5 (1995/2015); § 702-1:1-2-10 (1995/2015); § 702-1:1-2-17 (2009).
Connecticut	CONN. GEN. STAT. §§ 38a-702a to 38a-718 (2002/2004).		CONN. GEN. STAT. ANN. § 38a-702s (2014); BULLETIN 1-18 (2012).
Delaware		DEL. CODE ANN. tit. 18, §§ 1701 to 1724 (2002/2014).	
District of Columbia		D.C. CODE §§ 31-1131.01 to 31-1131.19 (2002/2013).	D.C. MUN. REGS. tit. 26A, §§ 100 to 199 (2003/2013).
Florida		FLA. STAT. §§ 626.011 to 626.711 (1959/2014.)	FLA. ADMIN. CODE ANN. r. 69B-228.010 to 69B-228-280 (1993/2009).
Georgia			GA. CODE ANN. §§ 33-23-1 to 33-23-46 (1992/2014); GA. COMP. R. & REGS. 120-2-3-.01 to 120-2-3-.50 (1965/2014).
Guam			22 GUAM CODE ANN. §§ 15701 to 15712 (2001).
Hawaii		HAW. REV. STAT. §§ 431-9A-101 to 431-9A-130 (2002/2012).	HAW. CODE R. §§ 16-171-301 to 16-171-318 (2005/2013).
Idaho	IDAHO CODE ANN. §§ 41-1001 to 41-1029 (2001/2005).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Illinois	.	215 ILL. COMP. STAT. 5/500-5 to 5/500-155 (2002/2014).	ILL. ADMIN. CODE tit. 50, §§ 3119.10 to 3119.80 (1985/2015); BULLETIN 2009-4 (2009); BULLETIN 2010-1 (2010).
Indiana	IND. CODE §§ 27-1-15.6-1 to 27-1-15.6-33 (2002/2014) (portions of model).		BULLETIN 218 (2015).
Iowa		IOWA CODE §§ 522B.1 to 522B.18 (2002/2014).	IOWA CODE § 508E.3 (2000/2009); IOWA ADMIN. CODE r. 191-10.1 to 191-10.51 (1963/2009); §§ 191-11.1 to191-111.14 (2009).
Kansas		KAN. STAT. ANN. §§ 40-4901 to 40-4918 (2001/2013).	KAN. ADMIN. REGS. §§ 81-3-1 to 81-3-7 (2006).
Kentucky		KY. REV. STAT. ANN. §§ 304.9-010 to 304.9-460 (1970/2011).	
Louisiana		LA. REV. STAT. ANN. §§ 22:2391 to 22:2395 (2013); §§ 22:1541 to 22:1573 (2008/2015).	ADVISORY LETTER 2010-1 (2010).
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 1420 to 1420-P (2001).	ME. REV. STAT. ANN. tit. 24-A, §§ 1401 to 1485 (1997/2010); BULLETIN 395 (2014).
Maryland			MD. CODE ANN., INS. §§ 10-101 to 10-133 (2008/2014); MD. CODE REGS. 31.03.02.01 to 31.03.02.17 (1987/2014).
Massachusetts		MASS. GEN. LAWS ch. 175, §§ 162 to 163 (2003).	MASS. GEN. LAWS ch. 175, §§ 164 to 177E (1969/2014); BULLETIN B-2005-09 (2005); BULLETIN B-2011-12 (2011); BULLETIN B-2013-09 (2013).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.1201 to 500.1247 (1972/2013).	BULLETIN 2006-09-INS (2006); MEMORANDUM 5-21-2009 (2009); MEMORANDUM 11-3-2009 (2009); BULLETIN 2013-17-INS (2013).
Minnesota		MINN. STAT. §§ 60K.30 to 60K.56 (2002/2011).	
Mississippi		MISS. CODE ANN. §§ 83-17-51 to 83-17-89 (2002/2015).	BULLETIN 2009-2 (2009); BULLETIN 2014-9 (2014).
Missouri		MO. REV. STAT. §§ 375.012 to 375.146 (1939/2014).	MO. CODE REGS. ANN. tit. 20, §§ 700-1.005 to 700-1.150 (1974/2008); § 700-3.200 (2009).
Montana			MONT. CODE ANN. §§ 33-17-101 to 33-17-1203 (1959/2013); MONT. ADMIN. R. 6.6.2801 to 6.6.2810 (1990/2009).
Nebraska		NEB. REV. STAT. §§ 44-4047 to 44-4066 (2001/2015).	210 NEB. ADMIN. CODE §§ 38-001 to 38-018 (2009).
Nevada		NEV. REV. STAT. §§ 683A.020 to 683A.490 (1971/2011).	NEV. ADMIN. CODE §§ 686A.320 to 686A.340 (2005).
New Hampshire		N.H. REV. STAT. ANN. §§ 402-J:1 to 402-J:19 (2001/2011).	
New Jersey		N.J. STAT. ANN. §§ 17:22A-26 to 17:22A-48 (2001).	N.J. ADMIN. CODE §§ 11:17-1.1 to 11:17-3.6 (2016); § 11:17B-3.1; BULLETIN 2004-20 (2004).
New Mexico	N.M. STAT. ANN. §§ 59A-11-1 to 59A-12-29 (1985/2003) (portions of model).		BULLETIN 2010-004 (2010).
New York			N.Y. INS. LAW §§ 2101 to 2139 (1984/2014); CIRCULAR LETTER 2010-18 (2010).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina		N.C. GEN. STAT. §§ 58-33-1 to 58-33-125 (1988/2013).	11 N.C. ADMIN. CODE 6A.0802 (2011); MEMORANDUM 10-1-2010 (2010); MEMORANDUM 11-4-2010 (2010).
North Dakota		N.D. CENT. CODE §§ 26.1-26-01 to 26.1-26-56 (1985/2013).	N.D. ADMIN. CODE §§ 45-02-02-01 to 45-02-02-15 (1983/2010).
Northern Marianas			4 N. MAR. I. CODE § 7303 (1984); 11-55 N. MAR. I. ADMIN. CODE § 2 (1984).
Ohio		OHIO REV. CODE ANN. §§ 3905.01 to 3905.99 (1953/2014).	OHIO ADMIN. CODE 3901-5-01 to 3901-5-13 (2010/2014).
Oklahoma		OKLA. STAT. tit. 36, §§ 1435.1 to 1435.41 (1980/2014).	OKLA. ADMIN. CODE § 365:1-9-15.1 (1998/2005); § 365:25-3-19 (2008/2012); BULLETIN 10-1-2007; BULLETIN 6-1-2009 (2009); BULLETIN 8-18-2010 (2010); BULLETIN PC 2013-02 (2013).
Oregon		OR. REV. STAT. §§ 744.052 to 744.089 (2003/2009).	OR. ADMIN. R. 836-071-0108 to 836-071-0351 (2000/2012).
Pennsylvania		40 PA. STAT. ANN. §§ 310.1 to 310.14 (2002).	
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 949 to 953i (2006).
Rhode Island	R.I. GEN. LAWS §§ 27-2.4-1 to 27-2.4-23 (2002/2013).		BULLETIN 2007-8 (2007); BULLETIN 2011-2 (2011); BULLETIN 2015-4 (2015).
South Carolina		S.C. CODE ANN. §§ 38-43-10 to 38-43-260 (1988/2009).	S.C. CODE ANN. REGS. 69-23 (1984/2010); BULLETIN 16-2009 (2009); BULLETIN 17-2009 (2009); BULLETIN 9-2010 (2010).
South Dakota		S.D. CODIFIED LAWS §§ 58-30-1.1 to 58-30-218 (1966/2015).	S.D. ADMIN. R. 20:06:18:01 to 20:06:18:22 (1985/2013).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee		TENN. CODE ANN. §§ 56-6-101 to 56-6-126 (2003/2014).	
Texas			TEX. INS. CODE ANN. §§ 4001.001 to 4001.359 (2005/2015); § 4002.008 (2009); §§ 4004.151 to 4004.155 (2009); § 4005.004 (2005) (compensation disclosure); § 4005.054 (2005); §§ 4008.001 to 4008.008 (2009); 28 TEX. ADMIN. CODE §§ 19.1001 to 19.1030 (1994/2010); BULLETIN B-0041-07 (2007).
Utah			UTAH CODE ANN. §§ 31A-23a-101 to 31A-23a-505 (1986/2014); UTAH ADMIN. CODE r. 590-244 (2009/2015); BULLETIN 2010-3 (2010); BULLETIN 2011-3 (2011).
Vermont		VT. STAT. ANN. tit. 8, §§ 4791 to 4813n (1974/2002).	BULLETIN 172 (2012).
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 751 to 793 (2016).		
Virginia			VA. CODE ANN. §§ 38.2-1800 to 38.2-1845 (1986/2013); § 54.1-118 (2012); ADMIN. LETTER 2012-10 (2012).
Washington		WASH. REV. CODE ANN. §§ 48.17.010 to 48.17.902 (1947/2012).	WASH. ADMIN. CODE §§ 284-17-001 to 284-17-835 (2008/2013); § 284-97-020 (2011).
West Virginia		W. VA. CODE §§ 33-12-1 to 33-12-38 (1957/2004).	W. VA. CODE R. §§ 114-2-1 to 114-2-7 (2008/2009); §§ 114-42-2 to 114-42-8 (1996/2012).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Wisconsin			WIS. STAT. §§ 628.01 to 628.12 (1975/2014); §§ 628.51 to 628.78 (1975/1981); WIS. ADMIN. CODE INS. §§ 6.50 to 6.75 (1981/2009).
Wyoming		WYO. STAT. ANN. §§ 26-9-201 to 26-9-235 (2001/2015).	

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

Table of Contents

Section 1. Statement of Purpose

The purpose of this regulation is to prevent the operation of illegal health insurers, including illegal multiple employer welfare arrangements (MEWAs), in this state. This regulation states the law on this topic and establishes specific standards for persons and licensees who become aware of, or are asked to assist such an operation. This regulation is designed to require those persons and licensees to establish and follow responsible procedures to identify and report illegal health insurers. The department expects that compliance with this regulation will protect the public from entities offering fraudulent or otherwise illegal health care coverage.

Drafting Note: A state department adopting this regulation may wish to cite its statutory authority for adopting it. This regulation may be enacted under the authority of the NAIC Model Unauthorized Insurers Act. State statutes that are the equivalent to the following NAIC Model Acts may also provide authority to adopt some or all of the provisions of this regulation include:

A. Section 19 of the NAIC Producer Licensing Model Act;

B. Section 12 of the NAIC Unfair Trade Practices Act;

C. Section 8 of the NAIC Unfair Claims Settlement Practices Act;

D. Section 4B of the NAIC Third Party Administrator Statute;

E. Section 3 of the NAIC Model Law on Examinations;

F. NAIC Nonadmitted Insurance Model Act; or

G. Section 12 of the NAIC Insurance Fraud Prevention Model Act.

Section 2. Definitions

A. "Admitted insurer" means an insurer licensed to do an insurance business in this state [including an entity licensed as a multiple employer welfare arrangement ("licensed MEWA"), a health maintenance organization or nonprofit hospital or medical service corporation under the laws of this state].

Drafting Note: States that have a specific statutory licensing category "multiple employer welfare arrangements" (MEWAs) may wish to include the licensee within this definition. In addition, states that separately license health maintenance organizations or nonprofit hospital or medical service corporations should include these licensed entities within this definition.

B. "Arrangement" means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits.

C. "Department" means the insurance department of this state.

D. "Employee leasing arrangement" means a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity.

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements to offer self-funded health benefit plans. Those states should take care to modify this regulation to reflect the applicable "professional employer organization" or "employee leasing" statutory structure

E. "Employee welfare benefit plan" or "health benefit plan" means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

F. "Fully insured" means that for the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:

(1) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and

(2) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member or dependent.

G. "Insurer" means [insert reference to appropriate state law].

H. "Licensee" means a person that is, or that is required to be, licensed or registered under the laws of this state as a producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization.

Drafting Note: A state should adjust the definition of "licensee" to reflect its licensing laws.

I. "MEWA contact" means the individual or position designated by the department to be the MEWA contact as identified on the department web site.

Drafting Note: Every state is strongly encouraged to have an individual who is trained and knowledgeable about the application of state laws to MEWAs serve as the designated MEWA contact. In the event that a state does not designate such an individual to serve as the MEWA contact, reference should be made to the Department of Insurance instead of to the MEWA contact. States are encouraged to identify a specific MEWA contact on their web sites and in their relevant publications.

. "Non-admitted insurer" means an insurer not licensed to do an insurance business in this state.

K. "Preferred provider organization" means an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan.

L. "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

M. "Professional employer organization" means an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an on-going and extended, rather than a temporary or project-specific, relationship

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this regulation to reflect that "professional employer organization" or "employee leasing" statutory structure

N. "Third party administrator" or "administrator" has the meaning provided under [insert reference to the state's third party administrator statute].

O. "Transacting of insurance" means [insert reference to the state equivalent of Section 3P of the NAIC Nonadmitted Insurance Model Act] and includes:

(1) Issuing a stop loss policy covering an employer located in this state. Stop loss policy coverage of an employer for claims incurred under the employer's self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;

(2) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, with an employer located in this state directly or indirectly the beneficiary of the trust;

(3) Agreeing to loan or advance funds to pay claims incurred under an employer's self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into similar loan or advance agreements; or

(4) Engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract.

P. "Unauthorized health insurance" means:

(1) Health insurance offered by a non-admitted insurer except to the extent the laws of this state allow the coverage to be offered by an non-admitted insurer licensed in another state through an employer or group located out of state; and

(2) includes health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not:

(a) Fully insured by an admitted insurer; or

[(b) Licensed or otherwise authorized under the laws of this state to offer a self-funded health benefit plan.]

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to include the optional bracketed language in this definition to reflect that statutory structure. The exception under Paragraph P (2) (b) is not intended to be adopted by states whose laws "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations unless those laws also include specific authority to self-fund a health benefit plan. Also, many states have laws that, under limited circumstances, permit a non-admitted insurer to provide coverage to a resident employer by an out of state employer or participating in an out of state group. Those states should modify this definition to reflect those provisions.

(3) "Unauthorized health insurance" does not include:

(a) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers (including one or more self-employed individuals), that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(b) Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under 29 U.S.C. §1002(40)(B).

(c) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under 29 U.S.C. §1002(40)(B).

(d) Health care benefits or coverage under a church plan as defined under 29 U.S.C §1002(33).

Section 3. Licensee Reporting Requirement

A. A licensee shall file a written report with the department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. Knowledge of a producer regarding an unrelated unauthorized health insurance arrangement is not imputed to licensed insurers represented by that producer.

B. Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this state, include when the licensee knows that any person is:

(1) Recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this state; or

(2) Seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public in this state.

C. Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:

(1) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to the multiple employers or generally to individuals.

(2) [The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers.]

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to omit the optional bracketed language.

(3) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

Drafting Note: Paragraph C is not intended to be a comprehensive list of possible illegal schemes. It includes only a few of the most common illegal arrangements.

D. (1) A report filed under this section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in any private action. Nothing in this regulation shall limit the commissioner's authority to use a report filed pursuant to this regulation in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this regulation.

(2) Nothing in this regulation shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this section to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this regulation. For reports filed under this section, [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act] applies.

E. A report filed under this Section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] except to the extent the commissioner determines disclosure is appropriate to accomplish a regulatory purpose.

F. [There is immunity from civil liability under Section [insert state law equivalent to Section 7 A of the NAIC Insurance Fraud Prevention Act].]

Drafting Note: The NAIC recommends that states give serious consideration to seeking statutory authority to retain MEWA contact reports as confidential and to seeking statutory immunity from civil liability related to filing a MEWA contact report, absent a showing of actual malice, prior to adopting this regulation. Many states may already have such provisions enacted as part of the NAIC Insurance Fraud Prevention Act or similar legislation. Those states should include the optional bracketed language. Those states should take care to clarify that their insurance fraud prevention acts do not, or are amended so as to not, prevent the sharing of the reports within the department. States are also encouraged to use the model MEWA contact form the NAIC ERISA Working Group plans to develop.

G. A licensee complies with this section if the licensee files the required report within thirty (30) days or a period reasonable under the circumstances, whichever is later.

Section 4. Responsibility to Exercise Due Diligence

A. Soliciting Producer

(1) A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) For any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements.

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

Drafting Note: Some states have a separate regulatory structure that recognizes a fully insured health plan of an employee leasing arrangement or professional employer organization as a single employer plan for certain regulatory purposes. Such a state should review Subparagraph (d) to ensure it conforms to such a provision.

B. Stop loss policy producer

(1) A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents, or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(b) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers.

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(c) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

C. Third Party Administrator

(1) A third party administrator, prior to entering into any administrative contract for a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

D. Insurer

(1) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents, or individuals located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(b) The health benefit plan is not offered by an employee leasing arrangement or professional employer organization to client employers.

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent, state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

(c) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

(2) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this state and the stop loss policy form has been filed and approved by the department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:

(a) Issuing a stop loss policy covering an employer located in this state. Coverage of an employer for claims incurred under the employer's self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance.

(b) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, when an employer located in this state is directly or indirectly the beneficiary of the trust.

(3) An insurer shall not engage in the transacting of insurance in this state by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:

(a) The employer is not covered for claims below the stop loss attachment point;

(b) A description of the attachment point, including the specific and aggregate attachment points; and

(c) The insurer provides no other coverage of the employer's retention.

E. Preferred provider organization

(1) A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with and approved by the department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and dependents of employees, of the employer and the employer controls and directs the work of the employee.

F. (1) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this section if:

(a) The information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact's advice, is accurate and complete; and

(b) The information is provided by the licensee or other person to the MEWA contact in writing.

(2) For the purpose of this regulation, the department's published list of admitted insurers on its web site is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this subsection relieves a licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

Drafting Note: A state insurance department adopting this regulation is expected to publish, on the internet, a regularly updated list of admitted insurers.

(3) A violation of this section is mitigated, and the department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:

(a) It maintained supervisory procedures and controls that complied with Section 5;

(b) The violation occurred despite the maintenance of those procedures and controls;

(c) It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance; and

(d) It took prompt corrective action.

G. Nothing in this section requires a producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

Drafting Note: This section requires producers, third party administrators, insurers, and preferred provider organization to exercise due diligence only to the extent that they assist or engage in the transacting of insurance relating to a health benefit plan. They are not required to investigate health benefit plans with respect to which they provide no services or transaction of insurance. For example, sale of a group life insurance policy does not require the selling producer or issuing agent to exercise due diligence as to the employer's health benefit plan.

Section 5. Supervisory Procedures and Controls

A. A producer, third party administrator, insurer, preferred provider organization or an agent of the same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this regulation.

B. The supervisory procedures shall include:

(1) Training;

(2) Internal controls;

(3) Periodic audits;

(4) Supervisory review; and

(5) Monitoring and enforcement of contractual provisions established under Section 4 C and E.

C. The extent of the supervisory procedures and controls a producer is required to maintain under this section may appropriately reflect the size and complexity of the producer's operations and the scope and nature of the producer's insurance activities.

Drafting Note: The NAIC encourages the national trade associations for health insurers, preferred provider organizations, third party administrators and insurance agents to develop compliance guidance, training and manuals to assist their members to implement supervisory procedures and controls. The NAIC ERISA Working Group is prepared to review the results of such an effort. State insurance departments are expected to give recognition to supervisory procedures and controls implemented by insurers, preferred provider organizations, third party administrators and insurance agents in accordance with guidance for effective programs developed by these trade organization. Companies also may seek review of their programs by their state insurance department.

Section 6. Licensing Education Requirements

A. A producer shall not be licensed in this state to sell health insurance unless the producer, prior to licensing, receives not less than one hour of education in:

(1) Identification of unauthorized health insurance; and

(2) The producer's responsibilities under this regulation.

Drafting Note: Subsection A would apply only to those states that have pre-licensing education requirements. The one-hour of education is intended to be included in, and not in addition to, the total pre-licensing requirement.

B. An insurer providing health insurance in this state shall require its listed producers to obtain not less that one hour of continuing education every four years covering:

(1) Identification of unauthorized health insurance; and

(2) The producer's responsibilities under this regulation.

Drafting Note: Subsection B should be adopted only by those states that have continuing education requirements. The one hour continuing education requirement should be included in the total hours required by the NAIC Producer Licensing Model Act.

C. A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under Section 5 in the [insert reference to the relevant statutory application requirement such as a statutory requirement to include a business plan]. A license may be denied under [insert reference to relevant statutory licensing criteria such as "contrary to the public interest"] if the applicant fails to demonstrate that the applicant maintains the required procedures and controls.

Section 7. Penalties and Liability

A. Except as provided in Subsection B, a person that violates this regulation is subject to [insert reference to general license and penalty provisions under the state insurance code, including the provisions equivalent to the remedy and penalty section of the NAIC Nonadmitted Insurance Model Act].

Drafting Note: The regulation should include a cross reference to penalty provisions equivalent to those in Section 7 of the NAIC Nonadmitted Insurance Model Act, as well as the remedial provision under Section 4D of that Act.

B. A person who violates Section 3 of this regulation is subject to a penalty of a [forfeiture of up to $1000] for each violation.

Drafting Note: A state insurance department should insert an appropriate penalty under the sanctions provided under its laws. Generally, a less severe penalty is appropriate compared to those for other violations under this regulation.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2006 Proc. 2nd Quarter 40, 62-75 *(adopted).*

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

The NAIC amended this model during the 2007 Summer National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2007 2nd Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Statement of Purpose

The purpose of this regulation is to prevent the operation of illegal health insurers, including illegal multiple employer welfare arrangements (MEWAs), in this state. This regulation states the law on this topic and establishes specific standards for persons and licensees who become aware of, or are asked to assist such an operation. This regulation is designed to require those persons and licensees to establish and follow responsible procedures to identify and report illegal health insurers. The department expects that compliance with this regulation will protect the public from entities offering fraudulent or otherwise illegal health care coverage.

Drafting Note: A state department adopting this regulation may wish to cite its statutory authority for adopting it. This regulation may be enacted under the authority of the NAIC Model Unauthorized Insurers Act. State statutes that are the equivalent to the following NAIC Model Acts may also provide authority to adopt some or all of the provisions of this regulation include:

A. Section 19 of the NAIC Producer Licensing Model Act;

B. Section 12 of the NAIC Unfair Trade Practices Act;

C. Section 8 of the NAIC Unfair Claims Settlement Practices Act;

D. Section 4B of the NAIC Third Party Administrator Statute;

E. Section 3 of the NAIC Model Law on Examinations;

F. NAIC Nonadmitted Insurance Model Act; or

G. Section 12 of the NAIC Insurance Fraud Prevention Model Act.

Section 2. Definitions

A. "Admitted insurer" means an insurer licensed to do an insurance business in this state [including an entity licensed as a multiple employer welfare arrangement ("licensed MEWA"), a health maintenance organization or nonprofit hospital or medical service corporation under the laws of this state].

Drafting Note: States that have a specific statutory licensing category "multiple employer welfare arrangements" (MEWAs) may wish to include the licensee within this definition. In addition, states that separately license health maintenance organizations or nonprofit hospital or medical service corporations should include these licensed entities within this definition.

B. "Arrangement" means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits.

C. "Department" means the insurance department of this state.

D. "Employee leasing arrangement" means a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity.

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements to offer self-funded health benefit plans. Those states should take care to modify this regulation to reflect the applicable "professional employer organization" or "employee leasing" statutory structure.

E. "Employee welfare benefit plan" or "health benefit plan" means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

F. "Fully insured" means that for the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:

(1) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and

(2) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member or dependent.

G. "Insurer" means [insert reference to appropriate state law].

H. "Licensee" means a person that is, or that is required to be, licensed or registered under the laws of this state as a producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization.

Drafting Note: A state should adjust the definition of "licensee" to reflect its licensing laws.

I. "MEWA contact" means the individual or position designated by the department to be the MEWA contact as identified on the department web site.

Drafting Note: Every state is strongly encouraged to have an individual who is trained and knowledgeable about the application of state laws to MEWAs serve as the designated MEWA contact. In the event that a state does not designate such an individual to serve as the MEWA contact, reference should be made to the Department of Insurance instead of to the MEWA contact. States are encouraged to identify a specific MEWA contact on their web sites and in their relevant publications.

J. "Non-admitted insurer" means an insurer not licensed to do an insurance business in this state.

K. "Preferred provider organization" means an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan.

L. "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

M. "Professional employer organization" means an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an on-going and extended, rather than a temporary or project-specific, relationship.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this regulation to reflect that "professional employer organization" or "employee leasing" statutory structure.

N. "Third party administrator" or "administrator" has the meaning provided under [insert reference to the state's third party administrator statute].

O. "Transacting of insurance" means [insert reference to the state equivalent of Section 3P of the NAIC Nonadmitted Insurance Model Act] and includes:

(1) Issuing a stop loss policy covering an employer located in this state. Stop loss policy coverage of an employer for claims incurred under the employer's self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;

(2) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, with an employer located in this state directly or indirectly the beneficiary of the trust;

(3) Agreeing to loan or advance funds to pay claims incurred under an employer's self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into similar loan or advance agreements; or

(4) Engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract.

P. "Unauthorized health insurance" means:

(1) Health insurance offered by a non-admitted insurer except to the extent the laws of this state allow the coverage to be offered by an non-admitted insurer licensed in another state through an employer or group located out of state; and

(1) Includes health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not:

(a) Fully insured by an admitted insurer; or

[(b) Licensed or otherwise authorized under the laws of this state to offer a self-funded health benefit plan.]

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to include the optional bracketed language in this definition to reflect that statutory structure. The exception under Paragraph P (2) (b) is not intended to be adopted by states whose laws "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations unless those laws also include specific authority to self-fund a health benefit plan. Also, many states have laws that, under limited circumstances, permit a non-admitted insurer to provide coverage to a resident employer by an out of state employer or participating in an out of state group. Those states should modify this definition to reflect those provisions.

(2) "Unauthorized health insurance" does not include:

(a) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers (including one or more self-employed individuals), that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(b) Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under 29 U.S.C. §1002(40)(B).

(c) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under 29 U.S.C. §1002(40)(B).

(d) Health care benefits or coverage under a church plan as defined under 29 U.S.C §1002(33).

Section 3. Licensee Reporting Requirement

A. A licensee shall file a written report with the department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. Knowledge of a producer regarding an unrelated unauthorized health insurance arrangement is not imputed to licensed insurers represented by that producer.

B. Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this state, include when the licensee knows that any person is:

(1) Recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this state; or

(2) Seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public in this state.

C. Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:

(1) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to the multiple employers or generally to individuals.

(2) [The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers.]

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to omit the optional bracketed language.

(3) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

Drafting Note: Paragraph C is not intended to be a comprehensive list of possible illegal schemes. It includes only a few of the most common illegal arrangements.

D. (1) A report filed under this section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in any private action. Nothing in this regulation shall limit the commissioner's authority to use a report filed pursuant to this regulation in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this regulation.

(2) Nothing in this regulation shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this section to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this regulation. For reports filed under this section, [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act] applies.

E. A report filed under this Section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] except to the extent the commissioner determines disclosure is appropriate to accomplish a regulatory purpose.

F. [There is immunity from civil liability under Section [insert state law equivalent to Section 7 A of the NAIC Insurance Fraud Prevention Act].]

Drafting Note: The NAIC recommends that states give serious consideration to seeking statutory authority to retain MEWA contact reports as confidential and to seeking statutory immunity from civil liability related to filing a MEWA contact report, absent a showing of actual malice, prior to adopting this regulation. Many states may already have such provisions enacted as part of the NAIC Insurance Fraud Prevention Act or similar legislation. Those states should include the optional bracketed language. Those states should take care to clarify that their insurance fraud prevention acts do not, or are amended so as to not, prevent the sharing of the reports within the department. States are also encouraged to use the model MEWA contact form the NAIC ERISA Working Group plans to develop.

G. A licensee complies with this section if the licensee files the required report within thirty (30) days or a period reasonable under the circumstances, whichever is later.

Section 4. Responsibility to Exercise Due Diligence

A. Soliciting Producer

(1) A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) For any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements.

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

Drafting Note: Some states have a separate regulatory structure that recognizes a fully insured health plan of an employee leasing arrangement or professional employer organization as a single employer plan for certain regulatory purposes. Such a state should review Subparagraph (d) to ensure it conforms to such a provision.

B. Stop loss policy producer

(1) A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents, or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

(a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(b) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers.

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (b) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(c) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

C. Third Party Administrator

(1) A third party administrator, prior to entering into any administrative contract for a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

D. Insurer

(1) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents, or individuals located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(b) The health benefit plan is not offered by an employee leasing arrangement or professional employer organization to client employers .

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

(c) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

(2) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this state and the stop loss policy form has been filed and approved by the department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:

(a) Issuing a stop loss policy covering an employer located in this state. Coverage of an employer for claims incurred under the employer's self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance.

(b) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, when an employer located in this state is directly or indirectly the beneficiary of the trust.

(3) An insurer shall not engage in the transacting of insurance in this state by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:

(a) The employer is not covered for claims below the stop loss attachment point;

(b) A description of the attachment point, including the specific and aggregate attachment points; and

(c) The insurer provides no other coverage of the employer's retention.

E. Preferred provider organization

(1) A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:

(a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

(i) The insurer issued the policy;

(ii) The coverage is as represented;

(iii) The insurer is an admitted insurer in this state; and

(iv) The policy has been filed with and approved by the department or is exempt from filing requirements;

(b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;

(c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

Drafting Note: Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that "register" or otherwise "authorize" employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

(d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

F. (1) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this section if:

(a) The information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact's advice, is accurate and complete; and

(b) The information is provided by the licensee or other person to the MEWA contact in writing.

(2) For the purpose of this regulation the department's published list of admitted insurers on its web site is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this subsection relieves a licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

Drafting Note: A state insurance department adopting this regulation is expected to publish, on the internet, a regularly updated list of admitted insurers.

(3) A violation of this section is mitigated, and the department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:

(a) It maintained supervisory procedures and controls that complied with Section 5;

(b) The violation occurred despite the maintenance of those procedures and controls;

(c) It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance; and

(d) It took prompt corrective action.

G. Nothing in this section requires a producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

Drafting Note: This section requires producers, third party administrators, insurers, and preferred provider organization to exercise due diligence only to the extent that they assist or engage in the transacting of insurance relating to a health benefit plan. They are not required to investigate health benefit plans with respect to which they provide no services or transaction of insurance. For example, sale of a group life insurance policy does not require the selling producer or issuing agent to exercise due diligence as to the employer's health benefit plan.

Section 5. Supervisory Procedures and Controls

A. A producer, third party administrator, insurer, preferred provider organization or an agent of the same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this regulation.

B. The supervisory procedures shall include:

(1) Training;

(2) Internal controls;

(3) Periodic audits;

(4) Supervisory review; and

(5) Monitoring and enforcement of contractual provisions established under Section 4 C and E.

C. The extent of the supervisory procedures and controls a producer is required to maintain under this section may appropriately reflect the size and complexity of the producer's operations and the scope and nature of the producer's insurance activities.

Drafting Note: The NAIC encourages the national trade associations for health insurers, preferred provider organizations, third party administrators and insurance agents to develop compliance guidance, training and manuals to assist their members to implement supervisory procedures and controls. The NAIC ERISA Working Group is prepared to review the results of such an effort. State insurance departments are expected to give recognition to supervisory procedures and controls implemented by insurers, preferred provider organizations, third party administrators and insurance agents in accordance with guidance for effective programs developed by these trade organization. Companies also may seek review of their programs by their state insurance department.

Section 6. Licensing Education Requirements

A. A producer shall not be licensed in this state to sell health insurance unless the producer, prior to licensing, receives not less than one hour of education in:

(1) Identification of unauthorized health insurance; and

(2) The producer's responsibilities under this regulation.

Drafting Note: Subsection A would apply only to those states that have pre-licensing education requirements. The one-hour of education is intended to be included in, and not in addition to, the total pre-licensing requirement.

B. An insurer providing health insurance in this state shall require its listed producers to obtain not less that one hour of continuing education every four years covering:

(1) Identification of unauthorized health insurance; and

(2) The producer's responsibilities under this regulation.

Drafting Note: Subsection B should be adopted only by those states that have continuing education requirements. The one hour continuing education requirement should be included in the total hours required by the NAIC Producer Licensing Model Act.

C. A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under Section 5 in the [insert reference to the relevant statutory application requirement such as a statutory requirement to include a business plan]. A license may be denied under [insert reference to relevant statutory licensing criteria such as "contrary to the public interest"] if the applicant fails to demonstrate that the applicant maintains the required procedures and controls.

Section 7. Penalties and Liability

A. Except as provided in Subsection B, a person that violates this regulation is subject to [insert reference to general license and penalty provisions under the state insurance code, including the provisions equivalent to the remedy and penalty section of the NAIC Nonadmitted Insurance Model Act].

Drafting Note: The regulation should include a cross reference to penalty provisions equivalent to those in Section 7 of the NAIC Nonadmitted Insurance Model Act, as well as the remedial provision under Section 4D of that Act.

B. A person who violates Section 3 of this regulation is subject to a penalty of a [forfeiture of up to $1000] for each violation.

Drafting Note: A state insurance department should insert an appropriate penalty under the sanctions provided under its laws. Generally a less severe penalty is appropriate compared to those for other violations under this regulation.

APPENDIX A

REPORTING FORM – UNAUTHORIZED MEWA OR HEALTH COVERAGE PROGRAM

Pursuant to [insert reference to state equivalent to Prevention of Unauthorized Multiple Employer Welfare Arrangements (MEWAs) and Other Unauthorized Insurers Model Regulation], licensees are required to file a written report with the [insert name and title of state insurance department MEWA contact] when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. This form may be used by persons and licensees seeking to comply with these requirements.

Please answer all questions as fully as possible.

LICENSEE IDENTIFICATION INFORMATION

1. Name of Licensee making report:

2. Address of Licensee:

3. Type of Licensee (Check all that apply):

- ☐ Producer
- ☐ Third Party Administrator
- ☐ Insurer (List Type of Insurer, i.e. Health, HMO, Stop Loss, Life…)
- ☐ Employee Leasing Arrangement
- ☐ Preferred Provider Organization
- ☐ Other: _____

Drafting Note: States should modify the list of licensees to include all persons that are required to be licensed or registered under the insurance laws of this state or other laws administered by the insurance department.

4. Name, address and phone number of representative(s) of the Licensee who can answer follow up questions.

UNAUTHORIZED ENTITY INFORMATION

5. Please describe the product that is, or is about to be offered to the public in this state, including the name of the product and the name(s) and all contact information you have for person(s) associated with the product (i.e., direct insurers, stop loss insurers, third party administrators, pharmacy benefit managers, and preferred provider organizations).

6. When and how did you learn about this product and that this product is, or is about to be, offered? To the extent possible, please provide a timeline of your interactions with the persons involved with this product. Please include the date when you first became aware of this product and the date of your last interaction with the persons involved with this product.

7. What information led you to conclude that you reasonably should know the product is unauthorized health insurance. Please check any of the descriptions listed below that apply and include as much detailed information as you can in the explanation section. Please attach any external documentation that you have regarding the plan or product that is the subject of this report (i.e., webpage printouts, marketing materials, application forms, insurance policies, and enrollee materials).

   ☐ A. The plan was represented as being insured, but misrepresented one or more of the following (check all that apply):

- ☐ The insurer that issued the policy
- ☐ The coverage that was represented
- ☐ The status of the insurer as an admitted insurer in this state
- ☐ That the policy has been filed with, and approved by, the department.
- ☐ That the policy is exempt from filing requirements

Additional Explanation:

☐ B. The plan was represented as being established or maintained pursuant to a collective bargaining agreement but fails to meet the criteria provided under 29 CFR 2510.3-40 as being established or maintained pursuant to a collective bargaining agreement.

Additional Explanation:

☐ C. The plan was represented as being a self-funded plan established or maintained pursuant to a collective bargaining agreement and the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

Additional Explanation:

☐ D. The product was represented as being a single employer self-funded plan and is offered widely to multiple employers or generally to individuals.

Additional Explanation:

☐ E. The product was represented as being a self-funded employee leasing arrangement plan or self-funded professional employer organization plan.

Additional Explanation:

Drafting Note: Some states have a separate regulatory structure that authorizes some employee leasing companies or professional employer organizations to self-fund health benefit plans. Those states should modify E to conform with state law. For example, state law may impose specific conditions upon a professional employer organization's ability to self-insure. In those cases. a company operating outside those conditions or requirements should be reported.

☐ F. The plan was represented as established by a single employer, but is extending coverage beyond the employees and dependents of the employees of the employer or the employer does not control and direct the work of the employees.

☐ G. The product involves the use of stop loss insurance issued to a trust or trustee with the employer as the direct or indirect beneficiary of the trust.

Additional Explanation:

☐ H. The product involves the use of stop loss insurance that is characterized as reinsurance.

Additional Explanation:

☐ I. The product involves the use of stop loss insurance issued by an insurer that is not admitted in this state or uses a policy form that has not been filed and approved by the insurance department.

Additional Explanation:

☐ J. Other information that led you to conclude that you reasonably should know the product is unauthorized health insurance.

Additional Explanation:

8. Have you heard that this product may be, or is about to be offered in any other states? Name those states, if possible.

CONFIDENTIALITY NOTICE AND NOTICE OF FURTHER DISCLOSURE

This reporting form and any information submitted on this reporting form is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in a private action. There is immunity from civil liability related to filing this report, absent a showing of actual malice, pursuant to [insert state law equivalent to Section 7A of the NAIC Insurance Fraud Prevention Act].

The insurance commissioner retains authority to use this report in furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purpose of preventing the operation of illegal health insurers, including illegal Multiple Employer Welfare Arrangements, in this state.

The insurance commissioner may disclose the contents of this report to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency, provided the agency or office receiving the report or matter relating thereto agrees to hold it confidential in a manner consistent with [insert reference to state equivalent to Prevention of Unauthorized Multiple Employer Welfare Arrangements (MEWAs) and Other Unauthorized Insurers Model Regulation]. This report is subject to [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act.]

Chronological Summary of Actions (All references are to the Proceedings of the NAIC).

2006 Proc. 2nd Quarter 40, 62-75 (original model adopted).
2007 Proc. 2nd Quarter Vol. I 129, 133, 211-215 (guideline amendments adopted).

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. §§ 21.85.010 to 21.85.500 (2010); BULLETIN 83-8 (1983).
American Samoa	NO CURRENT ACTIVITY		
Arizona			CIRCULAR LETTER 92-5 (1992).
Arkansas			ARK. CODE ANN. § 23-92-101 (1985).
California			CAL. INS. CODE §§ 742.20 to 742.43 (2008/2012).
Colorado			3 COLO. CODE REGS. § 702-4:4-2-10 (2017).
Connecticut			CONN. AGENCIES REGS. §§ 38a-272-1 to 38a-272-10 (1992/2013); BULLETIN HC-32 (1983).
Delaware			18 DEL. ADMIN. CODE 1405-1.0 to 1405-19.0 (2018).
District of Columbia			D.C. CODE ANN. § 31-3303.13c (2019).

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. ADMIN. CODE ANN. r. 69O-192 (1990).
Georgia			GA. CODE ANN. §§ 33-50-1 to 33-50-14 (2009).
Guam	NO CURRENT ACTIVITY		
Hawaii			MEMORANDUM 2005-1 (H) (2005).
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana			760 IND. ADMIN. CODE 1-68-1 to 1-68-19 (2007/2009); BULLETIN 113 (2002).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. tit. 24-A, §§ 6601 to 6616 (1996).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. COMP. LAWS ANN. §§ 500.7001 to 500.7090 (1956).
Minnesota			MINN. STAT. §§ 62H.10 to 62H.17 (1994).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. §§ 33-35-101 to 33-35-307 (1995/2013).

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska			210 NEB. ADMIN. CODE §§ 78.001 to 78.015 (2008).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. STAT. ANN. §§ 17B:27C-1 to 17B:27C-12 (2001).
New Mexico			N.M. CODE R. §§ 13.19.3.1 to 13.19.3.15 (1992/1997).
New York			CIRCULAR LETTER 1991-8 (1991).
North Carolina			11 N.C. ADMIN. CODE 18.0101 to 18. 0121 (2008).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 1739.01 to 1739.99 (2004/2014) (may not represent unlicensed MEWA).
Oklahoma			OKLA. STAT. ANN. tit. 36, §§ 633 to 650 (1992).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			230 R.I. CODE R. 20-30-11 (2009).
South Carolina			S.C. CODE ANN. §§ 38-41-10 to 38-41-110 (1993/2013).
South Dakota	NO CURRENT ACTIVITY		
Tennessee			BULLETIN 5-7-92 (1992).

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas			TEX. INS. CODE ANN. §§ 846.001 to 846.303 (2003).
Utah			UTAH ADMIN. CODE r. 590-88 (1989).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE 5-410 (2009).
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. ADMIN. CODE INS. § 6.62 (1990).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2006

PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS) AND OTHER ILLEGAL INSURERS MODEL REGULATION (#220)

1. Project Description

A chair discussion draft of the Illegal MEWA Prevention Model Regulation was first circulated and comments were solicited at the 2004 Winter National Meeting. This new model regulation was intended to replace Model #220: Reporting Requirements for Licensees Seeking to do Business with Certain Unauthorized Multiple Employer Welfare Arrangements (MEWAs) Model Regulation. A public hearing was held at the 2005 Spring National Meeting in order to obtain additional information and comments from licensees who would be affected by this model regulation. A new draft dated June 9, 2005, that took into account the testimony and comments received at the public hearing, was distributed at the Summer National Meeting and released for comment. Comments were due August 15, 2005. A new draft dated December 4, 2005, that took into account the comments received, was distributed at the Winter National Meeting and released for comment. Comments on the December 4, 2005 draft were due January 17, 2006. A new draft dated February, that took into account the comments received, was distributed at the 2006 Spring National Meeting. The working group discussed the new draft and agreed to adopt the model, with minor amendments.

2. Group Responsible for Drafting Model and States Participating

The ERISA (B) Working Group was responsible for drafting the Model Act, chaired by Fred Nepple (WI). The following states were members of the Working Group: Arkansas, Colorado, District of Columbia, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, Ohio, Oklahoma, South Dakota, Utah, Vermont, Virginia, Washington

3. Charge Authorizing Project

B Committee Charge: Review issues surrounding state regulation of insurance purchased by ERISA plans, and if appropriate, develop a model law on the subject.

4. Description of Drafting Process

2004 Winter National Meeting – A November 30, 2004 chair discussion draft titled Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation was distributed at the ERISA Working Group meeting. The working group decided to hold an informational public hearing at the 2005 Spring National Meeting.

2005 Spring National Meeting – A public hearing was held. The following individuals gave oral remarks at the hearing: Rick Ramsay representing America's Health Insurance Plans (AHIP); John Troy representing BlueCross BlueShield Association (BCBSA); D. Scott Asay from Employee Benefit Management Services, Inc. representing Society of Professional Benefit Administrators (SPBA); and Janet Trautwein representing the National Association of Health Underwriters (NAHU). Several interested parties submitted written comments in addition to or in lieu of testimony on the 11/30/04 discussion draft, including: William Schilling, National Association of Professional Employer Organizations (NAPEO); Fred Hunt, Society of Professional Benefit Administrators (SPBA); Gary Sanders, National Association of Insurance and Financial Advisors (NAIFA) and Association of Health Insurance Advisors (AHIA); Elizabeth Leight, Society of Professional Benefit Administrators (SPBA); D. Scott Asay, Employee Benefit Management Services, Inc. (EBMS); Janet Trautwein, National Association of Health Underwriters (NAHU); Karen Greenrose, American Association of Preferred Provider Organizations (AAPPO); David Starr, Church Alliance; and Mila Kofman, Georgetown University Institute for Health Care Research and Policy.

2005 Summer National Meeting: A new draft, which took into account the discussion and comments from the public hearing, was distributed and reviewed. Some amendments were suggested and agreed upon by the working group and a new draft dated June 9, 2005 was released and comments were requested by August 15, 2005.

2005 Fall National Meeting: Cancelled

2005 Winter National Meeting: A new draft, which took into account the discussion and comments from the public hearing, was distributed and reviewed. Some amendments were suggested and agreed upon by the working group and a new draft dated December 4, 2005, was distributed following the meeting. Comments on the December 4, 2005 draft were requested by January 17, 2006

2006 Spring National Meeting: A new draft dated February 2006, which took into account the discussion and comments on the December 4, 2005, draft, was distributed and reviewed. The working group agreed to adopt the model regulation, with minor amendments.

5. Significant Issues Raised

Interested parties wanted Section 3 to require reporting only when a licensee has actual knowledge of unauthorized insurance. Because actual knowledge is nearly impossible to prove in practice, the working group was of the opinion that there would be no realistic way to enforce any failure to report under the actual knowledge standard. Therefore, the working group decided to require reporting when a licensee knows or reasonably should know about unauthorized insurance.

A number of interested parties were concerned that, under the model regulation, a licensee might be legally liable if the information in the report under Section 3 turned out to be incorrect. The working group agreed that states should be encouraged to have laws in place that provide legal immunity to licensees as well as protect the confidentiality of information shared under this regulation prior to adopting the regulation. The working group, however, declined to insert language making state immunity and confidentiality laws a condition precedent to adopting the regulation.

The question was raised as to whether there was authority to impose the Section 4 due diligence requirements on preferred provider organizations (PPOs) in states that do not regulate PPOs. The working group was of the opinion that the states may want to consider whether they have the authority for the due diligence requirements of the regulation pursuant to the state law equivalent of the Non-Admitted Insurer Model Act, which imposes liability on any entity assisting in the unauthorized transaction of insurance.

Interested parties expressed concern that that the due diligence requirements under Section 4 were overly burdensome and were an attempt to have licensees do the work of the department of insurance by ferreting out unauthorized health insurance entities. The working group re-iterated that this is a regulation that adds detail to existing state requirements. Assisting in the unauthorized transaction of insurance is already prohibited. This regulation simply provides additional guidance as to how licensees can ensure that they are in compliance with the law.

A concern was raised that the due diligence requirements were not detailed enough for licensees to know exactly what they have to do to be in compliance. The working group was of the opinion that it is impossible to develop a definitive list as to what appropriate due diligence would be in every scenario. The exercise of good judgment is a necessary component of exercising due diligence and it cannot be legislated.

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

Table of Contents

Section 1. Purpose and Scope

The purpose of this Act is to set forth the requirements for states to obtain access to the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI) criminal history record information and secure information or reports from the Criminal Justice Information Services Division of the FBI.

The scope of this Act is to set forth the applicability of the criminal history record check to applicants for a home state insurance producer license.

Section 2. Definitions

When used in this Act:

A. "Applicant" means a natural person applying for any of the following:

(1) An initial home state license as an insurance producer;

(2) An additional line of authority under an existing home state insurance producer license where a criminal history record check has not been obtained; or

(3) A resident insurance producer license under change of home state provisions.

Drafting Note: This Act shall not apply to a person applying for renewal or continuation of a home state insurance producer license or a non-resident insurance producer license.

B. "Fingerprints" means an impression of the lines on the finger taken for the purpose of identification. The impression may be electronic or in ink converted to an electronic format.

C. "Insurance commissioner" or "commissioner" means the official in any state that is responsible for regulation of the business of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "Insurance commissioner" or "commissioner" appears.

D. "Insurance producer" means a natural person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

E. "Home State" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

Section 3. Authorization of the Insurance Commissioner

A. In order to make a determination of license eligibility, the commissioner is authorized to require fingerprints of applicants and submit such fingerprints and the fee required to perform the criminal history record checks to the state identification bureau (or state department of justice or other public state agency) and the FBI for state and national criminal history record checks.

Drafting Note: The FBI requires that fingerprints be submitted to the state Department of Law Enforcement, Public Safety or Criminal Justice for a check of state records before the fingerprints are submitted to the FBI for a criminal history record check. The FBI recommends all fingerprint submissions be in an electronic format. Public Law 92-544 requires specific parameters to submit fingerprints and obtain criminal history record information. The FBI has approved the language in Section 3A to authorize a state identification bureau to submit fingerprints on behalf of its applicants in conjunction with licensing and employment.

B. The commissioner shall require a criminal history record check on each applicant in accordance with this Act. The commissioner shall require each applicant to submit a full set of fingerprints (including a scanned file from a hard copy fingerprint) in order for the insurance commissioner to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

C. The insurance commissioner may contract for the collection and transmission of fingerprints authorized under this Act. If the commissioner does so, the commissioner may order the fee for collecting and transmitting fingerprints to be payable directly to the contractor by the applicant. The insurance commissioner may agree to a reasonable fingerprinting fee to be charged by the contractor.

D. The insurance commissioner is authorized to receive criminal history record information in lieu of the state identification bureau (or state department of justice or other public state agency) that submitted the fingerprints to the FBI.

Drafting Note: This provision does not permit the sharing of criminal history record information with the NAIC or other insurance commissioners as such sharing of information is prohibited by 28 CFR 20.33.

Section 4. Confidentiality

The commissioner shall treat and maintain an applicant's fingerprints and any criminal history record information obtained under the Act as confidential and shall apply security measures consistent with the Criminal Justice Information Services Division of the Federal Bureau Investigation standards for the electronic storage of fingerprints and necessary identifying information and limit the use of records solely to the purposes authorized in this Act. The fingerprints and any criminal history record information shall not be subject to subpoena, other than one issued in a criminal action or investigation, and shall be confidential by law and privileged, and shall not be subject to discovery or admissible in evidence in any private civil action.

Section 5. Regulations

The insurance commissioner may, in accordance with [insert appropriate reference to state law], promulgate regulations as are necessary for the administration of this Act.

Section 6. Effective Date

This Act shall take effect [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2006 Proc. 2nd Quarter 40, 83-89 (adopted).

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-146 (2009).
Alaska			ALASKA STAT. § 21.27.040 (2006); ALASKA ADMIN. CODE tit. 3, § 23-010 (1973/1989).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-142 (1977/2002); § 20-340.04 (2001/2002) (bail bonds); BULLETIN 2007-3 (2007).
Arkansas	NO CURRENT ACTIVITY		
California			CAL. CODE REGS. tit. 10, § 2175.4 (2003).
Colorado			COLO. REV. STAT. § 10-3-112 (2002); § 10-15-103 (1995/2013).
Connecticut			CONN. GEN. STAT. § 38a-660 (1988/2001) (bail bonds).
Delaware			DEL. CODE ANN. tit. 18, § 1706 (1974/2013); AGENT'S BULLETIN 5 (1997).
District of Columbia			D.C. CODE ANN. § 31-1131.06a (2008).

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 624.34 (1988/2003); § 626.211 (1959/2006); § 626.291 (1959/2004); § 626.8732 (1988/2004) (adjusters); §§ 648.34 to 648.355 (1955/2004) (bail bonds).
Georgia			GA. CODE ANN. § 33-23-5.1 (2008/2009).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:7-101 (1987/2009) (fees for check); § 431:2-201 (1987/2009); § 431:2-204 (1987/2009); § 431:2-209 (1987/2009).
Idaho			IDAHO CODE ANN. § 41-1007 (2001); § 41-1009 (2001); § 41-1011 (2001).
Illinois			215 ILL. COMP. STAT. § 5/401 (1937/2000).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. § 40-4905 (2001).
Kentucky	NO CURRENT ACTIVITY		
Louisiana		LA. REV. STAT. ANN. § 22:1546 (2009).	
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. 31.03.12.04 to 31.03.12.05 (2018).
Massachusetts			BULLETIN B-2001-14 (2014).

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan			MICH. COMP. LAWS § 500.249a (1956/1970).
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. CODE REGS. ANN. tit. 20, § 700-6.100 (2000/2006).
Montana			MONT. CODE ANN. § 33-17-220 (2003/2013).
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. § 683A.251 (2001/2005); § 692B.070 (1971); § 692B.190 (1971); § 697.173 (1997) (bail bonds); § 697.180 (1971/2003) (bail bonds); NEV. ADMIN. CODE § 683A.272 (2002/2004).
New Hampshire			BULLETIN 2-10-92 (1992); BULLETIN 5-20-96 (1996).
New Jersey			N.J. ADMIN. CODE § 11:1-28.6 (2001); § 11:1-28.7 (1971); § 17:17-10 (2003); 17:22A-32 (1950/2003); § 17B:18-42 (1971/2003); § 11:17-2.3 (1993/2003); § 11:17-2.11 (1988/2003); § 11:17-2.12 (2002); § 11:1-37.17 (2002) (adjusters); § 11:17-2.15 (1998/2003); § 11:17-7 Form C (1993); N.J. STAT. ANN. § 17:22B-6 (1993/1994); BULLETIN 2002-27 (2002).
New Mexico			N.M. STAT. ANN. § 59A-11-2 (1984/2003); § 59A-11-14 (1984/2001).

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York			N.Y. INS. LAW. § 1102 (1984/2003); 6802 (1984/2003) (bail bonds); §§ 7802 to 7803 (1993/2003) (viatical settlement producers); § 2108 (1984/2014) (adjusters).
North Carolina			N.C. GEN. STAT. § 58-7-37 (2001/2013); § 58-89A-60 (2004/2013); § 58-71-50 (1963/2009) (bail bonds); 11 N.C. ADMIN. CODE § 8.0911 (1992).
North Dakota			N.D. CENT. CODE ANN. § 26.1-26-13.3 (2001).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3905.051 (2010).
Oklahoma			OKLA. STAT. tit. 59, § 1305 (1965/2003) (bail bonds).
Oregon			OR. ADMIN. R. 836-071-0110 (1990/2012); 836-072-0010 (2012).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. REGS. 69-23 (1984/1988).
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. § 56-1-107 (2004); § 40-11-317 (2006) (bail bonds).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas			TEX. INS. CODE ANN. § 4056.051 (2003/2005); § 4056.053 (2003/2005); 28 TEX. ADMIN. CODE §§ 1.501 to 1.509 (2006/2010); §§ 19.709 to 19.710 (1985/2006) (adjusters).
Utah			UTAH CODE ANN. § 31A-3-105 (2010); § 31A-25-203 (1985/2006); § 31A-26-203 (1985/2012) (adjusters).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			ADMINISTRATIVE LETTER 2002-8 (2002).
Washington			WASH. REV. CODE ANN. § 48.06.040 (2012); § 48.15.070 (2017); § 48.17.090 (2009); § 48.56.030 (2002); § 308-19-102 (2005) (bail bonds); WASH. ADMIN. CODE § 284-97-020 (2011).
West Virginia	W. VA. CODE § 33-12-37 (2007).		W.VA. CODE § 33-41-8a (2005); W.VA. REGS. §§ 114-2A-1 to 114-2A-7 (2008).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2006

AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT (#222)

1. Project Description

The Authorization for Criminal History Record Check Model Act provides the basic regulatory framework for the use of electronic fingerprints provided by a resident insurance producer. This model language was developed for states to adopt in order to obtain access to the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI) criminal history record information and secure information or reports from the Criminal Justice Information Services Division of the FBI.

2. Group Responsible for Drafting the Model and States Participating

The Producer Licensing Working Group of the Market Regulation and Consumer Affairs (D) Committee was responsible for developing the model act. Laurie Wolf (ND) chaired the working group. The following states were members of the working group: Alaska, Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

To help facilitate the drafting process, the Producer Licensing Working Group appointed the Fingerprint Subgroup. Linda Brunette (AK) chaired this subgroup. The subgroup was comprised of Arizona, California, Delaware, Florida, Idaho, Indiana, Kentucky, Louisiana, Michigan, Nebraska, New York, North Carolina, North Dakota, Ohio, and Pennsylvania.

3. Project Authorized by What Charge and Date First Given to the Group

The Market Regulation and Consumer Affairs (D) Committee charge for the Producer Licensing Working Group reads as follows, "Appoint a working group to develop and implement uniform standards, interpretations and treatment of producer licensees and licensing terminology; coordinate and consult with the National Insurance Producer Registry Board of Directors to develop and implement uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology; develop a Uniform Adjuster Licensing Model Act; and monitor and respond to developments related to licensing reciprocity." The group first received the charge for the Authorization for Criminal History Background Check Model Act in March 2003.

4. Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open to comments and participation by all interested parties. Industry representatives participated fully in the process and discussion sessions. Drafts of the model were circulated for public comment. The process resulted in a total of fifteen drafts of the model.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Drafts of the model act were circulated for comment and posted on the NAIC Web site. The Producer Licensing (D) Working Group adopted the model act on Nov. 6, 2005. The Market Regulation & Consumer Affairs Committee held a meeting at the NAIC 2005 Winter National Meeting to receive comments and discuss the model. The Committee held another meeting via conference call on Jan. 20, 2006.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Earlier versions of the model included provisions for the creation of an NAIC centralized fingerprint repository. The working group received numerous comments from industry groups opposing the need for a centralized repository and raised concerns about the confidential, sensitive nature of an individual's fingerprints being stored at the NAIC. The working group also

received comments from the American Council of Life Insurers regarding NAIC control of the repository. All references to the NAIC fingerprint repository have been deleted from the model.

Earlier versions of the model included provisions as to when company officers and directors will be subject to the submission of fingerprints for background checks. All references to the fingerprinting of directors and officers have been eliminated.

Earlier versions of the model also included a fingerprint exemption for individuals who fulfilled the requirements of the United States Securities Exchange Commission Regulation 240.17(f)2 SEC rule 17f-2; 17CFR240.17f-2 and are currently licensed and in good standing with the National Association of Securities Dealers. This exemption has been eliminated from the model.

7. Any Other Important Information (e.g., amending an accreditation standard).

This model will allow states access to the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI) criminal history record information and secure information or reports from the Criminal Justice Information Services Division of the FBI.

Subsection 3A and 3B of the model must be enacted by a state exactly as written. The PLWG adopted the language in these sections after preliminary review and recommendations by the U.S. Department of Justice, who is the federal agency that provides comment on whether the proposed legislation is compliant with Public Law 92-544 and the parameters set forth by the FBI and the United States Department of Justice. Any changes to these sections would jeopardize approval by the U.S Department of Justice.

MANAGING GENERAL AGENTS ACT

Table of Contents

Section 1. Purpose and Scope

This Act may be cited as the Managing General Agents Act. This chapter governs the qualifications and procedures for resident and non-resident producers acquiring the status as a Managing General Agent.

Section 2. Definitions

As used in this Act:

A. "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

B. "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

C. "Insurer" means any person duly licensed in this state as an insurance company pursuant to [insert applicable licensing statute].

D. "Managing general agent" (MGA) means any person who:

(1) Manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office); and

(2) Acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with the following activity related to the business produced adjusts or pays claims in excess of $10,000 per claim or negotiates reinsurance on behalf of the insurer.

Drafting Note: Individuals or agents calling themselves "managing general agents" may not necessarily fall under the provisions of this Act. In other words, if the individual or agent does not perform the activities set forth in Paragraphs (1) and (2) then, for purposes of the Act, the individual is not an MGA.

Drafting Note: Insert the proper title for the chief insurance regulatory official wherever the term "Commissioner" appears.

(3) Notwithstanding the above, the following persons shall not be considered MGAs for the purposes of this Act:

(a) An employee of the insurer;

(b) A U.S. Manager of the United States branch of an alien insurer;

(c) An underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to the holding company regulatory act, and whose compensation is not based on the volume of premiums written;

(d) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

Drafting Note: A managing general agent does not fall within the definition of an "adjuster," or one "who negotiates reinsurance on behalf of the insurer" as stated in Paragraph (2).

E. "Person" means an individual or a business entity.

F. "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Drafting Note: If the enacting state has a third party administration (TPA) Act, it should be reviewed to eliminate any conflict.

Section 3. Licensure

A. No person shall act in the capacity of an MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed producer in this state.

B. No person shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a producer in this state (such license may be a nonresident license) pursuant to the provisions of this Act.

Section 4. Required Contract Provisions

No person acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

A. The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

Drafting Note: Nothing in the above subsection is intended to relieve the MGA or insurer of any other contractual obligation.

B. The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

C. All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in an institution that is insured by the FDIC. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months estimated claims payments and allocated loss adjustment expenses.

D. Separate records of business written by the MGA will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the commissioner shall have access to all books, bank accounts and records of the MGA in a form usable to the commissioner. Such records shall be retained according to [cite appropriate record retention statute].

E. The contract may not be assigned in whole or part by the MGA.

F. (1) Appropriate underwriting guidelines including:

(a) The maximum annual premium volume;

(b) The basis of the rates to be charged;

(c) The types of risks which may be written;

(d) Maximum limits of liability;

(e) Applicable exclusions;

(f) Territorial limitations;

(g) Policy cancellation provisions; and

(h) The maximum policy period.

(2) The insurer shall have the right to cancel or non-renew any policy of insurance subject to the applicable laws and regulations [concerning the cancellation and non-renewal of insurance policies].

G. The insurer shall require the MGA to obtain and maintain a surety bond for the protection of the insurer. The bond amount shall be at least $100,000 or ten percent (10%) of the managing general agent's total annual written premium nationwide produced by the MGA for the insurer in the prior calendar year, but in no event greater than $500,000.

Drafting Note: It is contemplated that one bond per company represented would be required.

H. The insurer may require the MGA to maintain an errors and omissions policy.

I. If the contract permits the MGA to settle claims on behalf of the insurer:

(1) All claims must be reported to the company in a timely manner.

(2) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(a) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company; whichever is less;

(b) Involves a coverage dispute;

(c) May exceed the MGA's claims settlement authority;

(d) Is open for more than six months; or

(e) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(3) All claim files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate; the MGA shall have reasonable access to and the right to copy the files on a timely basis.

(4) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

Drafting Note: Nothing in the above subsection is intended to relieve the MGA or insurer of any other contractual obligation.

J. Where electronic claims files are in existence, the contract must address the timely transmission of the data.

K. The MGA may use only advertising material pertaining to the business issued by an insurer that has been approved in writing by the insurer in advance of its use.

L. If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to Section 5 of this Act.

M. The MGA shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

(2) Commit the insurer to participate in insurance or reinsurance syndicates;

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed;

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(5) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer; without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(6) Except as provided in Section 5G, permit its subproducer to serve on the insurer's board of directors;

(7) Jointly employ an individual who is employed with the insurer; or

(8) Appoint a sub-MGA.

Section 5. Duties of Insurers

A. The insurer shall have on file an independent audited annual financial statement or reports for the two (2) most recent fiscal years that prove that the MGA has a positive net worth. If the MGA has been in existence for less than two fiscal years, the MGA shall include financial statements or reports, certified by an officer of the MGA and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis must include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included.

Drafting Note: If the MGA has been in existence for less than two (2) fiscal years or has not qualified as an MGA for that period and otherwise does not have the required audited financial statements or reports, the MGA shall include financial statements or reports, certified by an officer of the MGA and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which financial statements or reports have been completed.

B. If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

C. The insurer shall periodically (at least semi-annually) conduct an on-site review of the underwriting and claims processing operations of the MGA.

D. Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

E. Within thirty (30) days of entering into or terminating a contract with an MGA, the insurer shall provide written notification to the commissioner. Notices entering into a contract with an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

F. An insurer shall review its books and records each quarter to determine if any producer as defined by Section 2D has become, by operation of Section 2D, a MGA as defined in that section. If the insurer determines that a producer has become a MGA pursuant to the above, the insurer shall promptly notify the producer and the commissioner of such determination and the insurer and producer must fully comply with the provisions of this Act within thirty (30) days.

G. An insurer shall not appoint to its board of directors an officer, director, employee, subproducer or controlling shareholder of its MGAs. This subsection shall not apply to relationships governed by the Insurance Holding Company Systems Regulatory Act or, if applicable, the Business Transacted with Producer Controlled Property/Casualty Insurer Act.

H. The insurer shall keep the bond required by Section 4G on file for review by any applicable commissioner.

Section 6. Examination Authority

The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer.

Section 7. Penalties and Liabilities

A. If the commissioner determines that the MGA or any other person has not materially complied with this Act, or any regulation or Order promulgated thereunder, after notice and opportunity to be heard, the Commissioner may order:

(1) For each separate violation, a penalty in an amount not exceeding [insert amount];

(2) Revocation or suspension of the producer's license; and

(3) If it was found that because of such material non-compliance that the insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or other appropriate relief.

B. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to [insert state's rehabilitation or liquidation statute], and the receiver appointed under that order determines that the MGA or any other person has not materially complied with this Act, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

Drafting Note: If state law does not otherwise provide, amend the bracketed citation in the preceding paragraph to include the rehabilitation or liquidation statute of any reciprocal state. This is intended to codify the standing of a receiver to maintain a civil action in a reciprocal state.

C. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance law.

D. Nothing contained in this Act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and creditors.

Section 8. Rules and Regulations

The Commissioner of Insurance may adopt reasonable rules and regulations for the implementation and administration of the provisions of this Act.

Section 9. Effective Date

This Act shall take effect on [insert date]. No insurer may continue to utilize the services of an MGA on and after [insert date] unless such utilization is in compliance with this Act.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1990 Proc. I 12-14, 851, 853-856 (adopted at special plenary session in September 1989).
1990 Proc. I 6, 30, 838-839, 841-844 (amended at winter plenary and reprinted).
1991 Proc. I 9, 18, 907, 909 (amended).
1993 Proc. I 1128-1129, 1131, 1138-1142 (amended, reprinted and adopted by parent committee).
1993 Proc. 2nd Quarter 12, 102 (adopted by executive and plenary).
2002 Proc. 3rd Quarter 11, 888, 890-894 (amended and reprinted).

MANAGING GENERAL AGENTS ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MANAGING GENERAL AGENTS ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-6A-1 to 27-6A-8 (1993/2001).	ALA. ADMIN. CODE r. 482-1-106.01 to 482-1-106-.09 (1994/2013).
Alaska	ALASKA STAT. §§ 21.27.590 to 21.27.620 (1992/2006); § 21.97.900 (2006/2010) (portions of model).		ALASKA STAT. § 21.27.010 (1966/2014); BULLETIN 92-3 (1992).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-284 to 20-302 (1954/2014).	
Arkansas		ARK. CODE ANN. §§ 23-64-401 to 23-64-408 (1993).	
California		CAL. INS. CODE §§ 769.80 to 769.87 (1991/1992).	
Colorado		COLO. REV. STAT. §§ 10-2-401 to 10-2-408 (1992/2014).	3 COLO. CODE REGS. § 702-1:1-2-7 (1994/2012).
Connecticut		CONN. GEN. STAT. §§ 38a-90 to 38a-90h (1992/1993).	BULLETIN No. FS-17 (1993).
Delaware		DEL. CODE ANN. tit 18, §§ 1801 to 1809 (1991/1993).	
District of Columbia		D.C. CODE §§ 31-1501 to 31-1506 (1993).	

MANAGING GENERAL AGENTS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida		FLA. STAT. §§ 626.7451 to 626.7454 (1990/2013).	
Georgia		GA. CODE ANN. §§ 33-47-1 to 33-47-7 (1991/2009).	
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:9C-101 to 431:9C-107 (2002/2010).		HAW. CODE R. § 16-171-312 (2005/2012).
Idaho		IDAHO CODE ANN. §§ 41-1501 to 41-1507 (1991).	
Illinois	215 ILL. COMP. STAT. 5/141a (1991/2003) (portions of model).		
Indiana		IND. CODE §§ 27-1-33-1 to 27-1-11 (1992/2013).	760 IND. ADMIN. CODE 1-52-1 to 1-52-7 (2007/2013).
Iowa		IOWA CODE §§ 510.1A to 510.10 (1991/2004).	IOWA ADMIN. CODE r. § 191-5.43 (1991).
Kansas		KAN. STAT. ANN. §§ 40-2,129 to 40-2,137 (1991/2005).	KAN. ADMIN. REGS. § 40-3-48 (1991/2006); § 40-1-41 (1993).
Kentucky		KY. REV. STAT. ANN. §§ 304.3-500 to 304.3-570 (1992).	
Louisiana		LA. REV. STAT. ANN. §§ 22:1621 to 22:1627 (1992/2009).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 1491 to 1498 (1993/1997).	
Maryland		MD. CODE ANN., INS. § 8-201 to 8-213 (1991/2001).	
Massachusetts		MASS. GEN. LAWS ch. 175, §§ 177F to 177L (1993).	
Michigan		MICH. COMP. LAWS §§ 500.1401 to 500.1419 (1990/1991).	

MANAGING GENERAL AGENTS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota		MINN. STAT. §§ 60H.01 to 60H.09 (1991/1995).	
Mississippi		MISS. CODE ANN. §§ 83-18-101 to 83-18-111 (1992).	
Missouri		MO. REV. STAT. §§ 375.147 to 375.153 (1991/1999).	MO. CODE REGS. ANN. tit. 20, §§ 200-10.100 to 200-10.600 (1991/2004).
Montana		MONT. CODE ANN. §§ 33-2-1601 to 33-2-1605 (1993).	
Nebraska	NEB. REV. STAT. §§ 44-4901 to 44-4910 (1993).		210 NEB. CODE R. § 59 (1991/2006).
Nevada		NEV. ADMIN. CODE §§ 683A.450 to 683A.560 (1990/2002).	
New Hampshire		N.H. REV. STAT. ANN. §§ 402-E:1 to 402-E:7 (1992/2003).	
New Jersey		N.J. STAT. ANN. §§ 17:22C-1 to 17:22C-10 (1993).	N.J. ADMIN. CODE §§ 11:17-6.1 to 11:17-6.8 (1993/2010).
New Mexico		N.M. STAT. ANN. §§ 59A-12B-1 to 59A-12B-8 (1993).	
New York		N.Y. COMP. CODES & REGS. tit. 11, § 33 (1985/2003) (Regulation 120).	
North Carolina		N.C. GEN. STAT. § 58-34-2 (1991/2001).	
North Dakota	N.D. CENT. CODE §§ 26.1-26.3-01 to 26.1-26.3-07 (1991/1993); BULLETIN 2003-2 (2003).		
Northern Marianas	NO CURRENT ACTIVITY		

MANAGING GENERAL AGENTS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio		OHIO REV. CODE ANN. §§ 3905.71 to 3905.79 (1991/1997).	OHIO ADMIN. CODE 3901-3-10 (1993).
Oklahoma		OKLA. STAT. tit. 36, §§ 1471 to 1478 (1991/2012).	
Oregon		OR. REV. STAT. §§ 744.300 to 744.316 (1992/2003.	OR. ADMIN. R. 836-71-315 to 836-71-320 (1992).
Pennsylvania		40 PA. STAT. ANN. §§ 322.1 to 322.7 (1994).	
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		R.I. GEN. LAWS §§ 27-51-1 to 27-51-9 (1992/1996).	
South Carolina		S.C. CODE ANN. §§ 38-44-10 to 38-44-80 (1992/2004).	
South Dakota		S.D. CODIFIED LAWS §§ 58-30-124 to 58-30-139 (1992).	
Tennessee	TENN. CODE ANN. §§ 56-6-501 to 56-6-510 (1991/1992).		
Texas		28 TEX. ADMIN. CODE §§ 19.1201 to 19.1206 (1991).	TEX. INS. CODE ANN. §§ 4053.001 to 4053.152 (2005).
Utah		UTAH CODE ANN. §§ 31A-23a-601 to 31A-23a-605 (1992/2003).	BULLETIN 93-1 (1993).
Vermont	VT. STAT. ANN. tit. 8, §§ 4815 to 4824 (1992/1993).		VT. STAT. ANN. tit. 8, §§ 6070 to 6075 (1994) (managing general agents for risk retention groups); 4-3 VT. CODE R. § 25 (1994).
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 31-771 to 31-793 (2016).
Virginia		VA. CODE ANN. §§ 38.2-1358 to 38.2-1364 (1992/2001).	ADMIN. LETTER 2002-11 (2002).

MANAGING GENERAL AGENTS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington		WASH. REV. CODE ANN. §§ 48.98.005 to 48.98.901 (1993/2005).	WASH. ADMIN. CODE 284-12-200 to 284-12-280 (1993).
West Virginia	W. VA. CODE §§ 33-37-1 to 33-37-7 (1992/2014).		
Wisconsin		WIS. ADMIN. CODE INS. §§ 42.01 to 42.07 (1993/2006).	
Wyoming		WYO. STAT. ANN. §§ 26-46-101 to 26-46-107 (1992).	WYO. ADMIN. CODE 044.0002.29 (1988/1997).

PROJECT HISTORY - 2002

MANAGING GENERAL AGENTS MODEL ACT (#225)

1. Project Description

The Managing General Agents Model Act provides the basic regulatory framework for monitoring producers who have been classified as Managing General Agents (MGAs). While the initial review of the model act was begun to help create a reciprocal licensing system for MGAs, regulators and interested parties recognized that MGAs, in most states, must first be licensed producers and would be afforded licensing reciprocity under the reciprocity provisions of the NAIC Producer Licensing Model Act. In addition to reviewing licensing reciprocity for MGAs, the working group revised the model act to clarify the definition of an MGA, modify the bond requirements for MGAs, and update the duties of an insurer.

2. Group Responsible for Drafting Model and States Participating

The Agent Licensing Working Group of the Market Conduct and Consumer Affairs (D) Committee was responsible for revising the model act. Gene Reed (DE) and Sam Meyer (SD) co-chaired the working group. The following states were members of the working group: Alabama, Alaska, Arizona California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington and Wisconsin.

To help facilitate the drafting process, the Agent Licensing Working Group appointed the Managing General Agents Model Act Subgroup. Gene Reed (DE) chaired this subgroup. The initial subgroup was comprised of Nebraska, South Dakota and Texas. As the drafting process proceeded all members of the Agent Licensing Working Group were invited to join the subgroup.

The MGA subgroup, the Agent Licensing working group and the Market Regulation & Consumer Affairs (D) Committee unanimously adopted the revisions to the model act.

3. Charge Authorizing Project

The D Committee had the following charge during 2001: Appoint a working group to complete the review of the existing NAIC Managing General Agents Model Act and Third Party Administrator Statute. Consider modifications to the models to recognize that there have been and will be changes that will impact the delivery systems of insurance products and that this changing environment will require flexibility in regulating the production of insurance through various methodologies and technologies. Report by the NAIC Fall National Meeting.

4. General Description of Drafting Process

The drafting process was very open as the working group and subgroup solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group and subgroup also solicited key concerns from interested parties and funded consumer representatives. All of the meetings and conference calls of the working group, subgroup and the Market Conduct and Consumer Affairs (D) Committee were open to all interested parties. All revised drafts of the paper were posted on the NAIC website and circulated for public comment. The working group and subgroup received and reviewed numerous comments from interested parties.

5. Significant Issues Raised

The definition of an MGA was modified to provide a claim settlement threshold of $10,000. The prior version of the model act provided each state insurance commissioner with the discretion to determine the claim settlement threshold amount. Greater uniformity regarding what producers fall within the classification of an MGA should be achieved through a uniform claim settlement threshold amount. A drafting note was added to the model act to clarify that some producers may consider themselves MGAs even though they do not legally meet the criteria of being an MGA and thus subject to additional regulatory oversight.

The bond requirement was modified to be a be a minimum of $100,000 or ten percent (10%) of the managing general agent's total annual written premium nationwide for each insurer for which it acts as an MGA for the prior calendar year, not to

exceed $500,000 for each insurer. The bond shall be kept on file with each insurer with which the managing general agent has a contract.

The requirement for an insurer to maintain on file a financial examination of each MGA with which it does business was modified to coincide with the financial responsibility requirements of the recently revised Third Party Administrator Statute. The MGA model act now requires the insurer to have on file an independent audited annual financial statement or reports for the two (2) most recent fiscal years that prove that the MGA has a positive net worth. If the MGA has been in existence for less than two (2) fiscal years, the MGA shall include financial statements or reports, certified by an officer of the MGA and prepared in accordance with GAAP.

6. Other Pertinent Information

While there are a handful of states that issue a separate MGA license, the majority of states classify currently licensed producers as MGAs. Because of this, MGAs are already afforded licensing reciprocity under the reciprocity provisions of the NAIC Producer Licensing Model Act.

The revisions to the model act should help ensure states classify producers as MGAs in a uniform manner. In addition, the modifications to the bond requirements and financial responsibility requirements should help ensure greater regulatory oversight and financial stability of MGAs.

PUBLIC ADJUSTER LICENSING MODEL ACT

Table of Contents

Section 1. Purpose and Scope

This Act governs the qualifications and procedures for the licensing of public adjusters. It specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first party claims.

Drafting Note: It is recommended that any statute or regulation inconsistent with this Act be repealed or amended.

Drafting Note: This Act also requires a report to the insurance commissioner of any action in another jurisdiction against either the public adjuster license or licensee.

Section 2. Definitions

A. "Apprentice public adjuster" means the one who is qualified in all respects as a public adjuster except as to experience, education and/or training.

B. "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

C. "Catastrophic disaster" according to the Federal Response Plan, means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; and severely affects state, local and private sector capabilities to begin and sustain response activities. A catastrophic disaster shall be declared by the President of the United States or the Governor of the state or district in which the disaster occurred.

D. "Fingerprints" for the purposes of this act, means an impression of the lines on the finger taken for purpose of identification. The impression may be electronic or in ink converted to electronic format.

E. "Home state" means the District of Columbia and any state or territory of the United States in which the public adjuster's principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the 'home state.'

F. "Individual" means a natural person.

G. "Person" means an individual or a business entity.

H. "Public adjuster" means any person who, for compensation or any other thing of value on behalf of the insured:

(1) Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(2) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as an public adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(3) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

I. "Uniform individual application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Individual Application for resident and nonresident individuals.

J. [Optional] "Uniform business entity application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities.

Drafting Note: Subsection J is optional and would apply only to those states that have a business entity license requirement.

Drafting Note: If any term is similarly defined in a relevant section of the state's insurance code, do not include the definition of the term in this Act or, in the alternative, reference the statute: "[term] is defined in [insert appropriate reference to state law or regulation]."

Section 3. License Required

A. A person shall not act or hold himself out as a public adjuster in this state unless the person is licensed as a public adjuster in accordance with this Act.

B. A person licensed as a public adjuster shall not misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster unless so appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging that specific claimant a fee when appointed by the insurer and the appointment is accepted by the public adjuster.

C. A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the insurance commissioner shall find that:

(1) The business entity has paid the fees set forth in [insert appropriate reference to state law or regulation; and

(2) The business entity has designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

Drafting Note: Subsection C is optional and would apply only to those states that have a business entity license requirement.

D. Notwithstanding subsection A through C, a license as a public adjuster shall not be required of the following:

(1) An attorney-at-law admitted to practice in this state, when acting in his or her professional capacity as an attorney;

(2) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

(3) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers and handwriting experts;

(4) A licensed health care provider, or employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

(5) A person who settles subrogation claims between insurers.

Section 4. Application for License

A. A person applying for a public adjuster license shall make application to the commissioner on the appropriate uniform application or other application prescribed by the commissioner.

B. The applicant shall declare under penalty of perjury and under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief.

C. In order to make a determination of license eligibility, the insurance commissioner is authorized to require fingerprints of applicants and submit the fingerprints and the fee required to perform the criminal history record checks to the state identificationbureau (or state department of justice public state agency) and the Federal Bureau of Investigation (FBI) for state and national criminal history record checks; the insurance commissioner shall require a criminal history record check on each applicant in accordance with this Act. The insurance commissioner shall require each applicant to submit a full set of fingerprints in order for the insurance commissioner to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(1) The insurance commissioner may contract for the collection, transmission and resubmission of fingerprints required under this section. If the commissioner does so, the fee for collecting, transmitting and retaining fingerprints shall be payable directly to the contractor by the person. The insurance commissioner may agree to a reasonable fingerprinting fee to be charged by the contractor.

(2) The insurance commissioner may waive submission of fingerprints by any person that has previously furnished fingerprints and those fingerprints are on file with the Central Repository of the National Association of Insurance Commissioners (NAIC), its affiliates or subsidiaries.

(3) The insurance commissioner is authorized to receive criminal history record information in lieu of the [insert reference to Department of Justice/Public Safety Agency] that submitted the fingerprints to the FBI.

(4) The insurance commissioner is authorized to submit electronic fingerprint records and necessary identifying information to the NAIC, its affiliates or subsidiaries for permanent retention in a centralized repository. The purpose of such a centralized repository is to provide insurance commissioners with access to fingerprint records in order to perform criminal history record checks.

Drafting Note: The FBI requires that fingerprints be submitted to the state Department of Law Enforcement, Public Safety or Criminal Justice for a check of state records before the fingerprints are submitted to the FBI for a criminal history check. The FBI recommends all fingerprint submissions to be in an electronic format. The FBI has approved the language in Section 4 (C) to authorize a state identification bureau to submit fingerprints on behalf of its applicants in conjunction with licensing and employment.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.
Drafting Note: This provision does not permit the sharing of criminal history record information with the NAIC or other insurance commissioners as such sharing of information is prohibited by 28 CFR 20.33.

Section 5. Resident License

A. Before issuing a public adjuster license to an applicant under this section, the commissioner shall find that the applicant:

(1) Is eligible to designate this state as his or her home state or is a nonresident who is not eligible for a license under Section 8;

(2) Has not committed any act that is a ground for denial, suspension or revocation of a license as set forth in Section 11;

(3) Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the commissioner;

(4) Is financially responsible to exercise the license and has provided proof of financial responsibility as required in Section 12 of this Act;

(5) Has paid the fees set forth in [insert appropriate reference to state law or regulation]; and

(6) Maintains an office in the home state of residence with public access by reasonable appointment and/or regular business hours. This includes a designated office within a home state of residence.

B. In addition to satisfying the requirements of Subsection A, an individual shall

(1) Be at least eighteen (18) years of age; and

(2) Have successfully passed the public adjuster examination.

(3) Designate a licensed individual public adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state; and

(4) Designate only licensed individual public adjusters to exercise the business entity's license.

Drafting Note: Subsection C is optional and would apply only to those states that have a business entity license requirement. C's PLMA Section 6B.

C. The commissioner may require any documents reasonably necessary to verify the information contained in the application.

Section 6. Examination

A. An individual applying for a public adjuster license under this act shall pass a written examination unless exempt pursuant to Section 7. The examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the commissioner.

B. The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in [insert appropriate reference to state law or regulation].

C. Each individual applying for an examination shall remit a non-refundable fee as prescribed by the commissioner as set forth in [insert appropriate reference to state law or regulation].

D. An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

Drafting Note: A state may wish to prescribe by regulation limitations on the frequency of application for examination in addition to other prelicensing requirements.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.

Section 7. Exemptions from Examination

A. An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in another state based on an public adjuster examination shall not be required to complete any prelicensing examination. This exemption is only available if the person is currently licensed in that state or if the application is received within twelve (12) months of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records or records maintained by the NAIC, its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed in good standing.

B. A person licensed as a public adjuster in another state based on an public adjuster examination who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to Section 5. No prelicensing examination shall be required of that person to obtain a public adjuster license.

C. An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in this state shall not be required to complete any prelicensing examination. This exemption is only available if the application is received within twelve (12) months of the cancellation of the applicant's previous license in this state and if, at the time of cancellation, the applicant was in good standing in this state.

Drafting Note: If the state has adopted the Producer Licensing Model Act , it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.

Section 8. Nonresident License Reciprocity

A. Unless denied licensure pursuant to Section 11, a nonresident person shall receive a nonresident public adjuster license if:

(1) The person is currently licensed as a resident public adjuster and in good standing in his or her home state;

(2) The person has submitted the proper request for licensure, has paid the fees required by [insert appropriate reference to state law or regulation] [NAIC's PLMA Section 8A(2)], and has provided proof of financial responsibility as required in Section 12 of this Act;

(3) The person has submitted or transmitted to the commissioner the appropriate completed application for licensure; and

(4) The person's home state awards non-resident public adjuster licenses to residents of this state on the same basis.

B. The commissioner may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

C. As a condition to continuation of a public adjuster license issued under this section, the licensee shall maintain a resident public adjuster license in his or her home state. The non-resident public adjuster license issued under this section shall terminate and be surrendered immediately to the commissioner if the home state public adjuster license terminates for any reason, unless the public adjuster has been issued a license as a resident public adjuster in his or her new home state. Notification to the state or states where non-resident license is issued must be made as soon as possible, yet no later that thirty (30) days of change in new state resident license. Licensee shall include new and old address. A new state resident license is required for non-resident licenses to remain valid. The new state resident license must have reciprocity with the licensing non-resident state(s) for the non-resident license not to terminate.

Drafting Note: If the state has adopted the PLMA, it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.

Section 9. License

A. Unless denied licensure under this Act, persons who have met the requirements of this Act shall be issued a public adjuster license.

B. A public adjuster license shall remain in effect unless revoked, terminated or suspended as long as the request for renewal and fee set forth in [insert appropriate reference to state law or regulation] is paid and any other requirements for license renewal are met by the due date.

C. The licensee shall inform the commissioner by any means acceptable to the commissioner of a change of address, change of legal name, or change of information submitted on the application within thirty (30) days of the change.

D. A licensed public adjuster shall be subject to [cite state's Unfair Claims Settlement Act and state's Trade Practices and Fraud sections of the Insurance Code].

E. A public adjuster who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal, be issued a new public adjuster license upon the commissioner's receipt of the request for renewal. However, a penalty in the amount of double the unpaid renewal fee shall be required for the issue of the new public adjuster license. The new public adjuster license shall be effective the date the commissioner receives the request for renewal and the late payment penalty.

F. Any public adjuster licensee that fails to apply for renewal of a license before expiration of the current license shall pay a lapsed license fee of twice the license fee and be subject to other penalties as provided by law before the license will be renewed. If the Department receives the request for reinstatement and the required lapsed license fee within sixty (60) days of the date the license lapsed, the Department shall reinstate the license retroactively to the date the license lapsed. If the Department receives the request for reinstatement and the required lapsed license fee after sixty (60) days but within one year of the date the license lapsed, the Department shall reinstate the license prospectively with the date the license is reinstated. If the person applies for reinstatement more than one year from date of lapse, the person shall reapply for the license under this Act.

G. A licensed public adjuster that is unable to comply with license renewal procedures due to military service, a long-term medical disability, or some other extenuating circumstance, may request a waiver of those procedures. The public adjuster may also request a waiver of any examination requirement, fine, or other sanction imposed for failure to comply with renewal procedures.

Drafting Note: References to license "renewal" should be deleted in those states that do not require license renewal.

H. The license shall contain the licensee's name, city and state of business address, personal identification number, the date of issuance, the expiration date, and any other information the commissioner deems necessary.

I. In order to assist in the performance of the commissioner's duties, the commissioner may contract with non-governmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees and data, related to licensing that the commissioner may deem appropriate.]

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.

Section 10. Apprentice Public Adjuster License [Optional]

A. The apprentice public adjuster license is an optional license to facilitate the training necessary to ensure reasonable competency to fulfill the responsibilities of a public adjuster as defined in [insert state statute].

B. The apprentice public adjuster license shall be subject to the following terms and conditions:

(1) An attestation/certification from a licensed public adjuster (licensee) shall accompany an application for an initial apprentice public adjuster license assuming responsibility for all actions of such applicant;

(2) The apprentice public adjuster is authorized to adjust claims in the state that has issued licensure only;

(3) The apprentice public adjuster shall not be required to take and successfully complete the prescribed public adjuster examination;

(4) The licensee shall at all times be an employee of a public adjuster and subject to training, direction, and control by a licensed public adjuster;

(5) The apprentice public adjuster license is for a period not to exceed twelve (12) months, the license shall not be renewed;

(6) The licensee is restricted to participation in factual investigation, tentative closing and solicitation of losses subject to the review and final determination of a licensed public adjuster;

(7) Compensation of an apprentice public adjuster shall be on a salaried or hourly basis only; and

(8) The licensee shall be subject to suspension, revocation, or conditions in accordance with [Insert State Laws].

Section 11. License Denial, Non-renewal or Revocation

A. The commissioner may place on probation, suspend, revoke or refuse to issue or renew a public adjuster's license or may levy a civil penalty in accordance with [insert appropriate reference to state law] or any combination of actions, for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(2) Violating any insurance laws, or violating any regulation, subpoena, or order of the commissioner or of another state's insurance commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted or been found to have committed any insurance unfair trade practice or insurance fraud;

(8) Using fraudulent, coercive or dishonest practices; or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(9) Having an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district or territory;

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(11) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license;

(12) Knowingly accepting insurance business from an individual who is not licensed but who is required to be licensed by the commissioner;

(13) Failing to comply with an administrative or court order imposing a child support obligation; or

(14) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

Drafting Note: Paragraph (14) is for those states that have a state income tax.

B. In the event that the action by the commissioner is to deny an application for or not renew a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the non-renewal or denial of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner within [insert appropriate time period from state's administrative procedure act] for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within [insert time period from state law] and shall be held pursuant to [insert appropriate reference to state law].

C. The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the commissioner nor corrective action taken.

D. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine according to [insert appropriate reference to state law].

E. The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this Act and Title [insert appropriate reference to state law] against any person who is under investigation for or charged with a violation of this Act or Title [insert appropriate reference to state law] even if the person's license or registration has been surrendered or has lapsed by operation of law.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this section. The state may want to amend its relevant insurance producer statute to include public adjusters.

Section 12. Bond or Letter of Credit

Prior to issuance of a license as a public adjuster and for the duration of the license, the applicant shall secure evidence of financial responsibility in a format prescribed by the insurance commissioner through a security bond or irrevocable letter of credit:

A. A surety bond executed and issued by an insurer authorized to issue surety bonds in this state, which bond:

(1) Shall be in the minimum amount of $20,000;

(2) Shall be in favor of this state and shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices in his or her capacity as a public adjuster; and

(3) Shall not be terminated unless at least thirty (30) days' prior written notice will have been filed with the commissioner and given to the licensee.

A. An irrevocable letter of credit issued by a qualified financial institution, which letter of credit:

(1) Shall be in the minimum amount of $20,000;

(2) Shall be to an account to the commissioner and subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, failure to act, fraudulent acts, or unfair practices in his or her capacity as a public adjuster; and

(3) Shall not be terminated unless at least thirty (30) days' prior written notice will have been filed with the commissioner and given to the licensee.

C. The issuer of the evidence of financial responsibility shall notify the commissioner upon termination of the bond or letter of credit, unless otherwise directed by the commissioner.

D. The commissioner may ask for the evidence of financial responsibility at any time he or she deems relevant.

E. The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

Section 13. Continuing Education

A. An individual, who holds a public adjuster license and who is not exempt under Subsection B of this section, shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, including ethics, reported on a biennial basis in conjunction with the license renewal cycle.

B. This section shall not apply to:

(1) Licensees not licensed for one full year prior to the end of the applicable continuing education biennium; or

(2) Licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this state on the same basis.

C. Only continuing education courses approved by the commissioner shall be used to satisfy the continuing education requirement of Subsection A.

Section 14. Public Adjuster Fees

A. [Optional] A public adjuster may charge the insured a reasonable fee as determined by state law [insert appropriate reference to state law or regulation].

Drafting Note: This model designates Section 14A as optional. A majority of the states do not require a cap on fees of public adjusters.

B. A public adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed under this Act and is not so licensed.

C. A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed under this Act and is not so licensed.

D. A public adjuster may pay or assign commission, service fees or other valuable consideration to persons who do not investigate or settle claims in this state, unless the payment would violate [insert appropriate reference to state law, i.e. citation to anti-rebating statute or sharing commission statute, if applicable].

E. [Optional] In the event of a catastrophic disaster, there shall be limits on catastrophic fees, no public adjuster shall charge, agree to or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to more than ten percent (10%) of any insurance settlement or proceeds. No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit, or other thing of value, prior to settlement of a claim.

Drafting Note: This model designates Section 14E, as optional. It is recommended that the states that establish catastrophic fees utilize the recommended language in this model.

Section 15. Contract Between Public Adjuster and Insured

A. Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

(1) Legible full name of the adjuster signing the contract, as specified in Department of Insurance records;

(2) Permanent home state business address and phone number;

(3) Department of Insurance license number;

(4) Title of "Public Adjuster Contract";

(5) The insured's full name, street address, insurance company name and policy number, if known or upon notification;

(6) A description of the loss and its location, if applicable;

(7) Description of services to be provided to the insured;

(8) Signatures of the public adjuster and the insured;

(9) Date contract was signed by the public adjuster and date the contract was signed by the insured;

(10) Attestation language stating that the public adjuster is fully bonded pursuant to state law; and

(11) Full salary, fee, commission, compensation or other considerations the public adjuster is to receive for services.

B. The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

(1) If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

(2) Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured.

(3) Compensation provisions in a public adjusting contract shall not be redacted in any copy of the contract provided to the commissioner. Such a redaction shall constitute an omission of material fact in violation of [insert reference to relevant state law].

C. If the insurer, not later than seventy-two (72) hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

(1) Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

(2) Inform the insured that loss recovery amount might not be increased by insurer; and

(3) Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

D. A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any other party who is involved in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, including but not limited to any ownership of, other than as a minority stockholder, or any compensation expected to be received from, any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm which that provides estimates for work, or that performs any work, in conjunction with damages caused by the insured loss on which the public adjuster is engaged. The word "firm" shall include any corporation, partnership, association, joint-stock company or person.

E. A public adjuster contract may not contain any contract term that:

(1) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as percentage of each check issued by an insurance company;

(2) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

(3) Imposes collection costs or late fees; or

(4) Precludes a public adjuster from pursuing civil remedies.

F. Prior to the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

(1) Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. There are three (3) types of adjusters that could be involved in that process. The definitions of the three types are as follows:

(a) "Company adjuster" means the insurance adjusters who are employees of an insurance company. They represent the interest of the insurance company and are paid by the insurance company. They will not charge you a fee.

(b) "Independent adjuster" means the insurance adjusters who are hired on a contract basis by an insurance company to represent the insurance company's interest in the settlement of the claim. They are paid by your insurance company. They will not charge you a fee.

(c) "Public adjuster" means the insurance adjusters who do not work for any insurance company. They work for the insured to assist in the preparation, presentation and settlement of the claim. The insured hires them by signing a contract agreeing to pay them a fee or commission based on a percentage of the settlement, or other method of compensation.

(2) The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to do so.

(3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, and the insurer's attorney, or any other person regarding the settlement of the insured's claim.

(4) The public adjuster is not a representative or employee of the insurer.

(5) The salary, fee, commission or other consideration is the obligation of the insured, not the insurer.

G. The contracts shall be executed in duplicate to provide an original contract to the public adjuster, and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the commissioner.

H. The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

I. The public adjuster shall give the insured written notice of the insured's right as provided in [cite the state consumer protection laws].

J. The insured has the right to rescind the contract within three (3) business days after the date the contract was signed. The rescission shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three (3) business day period.

K. If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within fifteen (15) business days following the receipt by the public adjuster of the cancellation notice.

Drafting Note: The details in this section should comply with your state's consumer protection contract rescission law.

Section 16. Escrow or Trust Accounts

A public adjuster who receives, accepts or holds any funds on behalf of an insured, towards the settlement of a claim for loss or damage, shall deposit the funds in a non-interest bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

Section 17. Record Retention

A. A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section shall include the following:

(1) Name of the insured;

(2) Date, location and amount of the loss;

(3) Copy of the contract between the public adjuster and insured;

(4) Name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;

(5) Itemized statement of the insured's recoveries;

(6) Itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;

(7) A register of all monies received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees transfers and disbursements from a trust account and all transactions concerning all interest bearing accounts;

(8) Name of public adjuster who executed the contract;

(9) Name of the attorney representing the insured, if applicable, and the name of the claims representatives of the insurance company; and

(10) Evidence of financial responsibility in a format prescribed by the insurance commissioner.

B. Records shall be maintained for at least five (5) years after the termination of the transaction with an insured and shall be open to examination by the commissioner at all times.

C. Records submitted to the commissioner in accordance with this section that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the commissioner and shall not be subject to [insert reference to open record laws] of this state.

Section 18. Standards of Conduct of Public Adjuster

A. A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty the interest of his client alone; and to render to the insured such information, counsel and service, as within the knowledge, understanding and opinion in good faith of the licensee, as will best serve the insured's insurance claim needs and interest.

B. A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

C. A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this Act.

D. A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, unless full written disclosure has been made to the insured as set forth in Section 15G .

E. A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer as set forth in Section 15G.

F. The public adjuster shall abstain from referring or directing the insured to get needed repairs or services in connection with a loss from any person, unless disclosed to the insured:

(1) With whom the public adjuster has a financial interest; or

(2) From whom the public adjuster may receive direct or indirect compensation for the referral.

Drafting Note: Optional language for Subsection F: "Licensees may not solicit a client for employment between the hours of ___ pm and ___ am."

G. The public adjuster shall disclose to an insured if he or she has any interest or will be compensated by any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop or any other firm that performs any work in conjunction with damages caused by the insured loss. The word "firm" shall include any corporation, partnership, association, joint-stock company or individual as set forth in Section 15A(4).

H. Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing including the source and amount of any such compensation.

I. Public adjusters shall adhere to the following general ethical requirements:

(1) A public adjuster shall not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the public adjuster's current expertise;

(2) A public adjuster shall not knowingly make any oral or written material misrepresentations or statements which are false or maliciously critical and intended to injure any person engaged in the business of insurance to any insured client or potential insured client;

(3) No public adjuster, while so licensed by the Department, may represent or act as a company adjuster, or independent adjuster on the same claim;

Drafting Note: If a state only allows licensure in one class of adjuster licensing, the adjuster may not represent another type of licensure in any circumstance.

(4) The contract shall not be construed to prevent an insured from pursuing any civil remedy after the three-business day revocation or cancellation period;

(5) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work; and

(6) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

J. A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

Section 19. Reporting of Actions

A. The public adjuster shall report to the commissioner any administrative action taken against the public adjuster in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

B. Within thirty (30) days of the initial pretrial hearing date, the public adjuster shall report to the commissioner any criminal prosecution of the public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

Drafting Note: If the state has adopted the Producer Licensing Model Act , it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include public adjusters.

Section 20. Regulations

The commissioner may, in accordance with [insert appropriate reference to state law], promulgate reasonable regulations as are necessary or proper to carry out the purposes of this Act.

Section 21. Severability

If any provisions of this Act, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date

This Act shall take effect [insert date]. Provided, however that the provision of Section 4 do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

Drafting Note: A minimum of six months to one-year implementation time for proper notice of changes, fees, and procedures is recommended.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2005 Proc. 2nd Quarter 698 (adopted by parent committee).
2005 Proc. 3rd Quarter 26, 35-49 (amended and adopted by Plenary).

NAIC Public Insurance Adjuster Surety Bond Sample

BOND NO. _____

Know All Persons by These Presents:

That we, _____as Principal, whose address is _____ _____and _____as Surety, being a surety company authorized to do business in the State of _____re bound to the _____ Department of Insurance in the sum of $10,000.00 as specified at [insert reference to state law or regulation]. The specified sum is payable to the [insert state] Department of Insurance for the use and benefit of any customer of the above described Principal and as defined by the [insert state] Insurance Code, [insert citation] in acceptable currency of the United States in accordance with the statutory provision cited above. By this instrument, we jointly and severally firmly bind ourselves, out heir s, executors, administrators, successors and assigns.

The conditions of the above obligations are:

Whereas the above named Principal has applied to the [insert state] Department of Insurance for a license as a Public Insurance Adjuster to engage in or continue the business of insurance as a Public Insurance Adjuster in accordance with the [insert state] Insurance Code;

Now, Therefore, should the Principal discharge losses that result from any final judgment recovered against the Principal by any customer, this obligation will become void. If this obligation is not void, it remains in full force and effect, subject to the following conditions:

1. As of _____, 20_____, this bond will be in full force and effect indefinitely. Continuation or renewal certificates are unnecessary.

2. The surety may, at any time, terminate this bond by submitting written notice to the [insert state] Department of Insurance thirty (30) days prior to the termination date. The surety, however, remains liable for any defaults under this bond committed prior to the termination date.

3. In no event will the aggregate liability of the Surety under this bond, for any or all damages to one or more claimants, exceed the penal sum of this bond.

In Witness Whereof said Principal and Surety have executed this bond this _____day of _____ , 20___ to be effective the _____day of _____, 20 _____.

_____
PRINCIPAL

_____
BY

_____
ADDRESS

_____
SURETY

PUBLIC ADJUSTER LICENSING MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PUBLIC ADJUSTER LICENSING MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-281 to 20-302 (2001); §§ 20-321 to 20-321.02 (2001/2021).
Arkansas			ARK. CODE ANN. § 23-64-209 (1959/2017).
California	CAL. INS. CODE §§ 10000 to 15001 (1985/2017); §§ 15006 to 15013; §§ 15016 to 15018; §§ 15024 to 15030; §§ 15033 to 15037; § 15039.5; § 15043; §§ 15056 to 15059 (1985/2017).		BULLETIN 2013-2 (2013).
Colorado			COLO. REV. STAT. § 10-2-417 (1995/2014); 3 COLO. CODE REGS. §§ 702-1: 1-2-4 (1993/2015); 702-1:1-2-10 (1995/2015); 702-1:1-2-19 (2014).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut			CONN. GEN. STAT. § 38a-723 (1990/2010); § 38a-769; § 38a-771; § 38a-774; § 38a-788 (1949/2023); CONN. AGENCIES REGS. §§ 38a-788-1 to 788-8 (1984/2020)
Delaware	DEL. CODE ANN. tit. 18, §§ 1750 to 1761 (1995/2022); 18 DEL. ADMIN. CODE 504 (2004/2015). (portions of model).		
District of Columbia	D.C. CODE ANN. §§ 31-1631.01 to 31-1631.12 (2002/2010); D.C. MUN. REGS. tit. 26, §§ 3900 to 3999 (2003). (portions of model).		
Florida	FLA. STAT. § 626.015 (2003/2023); § 626.112 (2003/2021); § 626.221; §§ 626.851 to 626.854 (1959/2023); § 626.8561; § 626.8582; §§ 626.864 to 626.8651 (1959/2022); §§ 626.8698 to 626.871 (1959/2012); §§ 626.8732 to 626.8738 (2003/2012); §§ 626.875 to 626.8796 (1990/2023); FLA. ADMIN. CODE ANN. r. 69B-220.001 to 69B-220.201 (1993/2014). (portions of model).		
Georgia			GA. CODE ANN. §§ 33-23-1; 33-23-6; §§ 33-23-43 to 33-23-43.2 (1992/2014); GA. COMP. R. & REGS. 12-2-3-.06 to 12-2-3-.07 (1982/2016); 120-2-3-.09 (2003/2018); 120-2-3-.11 to 120-2-3-.12 (1996/2016); 120-2-3-.15 to 120-2-3-.18 (2004/2016); 120-2-3-.25 (1992/2018); 120-2-3-.34 to 120-2-3-.37 (1992/2012).
Guam	NO CURRENT ACTIVITY		

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	HAW. REV. STAT. § 431:9-101; § 431:9-105; § 431:9-201; §§ 431:9-203 to 431:9-204 (1987/2017); §§ 431:9-206 to 431:9-209; §§ 431:9-222 to 431:9-230; §§ 431:9-235 to 431:9-244 (1987/2021). (portions of model).		
Idaho	IDAHO CODE ANN. §§ 41-5801 to 5821 (2008).		
Illinois	215 ILL. COMP. STAT. §§ 5/1501 to 5/1615 (2010/2014).		215 ILL. COMP. STAT. §§ 5/512.51 to 5/512.64 (1983/2003).
Indiana			IND. CODE §§ 27-1-27-1 to 27-1-27-11 (1983/2023).
Iowa	IOWA ADMIN. CODE r. 191-55.1 to 191-55.21 (2007).		IOWA CODE §§ 522C.1 to 522C.6 (2007).
Kansas	KAN. STAT. ANN. §§ 40-5501 to 40-5519 (2009).		
Kentucky			KY. REV. STAT. ANN. §§ 304.9-020; § 304.9-105 to 304.9-107; §§ 304.9-120 to 304.9-133; § 304.9-140; §§ 304.9-150 to 304.9-210; § 304.9-260; § 304.9-295; §§ 304.9-350 to 304.9-360; §§ 304.9-373 to 304.9-377; § 304.9-390; §§ 304.9-421 to 304.9-435; §§ 304.9-440 to 304.9-450; §§ 304.9-465 to 304.9-467 (1970/2013); 806 KY. ADMIN. REGS. 9:030 (1975/2010); 9:220 (1995/2011).
Louisiana	LA. REV. STAT. ANN. §§ 22:1691 to 22:1708 (2006/2012).		LA. REV. STAT. ANN. § 22:1476 (2003); LA. ADMIN. CODE tit. 37, Pt XI, § 709 (2011); Pt XIII, §§ 15501 to 15525 (2018); Notice 9-2-2005 (#1) (2005) (registration requirement).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1401 to 1413 (2001/2012); §§ 1416-A to 1419; § 1424-A; §§ 1471 to 1476 (2001/2014); § 1482 (1997/2005); BULLETIN 433 (2019).
Maryland			MD. CODE ANN., INS. § 27-405 (1997/2009); §§ 10-401 to 10-416 (1995/2017) (portions of model).
Massachusetts			MASS. GEN. LAWS ch. 175 § 162 (1941/2005); §§ 172 (1941/2005).
Michigan			MICH. COMP. LAWS §§ 338.821 to 338.851 (1965/2008).
Minnesota			MINN. STAT. §§ 72B.01 to 72B.06; §§ 72B.11 to 72B.14; § 72B.135 (1971/2014).
Mississippi	MISS. CODE ANN. §§ 83-17-501 to 83-17-527 (2007/2016); 19 MISS. CODE R. §§ 36.01 to 36.14 (2007/2012); A.G. OPINION Sept. 14, 2005 (2005); BULLETIN 2006-10 (2006) (portions of model).		
Missouri			MO. REV. STAT. §§ 325.010 to 325.055 (1973/2008); MO. CODE REGS. ANN. tit. 20 §§ 100-1.100; §§ 700-2.005 to 700-2.300 (2006/2008).
Montana			MONT. CODE ANN. § 33-17-102 (1959/2017); §§ 33-17-301to 33-17-303 (1959/2017); §§ 33-17-1203 to 33-17-1205 (1993/2015); MONT. ADMIN. R. 6.6.1601 to 6.6.1613 (1983/2018).
Nebraska	NEB. REV. ST. §§ 44-9201 to 9219 (2018).		NEB. REV. STAT. §§ 44-2606 to 44-2635 (1980/1989).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada			NEV. REV. STAT. §§ 684A.010 to 684A.050; §§ 684A.060 to 684A.150; §§ 684A.170 to 684A.190; §§ 684A.210 to 684A.260 (1971/2001); BULLETIN 2010-001 (2010).
New Hampshire	N.H. REV. STAT. ANN. §§ 402-D:1 to 402-D:21 (1975/2012) (portions of model).		N.H. ADMIN. CODE INS. 1302.01 to 1302.05 (2007/2015).
New Jersey			N.J. STAT. ANN. §§ 17:22B-1 to 17:22B-20 (1993/2011); N.J. ADMIN. CODE §§ 11:1-37.1 to 11:1-37.19 (1994/2001); BULLETIN 2011-10 (2011).
New Mexico			N.M. STAT. ANN. §§ 59A-13-1 to 59A-13-17 (1984/2023); N.M. CODE R. § 13.4.7 (2018); BULLETIN 2000-011 (2000); BULLETIN 2012-002 (2012).
New York			N.Y. INS. LAW §§ 2101 to 2102; § 2108 (1998/2023); §§ 2110 to 2111 (1984/2022); § 2132 (2009/2018); N.Y. COMP. CODES R. & REGS. tit. 11, § 25.1 to 25.13 (1986/2021); Circular Letter 1993-17 (1993); OFF. GEN. COUNS. Opinion No. 2004-114 (2004); 2005-16; 2005-92; 2005-120; 2005-194; 2005-229; 2005-300 (2005); 6-20-2006 (# 2); 8-2-2006 (# 3) (2006); 10-4-2006 (2006); 6-22-2009 (2009).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	N.C. GEN. STAT. §§ 58-33A-1 to 58-33A-95 (2009/2013).		N.C. GEN. STAT. §§ 58-33-1 to 58-33-10 (1987/2009); §§ 58-33-26 to 58-33-35 (1987/2009); §§ 58-33-46 to 58-33-50 (1988/2009); 11 N.C. ADMIN. CODE § 6A.0906 (1996/2006); BULLETIN 04-B-3 (2004); BULLETIN 05-B-1 (2005); Memorandum 11-4-2010 (2010); Memorandum 2-3-2014 (#1) (2014).
North Dakota	N.D. CENT. CODE §§ 26.1-26.8-01 to 26.1-26.8-22 (portions of model).		N.D. CENT. CODE §§ 26.1-26-01 to 26.1-26-13 (1981/2001); § 26.1-26-31.1 (1985/2009).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3951.01 to 3951.10; 3951.99 (2001/2021); OHIO ADMIN. CODE r. 3901:1-24 (1972/2022); BULLETIN 2008-7 (2008).
Oklahoma			OKLA. STAT. tit. 36, § 1435.18; §§ 6201 to 6223 (1973/2023); BULLETIN PC-2013-05 (2013).
Oregon			OR. REV. STAT. § 744.505; § 744.515; §§ 744.525 to 744.528; §744.538 (1953/2020); OR. ADMIN. R. § 836–071–010; §§ 836–071–0130 to 836–071–0135 (2020).
Pennsylvania			63 PA. STAT. ANN. §§ 1601 to 1608 (1983/2012); 31 PA. CODE §§ 115.1 to 115.4; §§ 115.7 to 115.21 (2003/2012).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico			P.R. LAWS ANN. tit. 26, § 949f (2006/2014); § 949i (2006/2014); §§ 949m to 950h (2006/2014); §§ 951p to 952b (2006/2014); § 953b (2006/2014); §§ 953f to 953h (2006/2014); P.R.R. RULE IV Art. 1 to IV Art. 3 (1966/2003); CIRCULAR LETTER CC-2018-1931-D (2018).
Rhode Island	R.I. GEN. LAWS §§ 27-10-1 to 27-10-14 (1956/2014); 230-20 R.I. CODE R. §§ 50-4.1 to 50-4.14 (2019) (portions of model).		BULLETIN 2023-2 (2023).
South Carolina			S.C. CODE ANN. §§ 38-48-10 to 38-48-160 (2000/2016); BULLETIN 1-2001 (2001); A.G. Opinion 77-384 (1977).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. CODE ANN. §§ 56-6-901 to 56-6-920 (2006/2016); TENN. COMP. R. & REGS. 0780-1-91 (2007).		A.G. Opinion No. 05-133 (2005).
Texas			TEX. INS. CODE ANN. § 4102.001 to 4102.208 (2005/2021); 28 TEX. ADMIN. CODE §§ 19.701 to 19.713 (1984/2023).
Utah			UTAH CODE ANN. §§ 31A-26-101 to 31A26-102 (1985/2021); §§ 31A-26-201 to 31A-26-215 (1985/2020); § 31A-26-304 (1985); § 31A-26-311 (1986); §§ 31A-26-401 to 31A-26-403 (2017); UTAH ADMIN. CODE r. 590-102-3 (1986/2023).
Vermont			VT. STAT. ANN. tit. 8, § 4791; § 4793; §§ 4795 to 4798; §§ 4800 to 4800a; §§ 4803 to 4813o (1874/2019).

PUBLIC ADJUSTER LICENSING MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1845.1 to 38.2-1845.23 (2012/2014).		VA. CODE ANN. §§ 38.2-812 to 38.2-815 (2012); ADMIN. LETTER 2012-10 (2012).
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 751 to 758; § 765; § 768; §§ 774 to 793 (1968/2017).
Washington			WASH. REV. CODE ANN. § 48.17.010; § 48.17.060 (2009/2010); §§ 48.17.090 to 48.17.170; §§ 48.17.380 to 48.17.390 (2009/2010); §§ 48.17.410 to 48.17.430 (2009/2021); §§ 48.17.450 to 48.17.568 (1947); BULLETIN 90-3 (1990).
West Virginia	W. VA. CODE §§ 33-12B-1 to 33-12B-12 (1988/2021; W. VA. CODE R. §§ 114-25-1 to 114-25-20 (1990/2021).		)
Wisconsin	WIS. STAT. ANN. §§ 629.01 to 629.13 (2020).		
Wyoming			WYO. STAT. ANN. § 26-9-202; § 26-9-219; § 26-9-231; § 26-23-102 (1967/2023).

PROJECT HISTORY – 2005

PUBLIC ADJUSTER LICENSING MODEL ACT (#228)

1. Description of the Project, Issues Addressed, etc.

The Public Adjuster Licensing Model Act provides the basic regulatory framework for the qualifications and procedures for the licensing of Public Adjusters. The model statute specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first party claims.

2. Name of Group Responsible for Drafting the Model and States Participating

The Producer Licensing Working Group of the Market Regulation and Consumer Affairs (D) Committee was responsible for drafting the model act. Gene Reed (DE), Laurie Wolf (ND) and Jack Chaskey (NY) co-chaired the working group. The following states were members of the working group: Alaska, Arizona Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

To help facilitate the drafting process, the Producer Licensing Working Group appointed the Uniform Adjuster Licensing Model Act Subgroup. Gene Reed (DE) and Treva Wright-Donnell (KY) co-chaired this subgroup. The subgroup was comprised of the following states: Alaska, District of Columbia, Illinois, Indiana, Louisiana, Michigan, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The charge for the Producer Licensing (D) Working Group reads as follows: "Appoint a working group to develop and implement uniform standards, interpretations and treatment of producer licensees and licensing terminology; coordinate and consult with the National Insurance Producer Registry Board of Directors to develop and implement uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology; develop a Uniform Adjuster Licensing Model Act; and monitor and respond to developments related to licensing reciprocity." The group first received the charge for the Public Adjuster Model Act in March 2003.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open to comments and participation by all interested parties. Representatives from the insurance producer industry participated fully in the process and discussion sessions. All revised drafts of the model were circulated for public comment. Comments were received on each draft of the model and considered by the subgroup in open conference calls and meetings. The subgroup received and reviewed numerous comments from interested parties. The process resulted in a total of 19 revised drafts.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Copies of every draft were posted on the NAIC website or distributed by e-mail along with the solicitation for public comment. The Producer Licensing (D) Working Group adopted this model on May 22, 2005.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Industry representatives expressed concerns about the proposed cap on fees. In response, several surveys were distributed to the states to determine existing state caps on fees. Many states do not impose a fee limit; however, the states do have a fee limit preferred to have a fee limit established in the model. As a compromise, section 14 of the model act specifies "a public adjuster may charge the insured a reasonable fee as determined by state law." Additionally, the model act specifies that section 14 is optional.

The initial drafts of the model act included a section on Duties of Insurer, which included the insurer's duty to verify the licenses status of a public adjuster. Industry representatives indicated this requirement puts an undue burden upon the insurer. This section also included a mandate that the insurer issue all checks to the insured and public adjuster. It was later recognized that legitimate situations could arise in which the insurer issues a check to a party other than the insured and public adjuster outside of these two parties. In response, the subgroup agreed to remove this section from the model.

Finally, there was a proposed Apprentice Public Adjuster License section. A survey was conducted to determine what states had an apprentice program in place for adjusters. Based on state responses, the subgroup agreed to list this section as optional.

7. Any Other Important Information (e.g., amending an accreditation standard).

Pam Young from AIA brought up an issue after the model was adopted, relative language in section 15 of the PA Model Act. The language restricted the Insurers ability to contact the Insured, after a contract was executed between the Insured and the Public Adjuster. AIA proposed striking the language, the subcommittee chairs agreed that this restriction was not the groups intent. This change was vetted to Regulators, National Association of Public Insurance Adjusters (NAPIA), and American Association of Public Insurance Adjusters (AAPIA) who also agreed to striking the language.

> Section 15. Contract Between Public Adjuster and Insured (**Page 14 of PA Model Act #19)**
>
> F. (1) (c) (3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, and the insurer's attorney, or any other person regarding the settlement of the insured's claim.

This model will assist industry in complying with the licensing requirements for public adjusters. The development of the model was based upon the NAIC's Producer Licensing Model Act.

TITLE INSURANCE AGENT MODEL ACT

Drafting Note: This model Act should be adopted concurrently with the Title Insurers Model Act because the Acts contain many complementary provisions and both Acts are required to provide sufficient regulation of title insurance.

Table of Contents

Section 1. Title and Purpose

A. This Act shall be known and may be cited as the [insert state] Title Insurance Agent Act.

B. The purpose of this Act is to provide the state of [insert state] with a comprehensive body of law for the effective regulation and supervision of title insurance agents.

Section 2. Definitions

As used in this Act, unless the context otherwise requires:

A. "Abstract of title" or "abstract" means a written history, synopsis or summary of the recorded instruments affecting the title to real property.

B. "Associate" means any:

(1) Business organized for profit in which a producer of title business is a director, officer, partner, employee or an owner of a financial interest;

(2) Employee of a producer of title business;

(3) Franchiser or franchisee of a producer of title business;

(4) Spouse, parent or child of a producer of title insurance business who is a natural person;

(5) Person, other than a natural person, that controls, is controlled by, or is under common control with, a producer of title business;

(6) Person with whom a producer of title insurance business or any associate of the producer has an agreement, arrangement or understanding, or pursues a course of conduct, the purpose or effect of which is to provide financial benefits to that producer or associate for the referral of business.

C. "Bona fide employee" of the title insurer or title insurance agent means an individual who devotes substantially all of his or her time to performing services on behalf of a title insurer or title insurance agent and whose compensation for these services is in the form of salary or its equivalent paid by the title insurer or title insurance agent.

D. "Commissioner" means the insurance commissioner of [insert name of state], or the commissioner's representatives or the commissioner, director or superintendent of insurance in any other state.

E. "Controlled business" means any portion of a title insurance agent's business written in this state that was referred to it by a producer of title insurance business or by an associate of the producer, where the producer or associate, or both, have a financial interest in the title insurance agent.

F. "Escrow" means written instruments, money or other items deposited by one party with a depository, escrow agent or escrow for delivery to another party upon the performance of a specified condition or the happening of a certain event.

G. "Financial interest" means a direct or indirect interest, legal or beneficial, where the holder is or will be entitled to five percent (5%) or more of the net profits or net worth of the entity in which the interest is held.

H. "Foreign title insurer" means a title insurer incorporated or organized under the laws of any other state of the United States, the District of Columbia, or any other jurisdiction of the United States.

I. "Non-U.S. title insurer" means a title insurer incorporated or organized under the laws of any foreign nation or any foreign province or territory.

J. "Person" means a natural person, partnership, association, cooperative, corporation, trust or other legal entity.

K. "Producer" means a person, including an officer, director or owner of five percent (5%) or more of the equity or capital of any person, engaged in this state in the trade, business, occupation or profession of:

(1) Buying or selling interests in real property;

(2) Making loans secured by interests in real property; or

(3) Acting as broker, agent, representative or attorney of a person who buys or sells an interest in real property or who lends or borrows money with the interest as security.

L. "Qualified financial institution" means an institution that is:

(1) Organized or (in the case of a U.S. branch or agency office of a foreign banking organization) licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers;

(2) Regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies;

(3) Insured by the appropriate federal entity; and

(4) Qualified under any additional rules established by the commissioner.

M. "Referral" means the directing or the exercising of any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

N. "Security" or "security deposit" means funds or other property received by the title insurance agent as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which a title insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

O. "Title insurance agent" or "agent" means an authorized person, other than a bona fide employee of the title insurer who, on behalf of the title insurer, performs the following acts, in conjunction with the issuance of a title insurance report or policy:

(1) Determines insurability and issues title insurance reports or policies, or both, based upon the performance or review of a search, or an abstract of title; and

(2) Performs one or more of the following functions:

(a) Collects or disburses premiums, escrow or security deposits or other funds;

(b) Handles escrow, settlements or closings;

(c) Solicits or negotiates title insurance business; or

(d) Records closing documents.

P. "Title insurance business" or "business of title insurance" means:

(1) Issuing as insurer or offering to issue as insurer a title insurance policy;

(2) Transacting or proposing to transact by a title insurance agent any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(a) Soliciting or negotiating the issuance of a title insurance policy;

(b) Guaranteeing, warranting or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units and proprietary leases and for all liens or charges affecting the same;

(c) Handling of escrow, settlements or closings;

(d) Executing title insurance policies;

(e) Effecting contracts of reinsurance; or

(f) Abstracting, searching or examining titles;

(3) Guaranteeing, warranting or insuring searches or examinations of title to real property or any interest in real property;

(4) Guaranteeing or warranting the status of title as to ownership of or liens on real property and personal property by any person other than the principals to the transaction; or

(5) Doing or proposing to do any business substantially equivalent to any of the activities listed in this subsection in a manner designed to evade the provisions of this Act.

Q. "Title insurance policy" or "policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or any interest in real property, against loss or damage arising from any or all of the following conditions existing on or before the policy date and not excepted or excluded:

(1) Defects in or liens or encumbrances on the insured title;

(2) Unmarketability of the insured title;

(3) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the stated property;

(4) Lack of legal right of access to the land; or

(5) Unenforceability of rights in title to the land.

R. "Title insurance report" or "report" means a preliminary report, commitment or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy.

S. "Title insurance sub-agent" or "sub-agent" means a person, other than a bona fide employee of a title insurance agent who, on behalf of the title insurance agent, determines insurability and issues title insurance reports or policies, or both, based upon the performance or review of a search or abstract of title, provided that the performance of actual legal services such as title examination or closing services by a licensed attorney does not render the attorney a sub-agent.

T. "Title insurer" or "insurer" means a company organized under laws of this state for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in this state to transact the business of title insurance.

U. "Underwrite" means the authority to accept or reject risk on behalf of the title insurer.

Section 3. Licensing Requirements

A. A person shall not act in the capacity of a title insurance agent and a title insurer may not contract with any person to act in the capacity of a title insurance agent with respect to risks located in this state unless the person is a licensed title insurance agent in this state or possesses a license acceptable to the commissioner and issued by this state.

Drafting Note: Although a state agency other than the department of insurance might issue a limited license for one or more recognized agent functions, this does not imply a right of a licensed person to perform other agent functions unless lawfully licensed as a title insurance agent under the terms of this Act. For example, a state may wish to require licensing or registration of persons handling escrow accounts.

Drafting Note: States may want to expand this section to include competence, character, and integrity requirements; application procedures; fee requirements; procedures for withdrawal from the state and continuing education requirements. General state insurance licensing laws should also be considered and perhaps cross-referenced or incorporated into this subsection.

B. An individual employed by a licensed insurance agent to whom the agent delegates authority to act on that agent's behalf shall be either individually licensed or be named on the employing agent's license. Each person named on the license shall possess all qualifications determined by the commissioner to be appropriate. The commissioner may adopt rules, regulations, and requirements relating to licensing and practices of persons acting in the capacity of title insurance agents. These persons may include title insurance agents, employees of title insurance agents, and persons acting on behalf of title insurance agents. This subsection is not intended to include persons performing clerical functions.

C. (1) Every title insurance agent licensed in this state shall:

(a) Disclose on all correspondence that the agent is acting in a capacity as agent for a particular named underwriter; and

(b) Exclude or eliminate the word "insurer" or "underwriter" or similar term from its agency's name; and

(c) Provide, in a timely fashion, each title insurer with which it places business any information the title insurer requests in order to comply with reporting requirements of the commissioner.

(2) A title insurance agent licensed in this state prior to the effective date of this Act shall have ninety (90) days after the effective date of this Act to comply with the requirements of this subsection.

D. (1) The commissioner shall require the title insurance agent and any delegate performing the title search to maintain the following for the benefit of the title insurer in amounts commensurate with the agent's average exposure, under terms and conditions, and from insurers acceptable to the commissioner:

(a) An errors and omission policy which includes coverage for an agent's delegation of any agent functions; and

(b) Fidelity coverage if the agent handles escrow or security deposits.

(2) The commissioner may promulgate rules specifying acceptable alternatives to the preceding insurance requirements. The availability of closing or settlement protection shall not be construed to be an acceptable alternative to the requirements of this subsection.

E. (1) If the title insurance agent delegates the title search to a third party, such as an abstract company, the agent must first obtain proof that the third party:

(a) Is covered by or maintains the errors and omissions coverage required by Subsection D; and

(b) Is operating in compliance with rules and regulations established by the commissioner; and

(2) The third party shall provide the agent and the insurer with access to and the right to copy all accounts and records maintained by the third party with respect to business placed with the title insurer.

Section 4. Examination of Title Insurance Agents

The commissioner may, during normal business hours, examine, audit and inspect any and all books and records maintained by a title insurance agent under the provisions of this Act. However, if the title insurance agent is a depository institution, the commissioner shall have the power to examine and investigate the insurance activities of the depository in order to determine whether the depository institution has complied with the provisions of this Act. The commissioner shall notify the appropriate federal banking agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate federal banking agency of the suspected violations of state law, if any, prior to commencing the examination or investigation.

Drafting Note: This provision is intended to confer the authority to conduct examinations on an exception basis in the event of regulatory interest in a particular agency. States may wish to add a section requiring the regular periodic examination of agents and specifying the party conducting the examination and the party responsible for the cost of the examination. Such a section should include a hardship provision conferring authority on the commissioner to adopt rules reducing the frequency of periodic audits in the case of small agents. Further, in cases where the commissioner believes that access to the non-insurance related books and records of a depository institution is necessary, the commissioner must request this information from the functional regulator of the depository institution through the information-sharing agreements that currently exist.

Section 5. Prohibition of Rebate and Fee Splitting

A. A title insurance agent or other person shall not provide or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other service provided by a title insurance agent. However, if the title insurance agent or other person is a depository institution, or an affiliate of a depository institution, the title insurance agent or other person may make a payment to its unlicensed employees for referrals so long as the unlicensed employee does not discuss specific insurance policy terms and conditions. Further, in the case of a referral of a customer of the depository institution, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases title insurance from the licensed title insurance agent. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction.

Drafting Note: The last sentence of this paragraph further limits the referral for customers of personal, family and household insurance products, such as title insurance sold to individuals or families, as a result of Section 305 of the Gramm-Leach-Bliley Act and the subsequent adoption of regulations by the federal banking regulators at 12 CFR 14.50, 208.85, 343.50 and 536.50. The language in the paragraph was drafted to be consistent with the Gramm-Leach-Bliley Act and the federal regulations while maintaining the integrity of Section 104(d)(2)(B)(iv) and (v) of the Gramm-Leach-Bliley Act. Further, the NAIC crafted this language to be consistent with the provisions of Section 8 of the Real Estate Settlement Procedures Act (RESPA) in that it allows some exceptions specified in 12 USC 2607(c)(2).

[Optional Subsection B]

[B. A title insurance agent doing business in the same county as a title insurer or title insurance agent who may be in violation of the prohibitions or limitations of this section shall have a cause of action against the violating title insurer or title insurance agent or recipient and, upon establishing the existence of a violation, shall be entitled to injunctive relief as the court may deem necessary or desirable to prevent violations of this section in the future. In any action under this subsection, the court may award to the successful party the court costs of the action together with reasonable attorney fees.]

Drafting Note: "County" in the preceding subsection refers to counties, boroughs or parishes defined by the state.

Section 6. Controlled Business Provisions

A. Whenever the business to be written constitutes controlled business, prior to commencing the transaction, the title insurance agent shall ensure that its customer has been provided with disclosure of the existence of the controlled business arrangement and a written estimate of the charge or range of charges generally made for the title services provided by the agent.

B. The commissioner may establish rules for use by all title insurance agents in the recording and reporting of the agent's owners and of the agent's ownership interests in other persons or businesses and of material transactions between the parties.

C. The commissioner may require each title insurance agent to file on forms prescribed by the commissioner, reports setting forth the names and addresses of those persons, if any, that have a financial interest in the agent and who the agent knows or has reason to believe are producers of title insurance business or associates of producers.

[First Optional Subsection D]

D. Nothing in this act shall be construed as prohibiting controlled business arrangements in the provision of title insurance business so long as:

(1) The title insurance agent or party making a referral constituting controlled business, at or prior to the time of the referral, discloses the arrangement and, in connection with the referral, provides the person being referred with a written estimate of the charge or range of charges likely to be assessed and otherwise complies with the disclosure obligations of this section;

(2) The person being referred is not required to use a specified title insurance agent or insurer; and

(3) The only thing of value that is received by the title insurance agent or party making the referral, other than payments otherwise permitted, is a return on an ownership interest. For purposes of this subsection, the terms "required use" and "return on an ownership interest" shall have the meaning accorded to them under the Real Estate Settlement Procedures Act (RESPA), 12 U.S.C. § 2607, as amended and Regulation X, 24 C.F.R. § 3500 et seq.

Drafting Note: See drafting note following Third Optional Subsection D.

[Second Optional Subsection D]

[D. (1) A title insurance agent shall not accept an order for or issue a title insurance policy or guarantee or provide services to an applicant for title insurance or receive or retain any money in connection with a title insurance transaction, if:

(a) The title insurance agent knows or has reason to believe that the transaction will constitute controlled business; and

(b) When added to other controlled business written by the title insurance agent during the same calendar year, the aggregate controlled premiums written will exceed twenty percent (20%) of the title insurance agent's gross premiums written during the preceding calendar year. However, the twenty percent (20%) limitation shall be eighty percent (80%) in the first year after the effective date of this Act, sixty percent (60%) in the second calendar year after the effective date of this Act and forty percent (40%) in the third calendar year after the effective date of this Act.

(2) This provision does not apply if the title insurance agent is also a depository institution, or if the title insurance agent is affiliated with a depository institution.]

Drafting Note: See drafting note following third optional Subsection D.

[Third Optional Subsection D]

[D. (1) In addition to the requirements of Section 3D, the commissioner shall require the title insurance agent to maintain for the benefit of the title insurer, insured or the depositor, pursuant to terms and conditions to be prescribed by the commissioner, in amounts commensurate with the agent's average exposure and the volume and nature of its business, a sufficient net worth to ensure the agent's solvency and commitment to the purpose of being a bona-fide title insurance agent.

(2) In determining the precise amounts and terms and conditions of the above-described requirement, the commissioner may promulgate rules that:

(a) Specify acceptable alternatives to the preceding net worth requirements; and

(b) Exempt certain persons from complying with all or a portion of these requirements by virtue of their actual or expected volume of business (e.g., less than fifty (50) annual transactions or less than $5,000,000 in title insurance policies face value, or other amounts the commissioner may deem appropriate) or by virtue of individual circumstances that show that the requirements would pose an undue hardship on the title insurance agent and that the title insurance agent's conduct will be bona-fide and its services needed and desirable.

(3) The commissioner shall also require each title insurance agent to perform through its bona-fide employees the core title services listed below in order to receive compensation for the services it renders:

(a) The evaluation of a title search or abstract to determine the insurability of title;

(b) The clearance of underwriting objections; and

(c) Issuing and assuming responsibility for the issuance of the title insurance policy, and where customary, issuance of a title commitment.]

Drafting Note: Controlled title insurance business may or may not raise concerns and issues in a particular state and therefore, each state should decide whether and how to address this issue. The First, Second and Third Optional Subsections present three approaches. Their language should not be read to preclude other approaches or to suggest that any particular provision is necessarily desirable. Because in the Third Optional Subsection, the particular requirements that are appropriate are likely to vary from state to state, and possibly within areas of a single state, this provision is intended to permit the commissioner to set appropriate levels for net worth requirements with due regard for the prevailing circumstances and factors in each state or area.

Section 7. Favored Agent of Title Insurer

A title insurance agent shall not participate in any transaction in which it knows that a producer or other person requires, directly or indirectly, or through a trustee, director, officer, agent, employee or affiliate, as a condition, agreement or understanding to selling or furnishing any other person a loan, or loan extension, credit, sale, property, contract, lease or service, that the other person shall place a title insurance policy of any kind with particular title insurer or through particular title insurance agent.

Section 8. Required Provisions of Underwriting Contract with Title Insurer

A person, firm, association or corporation acting in the capacity of a title insurance agent shall not place business with a title insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party; and where both parties share responsibility for a particular function, specifies the division of such responsibilities; and which contains the following minimum provisions:

A. (1) The title insurer may terminate the contract upon written notice under the following circumstances:

(a) Fraud, insolvency, appointment of a receiver or conservator, bankruptcy, cancellation of the agent's license or permit to do business or the commencement of legal proceedings by the state of domicile of the agent, which if successful, would lead to cancellation of the agent's permit or license to do business;

(b) Material breach of any provision of the contract; or

(c) Notice of cancellation has been provided in accordance with contract termination requirements.

(2) Upon notice of termination, the agent shall immediately discontinue all underwriting. Nothing in this subsection is intended to relieve the title insurance agent or title insurer of any other contractual obligation.

B. The title insurance agent will render accounts to the title insurer detailing all transactions and remit all funds due under the contract to the title insurer by the earlier of the following:

(1) Forty-five (45) days after the end of the month of the effective date of the policy; or

(2) Within the time specified by the underwriting contract.

C. All funds collected for the account of a title insurer by a title insurance agent shall be held in a fiduciary capacity in a bank that is a qualified financial institution. A separate and exclusive account shall be established and maintained for each underwriter represented by the title insurance agent.

D. At the title insurer's request, the title insurance agent, its successor in interest, transferee, or receiver shall provide access to and the right to copy all escrow files and underwriting files involving a transaction in which a title insurance report or policy is or is to be issued.

Drafting Note: A possible conflict may exist in certain jurisdictions between the title insurance agent's fiduciary duty as the escrow holder to maintain the confidentiality of the information contained in the escrow files and the Section 8D requirement that the title insurance agent provide the title insurer access to and a right to copy the escrow files. If so, states may wish to adopt rules or regulations or establish requirements addressing the title insurance agent's need to recognize and address possible conflict.

E. Separate records of business written by the title insurance agent will be maintained for each title insurer. The title insurer shall have access to and a right to copy all accounts and records related to its business in a form acceptable to the title insurer. The commissioner shall have access to all books, bank accounts and records of the title insurance agent in a form usable to the commissioner. The records shall be retained according to Section [cite appropriate record retention statute] and Section 10 of this Act. However, if the title insurance agent is a depository institution, the commissioner shall only have access to the insurance-related books and records of that financial institution. In cases where the commissioner believes that access to the non-insurance related books and records of a depository institution is necessary, the commissioner must request this information from the functional regulator of the depository institution through the information-sharing

agreements that currently exist.

F. The contract may not be assigned in whole or in part by the title insurance agent without the expressed written consent of the title insurer.

G. Appropriate guidelines, relating to:

(1) The basis of the rates to be charged;

(2) The types of risks which may be written;

(3) Maximum limits of liability;

(4) Territorial limitations;

(5) Title searches, and examinations; and

(6) Underwriting.

H. It shall be the duty of the title insurance agent to immediately report and forward to the insurer all title-related escrow claims and title claims reported to the agent by policyholders or another person. However, if the contract permits the title insurance agent to settle claims on behalf of the title insurer:

(1) A copy of the claim file shall be sent to the title insurer at its request or as soon as it becomes known that the claim:

(a) Has the potential to exceed an amount established by the title insurer;

(b) Involves a coverage dispute;

(c) May exceed the title insurance agent's claims settlement authority;

(d) Is open for more than six (6) months; or

(e) Is closed by payment exceeding an amount established by the title insurer;

(2) All title and title-related escrow claims files settled by the agent will be the property of the title insurer;

(3) Any settlement authority granted to the title insurance agent may be terminated immediately upon the title insurer's written notice to the title insurance agent or upon the termination of the contract. The title insurer may suspend the settlement authority during the pendency of a dispute regarding the cause for termination. Nothing in this paragraph is intended to relieve the title insurance agent or title insurer of any other contractual obligation.

I. Where electronic claims files are in existence, the contract must address the immediate transmission of the data.

J. The title insurance agent shall not:

(1) Bind reinsurance or retrocessions on behalf of the title insurer;

(2) Permit a director, officer, controlling shareholder or employee to serve on the title insurer's board of directors if the agent wrote one percent (1%) or more of the title insurer's direct premiums written during the previous calendar year, as shown on the title insurer's most recent annual statement on file with the commissioner. This subsection shall not apply to relationships governed by the Insurance Holding Company Act.

(3) Jointly employ an individual who is employed with the title insurer unless the title insurer and the title insurance agent are affiliated or otherwise under common control as defined by Section [insert reference to insurance holding company act]; or

(4) Appoint a title insurance sub-agent.

K. The contract shall include specific terms of an agent's compensation.

L. The title insurance agent shall maintain an inventory of all policy forms or policy numbers assigned to the agent by the title insurer.

Drafting Note: See parallel provision in Section 11.

M. For each title insurance agent under contract with the insurer, the title insurer shall have on file a statement of financial condition, of each title insurance agent as of the end of the previous calendar year setting forth an income statement of business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31st certified by the agent as being a true and accurate representation of the agent's financial condition. Attorneys actively engaged in the practice of law, other than that related to title insurance business, are exempt from the requirements of this paragraph.

N. The title insurance agent shall annually, concurrent with the renewal date of its contract, furnish the title insurer with proof that the agent is in compliance with Section 3 of this Act.

O. If the title insurance agent delegates the title search to a third party, such as an abstract company, the agent must first obtain proof that the third party is operating in compliance with rules and regulations established by the commissioner.

P. The title insurance agent shall provide the insurer with access and the right to copy all accounts and records maintained by the title insurance agent with respect to business placed with the title insurer.

Section 9. Policyholder Treatment

A. When constituting an offer to issue an owner's title insurance policy covering the resale of owner-occupied residential property, a title insurance report shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the report cannot be delivered prior to the day of closing, the title insurer shall document the reasons for the delay. The report furnished to the purchaser-mortgagor shall incorporate the following statement on the first page in bold type:

Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land.

B. A title insurance agent issuing a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan, where no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the commissioner, to the purchaser-mortgagor at the time the commitment is prepared. The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage-lender, and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased. The notice shall explain what a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's policy. The notice shall also explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known. A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least five (5) years after the effective date of the policy.

Section 10. Conditions for Providing Escrow, Closing, or Settlement Services, and Maintaining Escrow and Security Deposit Accounts

A title insurance agent may operate as an escrow, security, settlement or closing agent, provided that:

A. All funds deposited with the title insurance agent in connection with an escrow, settlement, closing or security deposit shall be submitted for collection to or deposited in a separate fiduciary trust account or accounts in a qualified financial institution no later than the close of the next business day, in accordance with the following requirements:

(1) The funds shall be the property of the person or persons entitled to them under the provisions of the escrow, settlement, security deposit or closing agreement and shall be segregated for each depository by escrow, settlement, security deposit or closing in the records of the title insurance agent in a manner that permits the funds to be identified on an individual basis; and

(2) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

B. Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom such funds may be disbursed.

C. Funds held in a security deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurance agent with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions the commissioner may require.

D. Any interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid, net of administrative costs, to the depositing party, unless the instructions for the funds or a governing statute provides otherwise.

E. Disbursements may be made out of an escrow, settlement or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurance agent or the agent's depository;

(3) Checks, drafts, negotiable orders of withdrawal, money orders and any other item that has been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Federal Expedited Funds Availability Act, 12 U.S.C. § 4001, *et seq.*; or

(5) Credit transfers through the Automated Clearing House (ACH) which have been deemed available by the depository institution receiving the credits. The credits must conform to the operating rules set forth by the National Automated Clearing House Association (NACHA).

Drafting Note: States with an existing "good funds" statute should review it to determine if it is sufficient for application to title insurance business. If sufficient, Subsection E should be deleted and a cross-reference to the state good funds statute should be inserted. If the state good funds statute is insufficient, Subsection E should be retained and would be controlling for title insurance transactions.

F. The title insurance agent shall have an annual audit made of its escrow, settlement, closing and security deposit accounts, conducted by a certified public accountant on a calendar year basis at its expense within ninety (90) days after the close of the previous calendar year. The title insurance agent shall provide a copy of the audit report to each title insurance company which it represents. The commissioner may promulgate regulations setting forth the minimum threshold level at which an audit would be required, the standards of audit and the form of audit report required. Title insurance agents who are attorneys and who issue title insurance policies as part of their legal representation of clients are exempt from the requirements of this paragraph. However, the title insurer may, at its expense, conduct or cause to be conducted an annual audit of the escrow, settlement, closing and security deposit accounts of the attorney. Attorneys who are exclusively in the business of title insurance are not exempt from the requirements of this paragraph. The commissioner may also require the title insurance agent to provide a copy of its audit report to the commissioner.

G. If the title insurance agent is appointed by two (2) or more title insurers and maintains fiduciary trust accounts in connection with providing escrow, closing settlement services, the title insurance agent shall allow each title insurer reasonable access to the accounts and any or all of the supporting account information in order to ascertain the safety and security of the funds held by the title insurance agent.

H. Nothing in this Act shall be deemed to prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction, provided all parties consent to the transaction in writing.

I. Nothing in this section is intended to amend, alter, or supersede other sections of this Act, or the laws of this state or the United States, regarding an escrow holder's duties and obligations.

J. The commissioner may prescribe a standard agreement for escrow, settlement, closing or security deposit funds.

Section 11. Record Retention Requirements

The title insurance agent shall maintain sufficient records of its affairs, including its escrow operations and escrow trust accounts, so that the commissioner may adequately ensure that the title insurance agent is in compliance with all provisions of this Act. The commissioner may prescribe the specific record entries and documents to be kept, and the length of time for which the records must be maintained.

Drafting Note: States should ensure that their record-keeping requirements for the title insurance agency operations of depository institutions do not place the depository institutions in a position where they cannot comply with both the state requirements and the record-keeping requirements of the institution's primary functional regulator.

Section 12. Application of Other Insurance Code Sections to Title Insurance Agents

A title insurance agent shall be subject to all other applicable provisions of the insurance code unless specifically addressed by this Act and other state and federal law.

Section 13. Rules and Regulations

The commissioner may issue rules, regulations and orders necessary to carry out the provisions of this Act.

Section 14. Penalties and Liabilities

A. If the commissioner determines that the title insurance agent or any other person has violated this Act, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the commissioner may order:

(1) A penalty not exceeding $[insert amount] for each violation; and

(2) Revocation or suspension of the title insurance agent's license.

B. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to [insert state's rehabilitation or liquidation statute], and the receiver appointed under that order determines that the title insurance agent or any other person has not complied with this Act, or any related regulation or order, and the insurer suffered any resulting loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer and its policyholders and creditors.

Drafting Note: If state law does not otherwise provide, amend the bracketed citation in the preceding paragraph to include the rehabilitation or liquidation statute of any reciprocal state. This is intended to codify the standing of a receiver to maintain a civil action in a reciprocal state.

C. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance code.

Drafting Note: Each state should consider whether references to regulations or specific statutory chapters should replace "code" in this subsection.

D. Nothing contained in this Act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and creditors.

Section 15. Violations of the Real Estate Settlement Procedures Act (RESPA)

The commissioner or attorney general may bring an action in a court of competent jurisdiction to enjoin violations of RESPA, 12 U.S.C. Section 2607, as amended.

Section 16. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective as of [insert date] and applies to all activities or agreements of the title insurance agent engaged in or entered into after the effective date. The title insurance agent shall amend all existing agreements to comply with Section 8 of this Act within sixty (60) days from its effective date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 39, 695, 698, 710-719 (adopted).
2003 Proc.1st Quarter 45, 45-55 (amended and reprinted, adopted by working group).
2003 Proc. 2nd Quarter 12, 15 (adopted by Plenary

TITLE INSURANCE AGENT MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			§§ 27-25-1.1 to 27-25-10 (2005/2013); ALA. ADMIN. CODE r. 482-1-148-.01 to 482-1-148-.15 (2012).
Alaska			ALASKA STAT. § 21.66.270 (1974/1992); § 21.66.480 (2006).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1580 to 20-1590 (1967/1992).
Arkansas			ARK. CODE ANN. §§ 23-103-401 to 23-103-417 (2007/2013); CODE ARK. R. 054.00.87 (2010); BULLETIN 6-2013 (2013).
California			CAL INS. CODE § 12418 (2008); CAL. CODE REGS. tit. 10, 2194.50 to 2194.55 (2008/2009).
Colorado			COLO. REV. STAT. §§ 10-11-116 to 10-11-117 (1963/2012).
Connecticut			CONN. GEN. STAT. § 38a-413 (1990).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware			DEL. CODE ANN. tit. 18, § 1715 (1973/1992).
District of Columbia	D.C. CODE §§ 31-5041.01 to 31-5041.12 (2010/2013) (portions of model).		
Florida			FLA. STAT. §§ 626.841 to 626.8473 (1982/2012).
Georgia			GA. COMP. R. & REGS. 120-2-3-.25 (1992/2009).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. § 41-2710 (1973/2010).
Illinois			215 ILL. COMP. STAT. §§ 155/1 to 155/26 (1986/2014).
Indiana			BULLETIN 158 (2007).
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. §§ 40-1135 to 40-1141 (1999/2009) (portions of model).		KAN. STAT. ANN. § 40-2404 (1955/2005).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. REV. STAT. ANN. §§ 22:511 to 22:537 (1997/2006) (portions of model).		BULLETIN 3-3-2009 (2009).
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. § 10-121 (2009/2010); BULLETIN 18-2006 (2006).
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. COMP. LAWS §§ 500.7300 to 500.7318 (1956/1972).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	NO CURRENT ACTIVITY		
Mississippi			MISS. CODE ANN. § 83-15-3 (1892/1990).
Missouri			MO. REV. STAT. §§ 381.115 to 381.122 (2000); MO. CODE REGS. ANN. tit. 20, § 500-7.030 (2009); §§ 700-8.005 to 700-8.160 (2008); MEMORANDUM 5-27-2008 (2008).
Montana			MONT. CODE ANN. §§ 33-25-104 to 33-25-111 (1985/1989).
Nebraska	NEB. REV. STAT. §§ 44-19,106 to 44-19,123 (1997/2004).		210 NEB. ADMIN. CODE Ch. 34 (1994/2005).
Nevada			NEV. REV. STAT. §§ 692A.100 to 692A.270 (1977/2013).
New Hampshire			N.H. REV. STAT. ANN. § 416-A:15 (1971/2009).
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. STAT. ANN. §§ 59A-30-1 to 59A-30-15 (1985/1989); N.M. CODE R. §§ 13.14.1.1 to 13.14.10.19 (1996/2014).
New York			N.Y. INS. LAW §§ 2101 to 2139 (1984/2014); § 6409 (2014); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 35.1 to 35.9 (Reg. No. 206) (2014); GEN. COUNSEL OPINION 5-16-2006 (2006).
North Carolina			N.C. GEN. STAT. § 58-26-10 (1899/1993).
North Dakota			N.D. CENT. CODE § 26.1-20-01 (1983).
Northern Marianas	NO CURRENT ACTIVITY		

TITLE INSURANCE AGENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio			OHIO REV. CODE ANN. § 3953.22 (1971); OHIO ADMIN. CODE 3901-7-01 to 3901-7-04 (2007/2011).
Oklahoma			OKLA. STAT. tit. 36, § 5001 (1957/2013).
Oregon			OR. REV. STAT. § 744.086 (1979/1989) (only rate making and unfair trade practices laws apply to agents).
Pennsylvania			40 PA. STAT. ANN. §§ 910-1 to 910-55 (1992).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			BULLETIN 2010-6 (2010).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. § 56-35-201 (1989).
Texas			TEX. INS. CODE ANN. §§ 2651.001 to 2651.013 (2005/2009).
Utah			UTAH CODE ANN. § 31A-23a-204 (1985/2013); § 31A-23a-406 (1985/2013); BULLETIN 2012-1 (2012).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-1814.1 (1986/1989).
Washington			WASH. REV. CODE ANN. §§ 48.29.155 to 48.29.200 (1981/2005); WASH. ADMIN. CODE 284-29-100 to 284-29-340 (2009/2010).

TITLE INSURANCE AGENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			BULLETIN 4-30-2012 (2012).
Wyoming			WYO. STAT. ANN. § 26-23-316 to 26-23-324 (1983).

PROJECT HISTORY - 2003

TITLE INSURANCE AGENT MODEL ACT (#230)

1. What issues was the project intended to address?

On Feb. 1, 2001, the Kansas Insurance Department issued an opinion letter related to a request from a financial holding company asking whether certain provision of Kansas law were preempted by the Gramm-Leach-Bliley Act (GLBA). The opinion advised that certain portions of a Kansas law related to its controlled business provisions were preempted. A controlled business statute is one that limits the amount of business an agent can receive from a single source. It essentially means that any portion of a title insurance agent's business written that was referred to it by a producer of title insurance business or by an associate of the producer, where the producer or associate, or both, have a financial interest in the title insurance agent. A similar matter was referred by the Tennessee Department of Commerce and Insurance to the Tennessee Attorney General. In a similar fashion, the Tennessee Attorney General issued an opinion that certain Tennessee controlled business provisions were preempted. Since both of these state laws were based on the NAIC Title Insurance Agents Model Act, the Kansas Insurance Department and the Tennessee Department of Commerce and Insurance brought the matter to the attention of the NAIC through its then Functional Regulation (G) Working Group. The subgroup was appointed and asked to look at the title agent model and the Title Insurer Model Act for compliance with the GLBA.

Subsequently, the charge to the subgroup was expanded to look at any necessary update to the title agent act and the title act. Interested parties were invited to tender suggestions for changes to either of the models.

2. What states participated in drafting the model?

The following states are currently members of the subgroup: Tennessee (chair), Arkansas, California, Illinois, Kansas, Nebraska, North Dakota, Ohio, Oklahoma, Oregon, Utah, and Washington.

3. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?

The efforts of the subgroup were closely coordinated with all interested parties. In addition to open sessions at the quarterly meetings of the NAIC, five conference calls were held since Dec. 2002 to discuss the various submissions and drafts of the models. Notice of those conference calls was posted on the NAIC's home page on the Internet and e-mailed to everyone that expressed an interest in the project. Written comments were received from the Office of the Comptroller of the Currency, the McIntyre Law Firm on behalf of the American Bankers Insurance Association, the State of Utah and the American Land Title Association. Representatives of each organization along with several other interested parties participated in the meetings and conference calls. All meetings and conference calls were open to all participants.

4. What significant issues were raised during the drafting process, and how were those issues resolved?

Given the complexity of this topic and the myriad of discussions and opinions, it is impossible to put together a brief description that captures all of the issues raised and all of the detail underlying those issues. The reader is referred to the minutes of the subgroup for these details. This summary provides a broad overview and might omit various particulars of the project. However, the items below represent the major points of discussion:

A. Section 4 of the title agent act addresses the examination authority of the commissioner related to title insurance agents. It was amended to limit the commissioner's access to non-insurance books and records held by a depository institution. The model directs the commissioner to the information sharing agreements that have been entered into by most states and the OCC or other functional regulator when the title insurance agent is also a depository institution. These changes are similar to changes made last year to the NAIC's Unfair Trade Practices Act by the Functional Regulation Working Group.

B. Section 5A of the title agent act was amended to assure compliance with GLBA, regulations issued by federal banking regulators and Section 8 of the Real Estate Settlement Procedures Act (RESPA). It now allows payment of referral fees with express limitations provided in laws and regulations mentioned in the previous sentence. Similar modifications were made to the NAIC's Unfair Trade Practices Act last year.

C. The second optional Subsection D to Section 6 was amended so that it does not apply to depository institutions. This was the change that was required by the original charge regarding controlled business provisions. The subgroup

believed that it was preferable to keep controlled business provisions for entities other than depository institutions because they are intended to be an essential element of solvency protection for title insurers.

D. Section 8E of the title agent act addresses the business records requirements for title insurance agents. It was amended to limit the commissioner's access to non-insurance books and records held by a depository institution that is also a title insurance agent. The model directs the commissioner to the information sharing agreements that have been entered into by most states and the OCC or other functional regulator when the title insurance agent is also a depository institution.

E. A drafting note was added to Section 11 of the title agent act to suggest that states take steps to ensure that their record-keeping requirements for the title insurance agency operations of depository institutions do not place the depository institutions in a position where they cannot comply with both the state requirements and the record-keeping requirements of the institution's primary functional regulator.

F. Section 12 of the title agent act was amended to refer to other state and federal laws that may apply.

5. What are the implications of this project for accreditation and codification?

Since this project does not principally deal with solvency monitoring, there is no impact for accreditation and codification. However, there was concern expressed by subgroup members that modification of the controlled business provision could restrict the states' ability to monitor the solvency of title insurers. The subgroup observed that concentration of risk was a significant element in many past title insurer failures. The drafters believe that, at least for depository institutions that also operate as title insurance agents, particular attention should be paid to such title insurance agents in relationship to their risk concentration.

INTEREST-INDEXED ANNUITY CONTRACTS MODEL REGULATION

Table of Contents

Section 1. Definitions

"Interest-indexed annuity contract" means an annuity contract where the interest credits are linked to an external reference.

Section 2. Scope

This regulation applies only to individual annuity contracts.

Drafting Note: This regulation currently addresses only the indexing of interest credits. Should products be developed which involve the indexing of other factors such as expenses, this regulation may require modification.

Section 3. Initial Filing Requirements

The following information shall be submitted in connection with any filing of interest-indexed annuity contracts. All such information received shall be treated confidentially to the extent permitted by law.

A. A description of how the interest credits are determined, including:

(1) A description of the index;

(2) A provision for a substitute method of crediting interest if the index is discontinued; a substitute must be approved by the insurance department;

(3) A formula showing the derivation of the crediting rate based on the value of the index;

(4) The frequency and timing of determining the crediting rate; and

(5) The allocation of interest credits, if more than one crediting rate applies to different portions of the contract value;

B. A description of the insurer's investment policy, including:

(1) The amount and type of assets currently held for interest-indexed annuity contracts;

(2) An opinion by the insurer's actuary that the investments are appropriate considering the index being used;

(3) The amount (distribution) and type of assets expected to be acquired in the future for these contracts;

(4) How the insurer plans to address the risk that a sufficient quantity of appropriate investments may not be available; and

(5) How the insurer plans to address any mismatch risk inherent in the contract;

C. If contracts are to be linked to an index for some specified period less than the time to the maturity date of the contract, the date of expiration of the period and any minimum guaranteed rates that apply thereafter; and

D. A description of any interest guarantee in addition to or in lieu of the index and a description of how the insurer plans to address the risk that the indexed interest rate may fall below the minimum guarantee.

Section 4. Additional Filing Requirements

To the extent permitted by law, any material submitted as a result of the following requirements will be treated confidentially.

A. Prior to implementation, a domestic insurer shall submit a description of any material change in investment policy or method of determining the interest credits. A change is considered to be material if it would affect the form or definition of the index or if it would significantly change the amount or type of assets held for interest-indexed annuity contracts.

B. Annually, an insurer shall submit a description of the amount and type of assets currently held by the insurer to support its interest-indexed annuity contracts.

C. Annually, an insurer shall submit a Statement of Actuarial Opinion by the insurer's actuary that the assets under interest-indexed annuity products are sufficient to cover the contractual obligations under the contracts. If the insurer is unable to issue such an opinion, additional assets shall be allocated to these products so that an opinion can be submitted.

Drafting Note: The American Academy of Actuaries is developing guidelines that will delineate the responsibilities of the actuary in signing a Statement of Actuarial Opinion. Section 6 contains a sample Statement of Actuarial Opinion which the Advisory Committee believes will satisfy its guidelines. If necessary, this regulation should be revised to conform with the Academy's guidelines.

Section 5. Valuation Requirements

A. In filing the above items, the insurer demonstrates its ability to meet its future contractual obligations.

B. In developing life insurance reserves for interest-indexed annuity contracts, the insurer shall be in compliance with the minimum requirements of the standard valuation law of this state. If the insurer does not issue an opinion as required in Section 4C of this regulation, the minimum reserves for interest-indexed annuity business will be 115 percent of the minimum reserves otherwise required.

C. In the calculation of reserves for interest-indexed annuity contracts, future guarantees will be determined by assuming that future interest crediting rates will be equal to the statutory valuation interest rate for the contracts as defined in the standard valuation law.

Section 6. Statement of Actuarial Opinion for Interest-Indexed Annuity Contracts

I, _____ , am _____
(name) (position or relationship to insurer)

for the XYZ Life Insurance Company (the insurer) in the state of _____.
(state of domicile of insurer)

I am a member of the American Academy of Actuaries [or if not, state other qualifications to sign annual statement actuarial opinions].

I have examined the interest-indexed annuity contracts of the insurer in force as of December 31, 19XX, encompassing ____ [number of] contracts and $_____ of reserves.

I have considered the provisions of the contracts. I have considered the characteristics of the identified assets and the investment policy adopted by the insurer as they affect future insurance and investment cash flows under the contracts and related assets. My examination included such tests and calculations as I considered necessary to form an opinion concerning the insurance and investment cash flows arising from the contracts and related assets.

I relied on the investment policy of the insurer and on projected investment cash flows as provided by _____, Chief Investment Officer of the Insurer.

Drafting Note: If the actuary does not choose to rely on an investment officer for the projected investment cash flows, this statement should be modified to show the extent of the actuary's reliance. If the actuary has not examined the underlying records, but has relied on listings and summaries of contracts in force, an appropriate statement of such reliance should be included here.

The tests were calculated under various assumptions as to future interest rates, and particular attention was given to those provisions and characteristics that might cause future insurance and investment cash flows to vary with changes in the level of prevailing interest rates.

In my opinion, the anticipated insurance and investment cash flows referred to above make good and sufficient provision for the contractual obligations of the insurer under these contracts.

_____

Signature of Actuary

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1988 Proc. I 9, 19-20, 490-492, 600, 627 (adopted).

INTEREST-INDEXED ANNUITY CONTRACTS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INTEREST-INDEXED ANNUITY CONTRACTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADIOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			BULLETIN 82-5 (1982).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			BULLETIN 97-10 (1997).

INTEREST-INDEXED ANNUITY CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADIOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		

INTEREST-INDEXED ANNUITY CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADIOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont			BULLETIN 110 (1996); BULLETIN 121 (1998) (indexed life products).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

CHARITABLE GIFT ANNUITIES MODEL ACT

Section 1. Scope

This Act applies to charitable gift annuities issued by charitable organizations as herein defined and shall be known as the Charitable Gift Annuities Act.

Section 2. Definitions

A. (1) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes.

(2) "Charitable gift annuity" does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.

B. "Charitable organization" means an entity described by:

(1) Section 501(c)(3) Internal Revenue Code of 1986 [26 U.S.C. Section 501(c)(3)]; or

(2) Section 170(c), Internal Revenue Code of 1986 [26 U.S.C. Section 170(c)].

Section 3. Certificate of Authority

A. A charitable organization shall not receive transfer of property, conditioned upon its agreement to pay an annuity to the donor or other annuitant unless and until it has obtained from the commissioner a certificate of authority to issue charitable gift annuities.

B. A charitable organization shall file with the commissioner its application for a certificate of authority. The application shall be in form prescribed and furnished by the commissioner and shall be verified by two (2) of the applicant's officers. The application shall include or be accompanied by such proof as the commissioner may reasonably require that the applicant is qualified under this Act. At filing of the application the applicant shall pay to the commissioner the applicable filing fees as specified in [insert citation].

C. If after such investigation as the commissioner deems advisable, the commissioner finds that the applicant is in sound financial condition and is otherwise qualified, the commissioner shall issue to the applicant a certificate of authority. If the commissioner does not so find, the commissioner shall deny issuance of the certificate of authority and notify the applicant in writing stating the reasons for denial.

D. The certificate of authority of a charitable organization issued under this Act shall continue until suspended or revoked by the commissioner or terminated by the organization, subject to continuance each year by payment on or before March 1 of the continuance fee of $[insert amount] and filing of the annual report.

E. A person acting on behalf of a charitable organization to solicit the transfers of property in exchange for annuity payments shall not be required to be licensed; however, the person shall be authorized in writing by the charitable organization to act on its behalf. The charitable organization shall keep a file of current written authorizations.

Section 4. Surplus and Reserves

A. A charitable organization authorized by this Act shall maintain a segregated account for its charitable gift annuities. The assets of the account are not liable for any debts of the charitable organization other than those incurred pursuant to the issuance of charitable gift annuities. The assets of the account shall at least equal in amount the sum of the reserves on its outstanding annuities plus a surplus of ten percent (10%) of the reserves.

B. (1) Reserves on the outstanding annuities shall not be less than reserves calculated using:

(a) The Commissioner's Annuity Reserve Valuation Method as defined in the charitable organization's domestic state standard valuation law;

(b) Any mortality table permitted under the charitable organization's domestic state standard valuation law to be used in determining the minimum standard for the valuation of individual annuities issued during the same calendar year as the charitable gift annuity; and

(c) The maximum interest rate permitted under the charitable organization's domestic state standard valuation law to be used in determining the minimum standard for the valuation of individual annuities issued during the same calendar year as the charitable gift annuity.

(2) In determining the reserves, a deduction shall be made for any portion of the annuity risk that is reinsured by an authorized insurer or reinsurer. For this purpose, any annuity contract purchased from an authorized insurer or reinsurer by the charitable organization is considered to be "annuity risk reinsured."

C. The general assets of the charitable organization shall be liable for annuity agreements to the extent that the segregated account is inadequate.

Section 5. Investments

The segregated assets shall be invested in the same manner and subject to the same investment laws applicable to domestic life insurers found in [insert section].

Section 6. Annual Reports

A. A charitable organization authorized under this Act shall annually file a report verified by at least two (2) principal officers with the commissioner covering the preceding fiscal year. The report is due ninety (90) days after the close of the charity's fiscal year or at a later date approved by the commissioner.

B. The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year;

(2) Any material changes in the information;

(3) The number of gift annuity contracts issued during the year, the number of gift annuity contracts as of the end of the year and the number of gift annuity contracts that terminated during the year;

(4) The amount of annuity payments made during the year and the amounts transferred from the segregated account to the general account during the year; and

(5) Other information relating to the performance of the charitable gift annuity segment of the charitable organization necessary to enable the commissioner to:

(a) Issue certificates of authority;

(b) Ascertain maintenance of records;

(c) Evaluate solvency;

(d) Respond to consumer complaints; and

(e) Conduct hearings to determine compliance with this Act.

C. A copy of a report containing the information required in Subsection B that has been filed in the state of domicile of the charitable organization will be deemed to satisfy the requirement of this section. The commissioner shall have the authority to request additional information.

Section 7. Examination

Whenever the commissioner determines it to be expedient, the commissioner may make or cause to be made an examination of the assets and liabilities and other affairs of the charitable organization as they pertain to annuity agreements entered into pursuant to this Act. The commissioner shall keep information obtained in the course of examinations confidential until the examination is completed. The reasonable expenses incurred for an examination shall be paid by the charitable organization.

Section 8. Filing of Contracts

A. An authorized charitable organization shall file for information with the commissioner a copy of each form of agreement that it proposes to issue to donors in exchange for property transferred to the organization. {Within [insert number] days the commissioner shall approve or disapprove the proposed agreement forms and shall notify the charitable organization as soon as practicable.}

Drafting Note: Insert the bracketed material in prior approval states.

B. Each annuity agreement form shall include the following information:

(1) The value of the property to be transferred;

(2) The amount of the annuity to be paid to the donor or other annuitant;

(3) The manner in which and the intervals at which payment is to be made;

(4) The age and sex of the person or persons during whose life payment is to be made;

(5) The reasonable value as of the date of the agreement of the benefits created; and

(6) The date that payments are to begin.

Section 9. Disclosure

A. Before accepting the property transferred in exchange for the annuity agreement, the organization shall obtain a signed statement from a prospective donor acknowledging the following terms of the agreement:

(1) The value of the property transferred;

(2) The amount of the periodic annuity benefits to be paid;

(3) The manner in which and the intervals at which payment is to be made;

(4) The reasonable value as of the date of the agreement of the benefits created; and

(5) The date that payments are to begin.

B. In addition to the above disclosure, the charitable organization shall obtain a signed statement from a prospective donor acknowledging that he or she has been informed that payments made under a charitable gift annuity are backed solely by the full faith and credit of the organization, are not insured or guaranteed by an insurance company, are not protected by any insurance guaranty association, and are not backed in any way by the State of [insert state].

C. The requirements of Subsection A and B may be satisfied by an acknowledgment that is a part of the annuity agreement that is signed by the donor.

Section 10. Other Applicable Code Provisions

A. These provisions of the insurance code apply to the transactions covered by this Act:

(1) [insert citation to receivership law];

(2) [insert citation to laws on hazardous financial condition];

(3) [insert citation to laws governing unfair trade practices]; and

(4) [insert citation to laws governing investments].

B. The provisions of [insert reference to state guaranty association law] do not apply to charitable gift annuities.

Drafting Note: In order to ensure consistency and uniformity in state insurance laws, it is recommended that states adopting this model act also amend their state guaranty association statutes to comply with Section 5L(7) of the Life and Health Guaranty Association Model Act. That provision states that for the purpose of providing guaranty association protection to policy owners, insureds, beneficiaries, annuitants, payees and assignees, a "member insurer" shall not include "(a)n organization that has a certificate or license limited to the issuance of charitable gift annuities under [insert appropriate section of the state code.]"

Section 11. Severability

If any provision of this Act or the application of the provision to any circumstances is held invalid, the remainder of the Act or the application of the provision to other circumstances shall not be affected.

Section 12. Effective Date

This Act shall become effective [insert date] and shall apply to charitable gift annuities agreements entered into on or after the effective date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1998 Proc. 3rd Quarter 14-15, 518-519, 567-570 (adopted).

CHARITABLE GIFT ANNUITIES MODEL ACT

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CHARITABLE GIFT ANNUITIES MODEL ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.03.070 (2001).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-103 (1954/2014) (contracts are not insurance); § 20-119 (1997/2004).
Arkansas			ARK. CODE ANN. § 23-63-201 (1959/2013); CODE ARK. R. 054.00.090 (2010).
California			CAL. INS. CODE §§ 11520 to 11524 (1935/1995).
Colorado			COLO. REV. STAT. § 10-3-903 (1963/1998).
Connecticut			CONN. GEN. STAT. §§ 38a-1030 to 38a-1039 (1999).
Delaware			DEL. CODE ANN. tit. 18, § 2902 (1953/1983).

CHARITABLE GIFT ANNUITIES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.481 (1974/2002); FLA. ADMIN. CODE ANN. r. 69O-202.001 to 69O-202.015 (1990/2003).
Georgia			GA. CODE ANN. §§ 33-58-1 to 33-58-6 (2000).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:1-204 (1987/2005).
Idaho			IDAHO CODE ANN. § 41-120 (1996).
Illinois			215 ILL. COMP. STAT. 5/121-2.10 (1995/1996).
Indiana			IND. CODE § 27-1-12.4 (1994).
Iowa			IOWA CODE §§ 508F.1 to 508F.8 (2001).
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.1-120 (1970/2013).
Louisiana			LA. REV. STAT. ANN. §§ 22:951 to 22:952 (1958/1993).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 703 to 703-A (1962/1995).
Maryland			MD. CODE ANN., INS. § 16-114 (1957/1996); MD. CODE REGS. 31.9.07.01 to 31.9.07.07 (1995).
Massachusetts			MASS. GEN. LAWS ch. 175, § 118 (1870/1968).

CHARITABLE GIFT ANNUITIES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi			MISS. CODE ANN. §§ 79-11-651 to 79-11-661 (2001).
Missouri			MO. REV. STAT. §§ 352.500 to 352.520 (1996/2001).
Montana			MONT. CODE ANN. §§ 33-20-701 to 33-20-702 (2003/2005).
Nebraska			NEB. REV. STAT. ANN. §§ 59-1801 to 59-1803 (1996).
Nevada			NEV. REV. STAT. §§ 688A.281 to 688A.285 (1999).
New Hampshire			N.H. REV. STAT. ANN. §§ 403-E:1 to 403-E:5 (1999).
New Jersey			N.J. STAT. ANN. § 17B:17-13.1 (1971/2004); N.J. ADMIN. CODE §§ 11:4-8.1 to 11:4-8.11 (1971/2005).
New Mexico			N.M. STAT. ANN. § 59A-1-16.1 (1999).
New York			N.Y. INS. LAW § 1110 (1984/2013).
North Carolina			N.C. GEN. STAT. § 58-3-6 (1998).
North Dakota			N.D. CENT. CODE §§ 26.1-34.1-01 to 26.1-34.1-07 (1991).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, §§ 4071 to 4082 (1998).

CHARITABLE GIFT ANNUITIES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon			OR. REV. STAT. ANN. § 731.038 (2005).
Pennsylvania			10 PA. STAT. ANN. §§ 361 to 364 (1996).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-5-20 (1987/1993).
South Dakota			S.D. CODIFIED LAWS §§ 58-1-16 to 58-1-17 (1994/2001).
Tennessee	TENN. CODE ANN. §§ 56-52-101 to 56-52-111 (2007/2012).		
Texas			TEX. INS. CODE ANN. § 102.051 (1999); §§ 102.101 to 102.104 (1995/1999).
Utah			UTAH CODE ANN. § 31A-1-301 (1985/2014); § 31A-22-1305 (1986).
Vermont		VT. STAT. ANN. tit. 8, § 3718a (2001).	VT. STAT. ANN. tit. 9, §§ 2517 to 2518 (2001).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-106 to 38.2-106.1 (1986/1996).
Washington			WASH. REV. CODE ANN. §§ 48.38.010 to 48.38.075 (1979/2002); WASH. ADMIN. CODE 284-38-010 to 284-38-200 (1979).
West Virginia			W. VA. CODE §§ 33-13B-1 to 33-13B-6 (2006).
Wisconsin			WIS. STAT. § 632.65 (2014).
Wyoming	NO CURRENT ACTIVITY		

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

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Section 1. Definitions

A. "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes.

B. "Charitable organization" means an entity described by:

(1) Section 501(c)(3), Internal Revenue Code of 1986 (26 U.S.C. Section 501(c)(3)); or

(2) Section 170(c), Internal Revenue Code of 1986 (26 U.S.C. Section 170(c)).

C. "Qualified charitable gift annuity" means a charitable gift annuity described by Section 501(m)(5), Internal Revenue Code of 1986 (26 U.S.C. Section 501(m)(5)), and Section 514(c)(5), Internal Revenue Code of 1986 (26 U.S.C. Section 514(c)(5)), that is issued by a charitable organization that on the date of the annuity agreement:

(1) Has a minimum of $300,000 in unrestricted cash, cash equivalents, or publicly traded securities, exclusive of the assets funding the annuity agreement; and

(2) Has been in continuous operation for at least three (3) years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three (3) years.

Section 2. Charitable Gift Annuity Is Not Insurance

A. The issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this state.

B. A charitable gift annuity issued before [insert effective date of this statute] is a qualified charitable gift annuity for purposes of this Act, and the issuance of that charitable gift annuity does not constitute engaging in the business of insurance in this state.

Section 3. Notice to Donor

A. When entering into an agreement for a qualified charitable gift annuity, the charitable organization shall disclose to the donor in writing in the annuity agreement that a qualified charitable gift annuity is not insurance under the laws of this state and is not subject to regulation by the insurance commissioner or protected by an insurance guaranty association.

B. The notice provisions required by this section shall be in a separate paragraph in a print size no smaller than that employed in the annuity agreement generally.

Section 4. Notice to Department

A. A charitable organization that issues qualified charitable gift annuities shall notify the commissioner in writing by the later of ninety (90) days after the effective date of this Act or the date on which it enters into the organization's first qualified charitable gift annuity agreement. The notice shall:

(1) Be signed by an officer or director of the organization;

(2) Identify the organization; and

(3) Certify that:

(a) The organization is a charitable organization; and

(b) The annuities issued by the organization are qualified charitable gift annuities.

B. The organization shall not be required to submit additional information except to determine appropriate penalties that may be applicable under Section 5 of this Act.

Section. 5. Effect of Failure to Provide Required Notice

The failure of a charitable organization to comply with the notice requirements imposed under Section 3 or 4 of this Act does not prevent a charitable gift annuity that otherwise meets the requirements of this Act from constituting a qualified charitable gift annuity. The commissioner may enforce performance of the requirements of Sections 3 and 4 of this Act by sending a letter by certified mail, return receipt requested, demanding that the charitable organization comply with the requirements of Sections 3 and 4 of this Act. The commissioner may fine the charitable organization in an amount not to exceed $1,000 per qualified charitable gift annuity agreement issued until such time as the charitable organization complies with Sections 3 and 4 of this Act.

Section 6. Not Unfair or Deceptive Trade Practice

The issuance of a qualified charitable gift annuity does not constitute a violation of [insert reference to unfair trade practices law].

Section 7. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1998 Proc. 3rd Quarter 14-15, 518-519, 567, 571-572 (adopted).

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	ALASKA STAT. § 21.03.070 (2001).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-103 (1954/2014); § 20-119 (1997/2004).
Arkansas			ARK. CODE ANN. § 23-63-201 (1959/2013); CODE ARK. R. 054.00.090 (2010).
California			CAL. INS. CODE §§ 11520 to 11524 (1935/1995).
Colorado			COLO. REV. STAT. § 10-3-903 (1963/1998).
Connecticut	CONN. GEN. STAT. §§ 38a-1030 to 38a-1039 (1999) (portions of model).		
Delaware			DEL. CODE ANN. tit. 18, § 2902 (1953/1983).
District of Columbia	NO CURRENT ACTIVITY		

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 627.481 (1974/2002); FLA. ADMIN. CODE ANN. r. 69O-202.001 to 69O-202.015 (1990/2003).
Georgia	GA. CODE ANN. §§ 33-58-1 to 33-58-6 (2000).		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:1-204 (1987/2005).
Idaho			IDAHO CODE ANN. § 41-120 (1996).
Illinois			215 ILL. COMP. STAT. 5/121-2.10 (1995/1996).
Indiana			IND. CODE § 27-1-12.4 (1994).
Iowa	IOWA CODE §§ 508F.1 to 508F.8 (2001).		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.1-120 (1970/2013).
Louisiana			LA. REV. STAT. ANN. §§ 22:951 to 22:952 (1958/1993).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 703 to 703-A (1962/1995).
Maryland			MD. CODE ANN., INS. § 16-114 (1957/1996); MD. CODE REGS. 31.9. 07.01 to 31.9.07.07 (1995).
Massachusetts			MASS. GEN. LAWS ch. 175, § 118 (1870/1968).
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	MISS. CODE ANN. §§ 79-11-651 to 79-11-661 (2001).		

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. REV. STAT. §§ 352.500 to 352.520 (1996/2001).		
Montana		MONT. CODE ANN. §§ 33-20-701 to 33-20-702 (2003/2005).	
Nebraska			NEB. REV. STAT. ANN. §§ 59-1801 to 59-1803 (1996).
Nevada	NEV. REV. STAT. §§ 688A.281 to 688A.285 (1999).		
New Hampshire	N.H. REV. STAT. ANN. §§ 403-E:1 to 403-E:5 (1999).		
New Jersey			N.J. STAT. ANN. § 17B:17-13.1 (1971/2004); N.J. ADMIN. CODE §§ 11:4-8.1 to 11:4-8.11 (1971/2005).
New Mexico	N.M. STAT. ANN. § 59A-1-16.1 (1999).		
New York			N.Y. INS. LAW § 1110 (1984/2013).
North Carolina			N.C. GEN. STAT. § 58-3-6 (1998).
North Dakota			N.D. CENT. CODE §§ 26.1-34.1-01 to 26.1-34.1-07 (1991).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36, §§ 4071 to 4082 (1998).
Oregon			OR. REV. STAT. ANN. § 731.038 (2005).
Pennsylvania			10 PA. STAT. ANN. §§ 361 to 364 (1996).
Puerto Rico	NO CURRENT ACTIVITY		

CHARITABLE GIFT ANNUITIES EXEMPTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. § 38-5-20 (1987/1993).
South Dakota			S.D. CODIFIED LAWS §§ 58-1-16 to 58-1-17 (1994/2001).
Tennessee			TENN. CODE ANN. §§ 56-52-101 to 56-52-111 (2007/2012).
Texas	TEX. INS. CODE ANN. § 102.051 (1999); §§ 102.101 to 102.104 (1995/1999).		
Utah			UTAH CODE ANN. § 31A-1-301 (1985/2014); § 31A-22-1305 (1986).
Vermont	VT. STAT. ANN. tit. 9, §§ 2517 to 2518 (2001); VT. STAT. ANN. tit. 8, § 3718a (2001).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-106 to 38.2-106.1 (1986/1996).
Washington			WASH. REV. CODE ANN. §§ 48.38.010 to 48.38.075 (1979/2002); WASH. ADMIN. CODE 284-38-010 to 284-38-200 (1979).
West Virginia	W. VA. CODE §§ 33-13B-1 to 33-13B-6 (2006).		
Wisconsin			WIS. STAT. § 632.65 (2014).
Wyoming	NO CURRENT ACTIVITY		

ANNUITY DISCLOSURE MODEL REGULATION

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Section 1. Purpose

The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Section 2. Authority

This regulation is issued based upon the authority granted the commissioner under Section [cite any enabling legislation and state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

Section 3. Applicability and Scope

This regulation applies to all group and individual annuity contracts and certificates except:

A. Immediate and deferred annuities that contain no non-guaranteed elements;

B. (1) Annuities used to fund:

(a) An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer,

(c) A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(2) Notwithstanding Paragraph (1), the regulation shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

C. Non-registered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

D. (1) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with Section 5 shall be required after January 1, 2014, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

(2) Notwithstanding Subsection D(1), the delivery of the Buyer's Guide is required in sales of variable annuities, and when appropriate, in sales of other registered products.

Drafting Note: The requirement to provide a Buyer's Guide would not be appropriate for contingent deferred annuities unless, or until such time as, the NAIC adopts a Buyer's Guide that specifically addresses contingent deferred annuities.

(3) Nothing in this subsection shall limit the commissioner's ability to enforce the provisions of this regulation or to require additional disclosure.

E. Structured settlement annuities;

F. [Charitable gift annuities; and]

G. [Funding agreements].

Drafting Note: States that regulate charitable gift annuities should exempt them from the requirements of this regulation. States that recognize or regulate funding agreements as annuities should exempt them from the requirements of this regulation.

Section 4. Definitions

For the purposes of this regulation:

A. "Buyer's Guide" means the National Association of Insurance Commissioner's approved Annuity Buyer's Guide.

B. ["Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.]

C. "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

D. "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

E. ["Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.]

F. "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

G. "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed or have determinable elements at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

H. "Illustration" means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

I. "Market Value Adjustment" or "MVA" feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company's current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

J. "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

K. "Registered product" means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered products include, but are not limited to, contingent deferred annuities.

L. "Structured settlement annuity" means a "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

Section 5. Standards for the Disclosure Document and Buyer's Guide

A. (1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and the Buyer's Guide, if any.

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than five (5) business days after the completed application is received by the insurer.

(a) With respect to an application received as a result of a direct solicitation through the mail:

(i) Providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business days after receipt of the application.

(ii) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b) With respect to an application received via the Internet:

(i) Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business day of receipt of the application.

(ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer's Guide.

(d) Where the Buyer's Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or regulation.

B. At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer's legal name, physical address, website address and telephone number;

(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate:

(a) The guaranteed and non-guaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(b) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(c) Periodic income options both on a guaranteed and non-guaranteed basis;

(d) Any value reductions caused by withdrawals from or surrender of the contract;

(e) How values in the contract can be accessed;

(f) The death benefit, if available and how it will be calculated;

(g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(h) Impact of any rider, including, but not limited to, a guaranteed living benefit or long-term care rider;

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

Section 6. Standards for Annuity Illustrations

A. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this section and:

(1) Clearly labeled as an illustration;

(2) Includes a statement referring consumers to the disclosure document and Buyer's Guide provided to them at time of purchase for additional information about their annuity; and

(3) Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

B. An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

C. The illustration shall not be provided unless accompanied by the disclosure document referenced in Section 5.

D. When using an illustration, the illustration shall not:

(1) Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(2) State or imply that the payment or amount of non-guaranteed elements is guaranteed; or

(3) Be incomplete.

E. Costs and fees of any type shall be individually noted and explained.

F. An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;

(8) Except as provided in Paragraph (22), the non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

(9) In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and

(i) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page 1 for guaranteed elements");

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

(22) For participating immediate and deferred income annuities:

(a) Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);

(b) Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;

(c) If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;

(d) If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:

(i) Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and

(ii) The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subparagraph iii, below, based on the time to maturity or reinvestment (the "Tenor") of the investments supporting the cohort of policies.

(iii) Maximum long-term interest rates should be calculated for tenors of 3 months (or less), 5 years, 10 years and 20 years (or more), using U.S. Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).

(iv) The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.

(v) Grading to the maximum long-term interest rates should take place over:

(I) No less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates; or

(II) No more than 20 years from the issue if the U.S. Treasury rates as of the illustration date ate above the long-term rates.

(vi) When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall satisfy the following conditions:

(I) Assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates, and

(II) Illustrate dividends no less than half of the dividends illustrated under the current dividend scales.

(III) If (a) and (b) above are in conflict—i.e., if half of the current dividends are greater than would be permitted by Condition (a)—then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.

(vii) The illustration should include a disclosure that is substantially similar to the following:

The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current interest rates to long-term interest rates, over a period of [twenty] years. By regulation, the long-term assumed interest rates cannot and do not exceed the rates listed in column (c) of the table below.

(viii) If the illustration contains an additional dividend scale pursuant to subparagraph (vi) above, then the illustration should also include a disclosure that is substantially similar to the following:

The additional illustrated dividend scale is based on interest rates that are assumed no to increase and do not exceed the interest rates in column (b) of the table below.

Tenor	**Current Interest Rate**	**Long Term**
	Treasury Rate as of 12/31/2016	**Mean Reversed Treasury Rate**
3 Month (or less)	0.51%	3.00%
5 Year	1.93%	4.50%
10 Year	2.45%	5.00%
20 Years (or more)	3.06%	5.50%

G. An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:

(1) A brief description of any contract features, riders or options, guaranteed and/or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;

(2) A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;

(3) Identification and a brief definition of column headings and key terms used in the illustration;

(4) A statement containing in substance the following:

(a) For other than fixed indexed annuities:

This illustration assumes the annuity's current nonguaranteed elements will not change. It is likely that they **will** change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

(b) For fixed indexed annuities:

This illustration assumes the index will repeat historical performance and that the annuity's current non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index **will not** repeat historical performance, the non-guaranteed elements **will** change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information; and

(5) Additional explanations as follows:

(a) Minimum guarantees shall be clearly explained;

(b) The effect on contract values of contract surrender prior to maturity shall be explained;

(c) Any conditions on the payment of bonuses shall be explained;

(d) For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

(e) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and

(f) A brief description of the types of annuity income options available shall be explained, including:

(i) The earliest or only maturity date for annuitization (as the term is defined in the contract);

(ii) For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age seventy (70) or ten (10) years after issue, but in no case later than the maximum annuitization age or date in the contract;

(iii) For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

(iv) The periodic income amount based on the currently available periodic income rates for the annuity income option in item (ii) or item (iii), if desired.

H. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

(1) (a) First ten (10) contract years; or

(b) Surrender charge period if longer than ten (10) years, including any renewal surrender charge period(s);

(2) Every tenth contract year up to the later of thirty (30) years or age seventy (70); and

(3) (a) Required annuitization age; or

(b) Required annuitization date.

I. If the annuity contains a market value adjustment, hereafter MVA, the following provisions apply to the illustration:

(1) The MVA shall be referred to as such throughout the illustration;

(2) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

(3) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;

(4) A statement, containing in substance the following, shall be included:

When you make a withdrawal the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.

(5) Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment;

(6) The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;

(7) Actual MVA floors and ceilings as listed in the contract shall be illustrated; and

(8) If the MVA has significant characteristics not addressed by Paragraphs (1) – (6), the effect of such characteristics shall be shown in the illustration.

Drafting Note: Appendix A provides an example of an illustration of an annuity containing an MVA that addresses Paragraphs (1) – (6) above.

J. A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

(1) An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:

(a) The Index(es) which will be used to determine the index-based interest;

(b) The Indexing Method – such as point-to-point, daily averaging, monthly averaging;

(c) The Index Term – the period over which indexed-based interest is calculated;

(d) The Participation Rate, if applicable;

(e) The Cap, if applicable; and

(f) The Spread, if applicable;

(2) The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

(3) The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and

(4) If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(a) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

(b) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.

K. A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

(1) The assumed growth rate of the index in accordance with Subsection F(9);

(2) The assumed values for the participation rate, cap and spread, if applicable; and

(3) The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with Subsection F(9).

L. If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including, but not limited to changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.

Section 7. Report to Contract Owners

For annuities in the payout period that include non-guaranteed elements, and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. The beginning and end date of the current report period;

B. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

D. The amount of outstanding loans, if any, as of the end of the current report period.

Section 8. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Section [cite state's unfair trade practices act].

Section 9. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 10. [Optional] Recordkeeping

A. Insurers or insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information provided in the disclosure statement (including illustrations) for [insert number] years after the contract is delivered by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

Section 11. Effective Date

This regulation shall become effective [insert effective date] and shall apply to contracts sold on or after the effective date.

Annuity Illustration Example
[The following illustration is an example only
And does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company
Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)
An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

Sex: Male	Initial Premium Payment: $100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period *:	3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:
- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant's life with payments guaranteed for 10-year period.
Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/$1,000 of Account Value *	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	$164,798	$5.00	$823.99
Based on Rates Currently Offered by the Company	$171,976	$6.50	$1,117.84

* If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

		Values Based on Guaranteed Rates				Values Based on Assumption that Initial Guaranteed Rates Continue		
Contract Year/Age	Premium Payment	Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	$ 100,000	4.15%	$ 104,150	$ 95,818	$ 92,000	4.15%	$ 104,150	$ 95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,153
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

For column descriptions, turn to page 245-14

Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown

Values Based on Guaranteed Rates

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

Values Based on Assumption that Initial Guaranteed Rates Continue

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take **no** withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

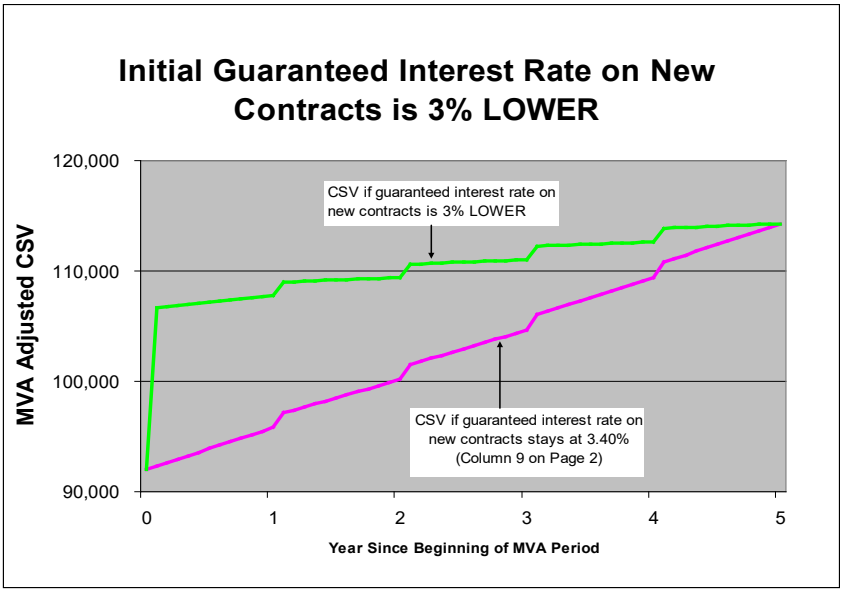
MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

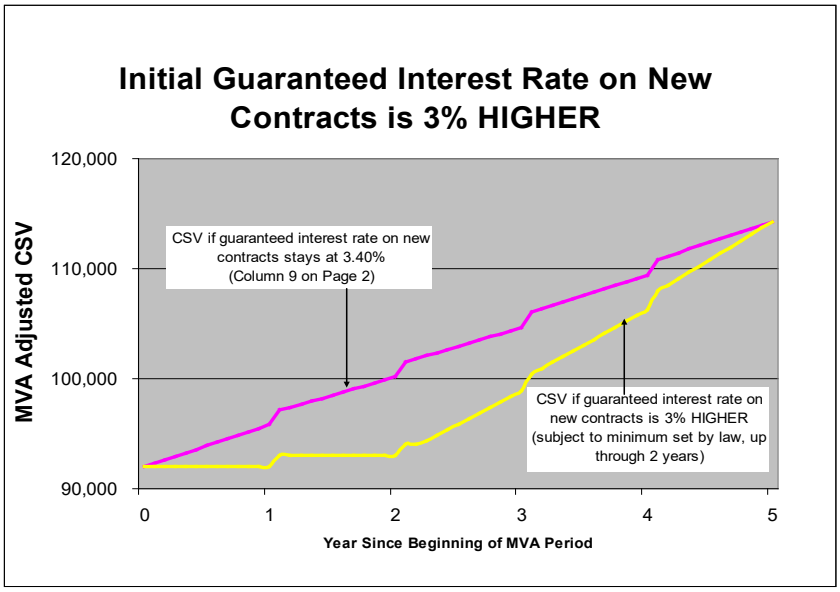
The graphs below shows MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.





Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1998 Proc. 4th Quarter 15, 17, 608, 628, 629-632 (adopted).
2011 Ex/Plenary Conference Call Oct 11, 2011 (amendments adopted)
2013 Proc. 3rd Quarter, Vol. I 121, 135, 138, 157, 225-319, 331, 500-512 (Guideline Amendments adopted).
2015 Proc. 1st Quarter, Vol. I 117-118, 131-134, 317-325, 431 (amended).
2021 Summer National Meeting (amended).

This model replaced an earlier version:

1978 Proc. II 31, 34, 295, 380, 382, 388-391 (adopted).
1980 Proc. I 34, 38, 406, 516, 518 (amended).
1982 Proc. II 505-512 (copy of most amendments adopted 1983 Proc. I).
1983 Proc. I 6, 35, 447, 569, 572-579 (amended; incorrectly reprinted).
1983 Proc. II 16, 22, 554, 613 (Buyer's Guide modified).
1988 Proc. I 9, 19-20, 601, 603-609 (adopted technical amendments; reprinted).
1988 Proc. II 5, 12, 478, 490-497 (amended and reprinted).
1998 Proc. 3rd Quarter 15, 518, 542, 545-553 (Buyer's Guide amended and reprinted).

ANNUITY DISCLOSURE MODEL REGULATION

The NAIC amended this model during the 2013 Fall National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The December 2013 Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Purpose

The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Section 2. Authority

This regulation is issued based upon the authority granted the commissioner under Section [cite any enabling legislation and state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

Section 3. Applicability and Scope

This regulation applies to all group and individual annuity contracts and certificates except:

A. Immediate and deferred annuities that contain no non-guaranteed elements;

B. (1) Annuities used to fund:

(a) An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer,

(c) A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(2) Notwithstanding Paragraph (1), the regulation shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

C. Non-registered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

D. (1) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with Section 5 shall be required after January 1, 2014, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

Drafting Note: States should be aware that the provision in paragraph (1) above requiring transactions involving variable annuities and other registered products to comply with the requirements of Section 5 of the regulation after Jan. 1, 2014 unless the U.S. Securities and Exchange Commission (SEC) adopts a summary prospectus rule or the Financial Industry Regulatory Authority (FINRA) approves for use a simplified disclosure form applicable to variable annuities or other registered products could be preempted by the National Securities Markets Improvement Act of 1996 (NSMIA). NSMIA prohibits the States from making laws establishing record-making or record-keeping requirements for broker-dealers. Given this, in adopting this regulation, States may want to omit the language in paragraph (1) above that eliminates the exemption for these transactions after Jan. 1, 2014 and, as a consequence, would require broker-dealers to comply with Section 5 of this regulation unless or until the SEC or FINRA takes the delineated action. States should consider only adopting the language from paragraph (1) above that exempts transactions involving variable annuities and other registered products in compliance with the SEC and FINRA rules relating to disclosures and illustrations from having to comply with the regulation.

(2) Notwithstanding Subsection D(1), the delivery of the Buyer's Guide is required in sales of variable annuities, and when appropriate, in sales of other registered products.

Drafting Note: The requirement to provide a Buyer's Guide would not be appropriate for contingent deferred annuities unless, or until such time as, the NAIC adopts a Buyer's Guide that specifically addresses contingent deferred annuities.

(3) Nothing in this subsection shall limit the commissioner's ability to enforce the provisions of this regulation or to require additional disclosure.

E. Structured settlement annuities;

F. [Charitable gift annuities; and]

G. [Funding agreements].

Drafting Note: States that regulate charitable gift annuities should exempt them from the requirements of this regulation. States that recognize or regulate funding agreements as annuities should exempt them from the requirements of this regulation.

Section 4. Definitions

For the purposes of this regulation:

A. "Buyer's Guide" means the National Association of Insurance Commissioner's approved Annuity Buyer's Guide.

B. ["Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.]

C. "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

D. "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

E. ["Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.]

F. "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

G. "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed or have determinable elements at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

H. "Illustration" means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

I. "Market Value Adjustment" or "MVA" feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company's current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

K. "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

L. "Registered product" means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered products include, but are not limited to, contingent deferred annuities.

L. "Structured settlement annuity" means a "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

Section 5. Standards for the Disclosure Document and Buyer's Guide

A. (1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and the Buyer's Guide, if any.

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than five (5) business days after the completed application is received by the insurer.

(a) With respect to an application received as a result of a direct solicitation through the mail:

(i) Providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business days after receipt of the application.

(ii) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b) With respect to an application received via the Internet:

(i) Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five (5) business day of receipt of the application.

(ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer's Guide.

(d) Where the Buyer's Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or regulation.

B. At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer's legal name, physical address, website address and telephone number;

(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate:

(a) The guaranteed and non-guaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(b) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(c) Periodic income options both on a guaranteed and non-guaranteed basis;

(d) Any value reductions caused by withdrawals from or surrender of the contract;

(e) How values in the contract can be accessed;

(f) The death benefit, if available and how it will be calculated;

(g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(h) Impact of any rider, including, but not limited to, a guaranteed living benefit or long-term care rider;

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

Section 6. Standards for Annuity Illustrations

A. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this section and:

(1) Clearly labeled as an illustration;

(2) Includes a statement referring consumers to the disclosure document and Buyer's Guide provided to them at time of purchase for additional information about their annuity; and

(3) Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

B. An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

C. The illustration shall not be provided unless accompanied by the disclosure document referenced in Section 5.

D. When using an illustration, the illustration shall not:

(1) Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(2) State or imply that the payment or amount of non-guaranteed elements is guaranteed; or

(3) Be incomplete.

E. Costs and fees of any type shall be individually noted and explained.

F. An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;

(8) The non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

(9) In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and

(i) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page 1 for guaranteed elements");

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

G. An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:

(1) A brief description of any contract features, riders or options, guaranteed and/or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;

(2) A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;

(3) Identification and a brief definition of column headings and key terms used in the illustration;

(4) A statement containing in substance the following:

(a) For other than fixed indexed annuities:

This illustration assumes the annuity's current nonguaranteed elements will not change. It is likely that they **will** change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

(b) For fixed indexed annuities:

This illustration assumes the index will repeat historical performance and that the annuity's current non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index **will not** repeat historical performance, the non-guaranteed elements **will** change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information; and

(5) Additional explanations as follows:

(a) Minimum guarantees shall be clearly explained;

(b) The effect on contract values of contract surrender prior to maturity shall be explained;

(c) Any conditions on the payment of bonuses shall be explained;

(d) For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

(e) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and

(f) A brief description of the types of annuity income options available shall be explained, including:

(i) The earliest or only maturity date for annuitization (as the term is defined in the contract);

(ii) For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age seventy (70) or ten (10) years after issue, but in no case later than the maximum annuitization age or date in the contract;

(iii) For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

(iv) The periodic income amount based on the currently available periodic income rates for the annuity income option in item (ii) or item (iii), if desired.

H. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

(1) (a) First ten (10) contract years; or

(b) Surrender charge period if longer than ten (10) years, including any renewal surrender charge period(s);

(2) Every tenth contract year up to the later of thirty (30) years or age seventy (70); and

(3) (a) Required annuitization age; or

(b) Required annuitization date.

I. If the annuity contains a market value adjustment, hereafter MVA, the following provisions apply to the illustration:

(1) The MVA shall be referred to as such throughout the illustration;

(2) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

(3) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;

(4) A statement, containing in substance the following, shall be included:

When you make a withdrawal the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.

(5) Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment;

(6) The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;

(7) Actual MVA floors and ceilings as listed in the contract shall be illustrated; and

(8) If the MVA has significant characteristics not addressed by Paragraphs (1) – (6), the effect of such characteristics shall be shown in the illustration.

Drafting Note: Appendix A provides an example of an illustration of an annuity containing an MVA that addresses Paragraphs (1) – (6) above.

J. A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

(1) An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:

(a) The Index(es) which will be used to determine the index-based interest;

(b) The Indexing Method – such as point-to-point, daily averaging, monthly averaging;

(c) The Index Term – the period over which indexed-based interest is calculated;

(d) The Participation Rate, if applicable;

(e) The Cap, if applicable; and

(f) The Spread, if applicable;

(2) The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

(3) The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and

(4) If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(a) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

(b) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.

K. A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

(1) The assumed growth rate of the index in accordance with Subsection F(9);

(2) The assumed values for the participation rate, cap and spread, if applicable; and

(3) The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with Subsection F(9).

L. If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including, but not limited to changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.

Section 7. Report to Contract Owners

For annuities in the payout period that include non-guaranteed elements, and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. The beginning and end date of the current report period;

B. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

D. The amount of outstanding loans, if any, as of the end of the current report period.

Section 8. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Section [cite state's unfair trade practices act].

Section 9. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 10. [Optional] Recordkeeping

A. Insurers or insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information provided in the disclosure statement (including illustrations) for [insert number] years after the contract is delivered by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

Section 11. Effective Date

This regulation shall become effective [insert effective date] and shall apply to contracts sold on or after the effective date.

Annuity Illustration Example
[The following illustration is an example only
And does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company
Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)
An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

Sex: Male	Initial Premium Payment: $100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period *:	3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:
- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant's life with payments guaranteed for 10-year period.
Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/$1,000 of Account Value *	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	$164,798	$5.00	$823.99
Based on Rates Currently Offered by the Company	$171,976	$6.50	$1,117.84

* If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

		Values Based on Guaranteed Rates				Values Based on Assumption that Initial Guaranteed Rates Continue		
Contract Year/Age	Premium Payment	Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	$ 100,000	4.15%	$ 104,150	$ 95,818	$ 92,000	4.15%	$ 104,150	$ 95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,153
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

For column descriptions, turn to page 245-17

Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown

Values Based on Guaranteed Rates

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

Values Based on Assumption that Initial Guaranteed Rates Continue

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take **no** withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

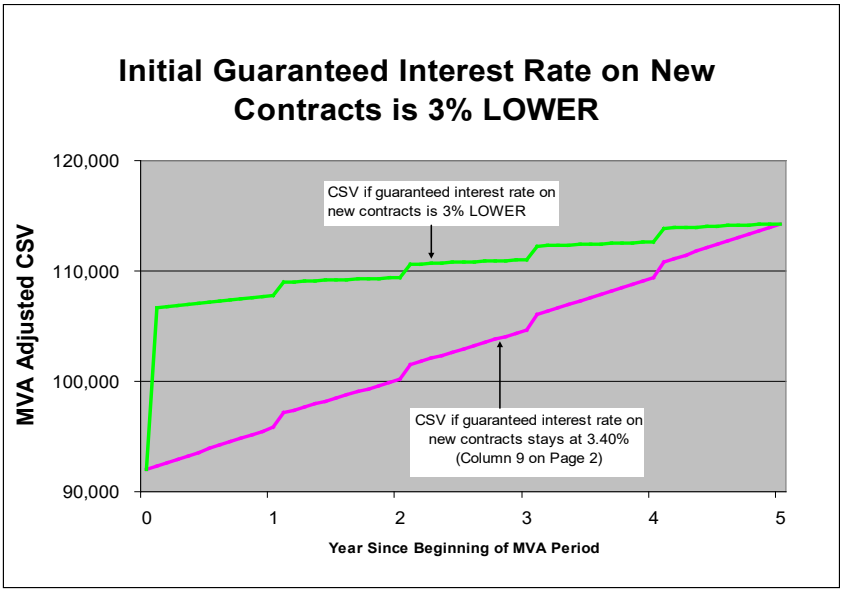
MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

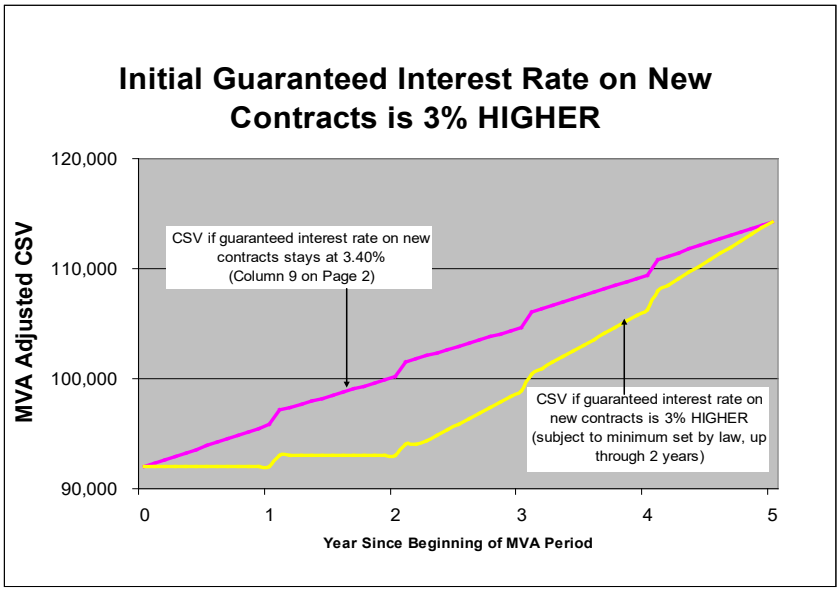
The graphs below shows MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.





Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1998 Proc. 4th Quarter 15, 17, 608, 628, 629-632 (adopted).
2011 Proc. 3rd Quarter I 3-4 (amended).
2013 Proc. 3rd Quarter, Vol. I 121, 135, 138, 157, 225-319, 331, 500-512 (Guideline Amendments adopted).
2015 Proc. 1st Quarter, Vol. I 117-118, 131-134, 317-325, 431 (amended).

This model replaced an earlier version:

1978 Proc. II 31, 34, 295, 380, 382, 388-391 (adopted).
1980 Proc. I 34, 38, 406, 516, 518 (amended).
1982 Proc. II 505-512 (copy of most amendments adopted 1983 Proc. I).
1983 Proc. I 6, 35, 447, 569, 572-579 (amended; incorrectly reprinted).
1983 Proc. II 16, 22, 554, 613 (Buyer's Guide modified).
1988 Proc. I 9, 19-20, 601, 603-609 (adopted technical amendments; reprinted).
1988 Proc. II 5, 12, 478, 490-497 (amended and reprinted).
1998 Proc. 3rd Quarter 15, 518, 542, 545-553 (Buyer's Guide amended and reprinted).

ANNUITY DISCLOSURE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ANNUITY DISCLOSURE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-129 (2003/2019).	
Alaska		ALASKA ADMIN. CODE tit. 3, §§ 26.750 to 26.769 (2008/2016).	
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-212.02 (2022).	ARIZ. REV. STAT. ANN. §§ 20-1242 to 20-1242.05 (2003).	ARIZ. ADMIN. CODE § R20-6-212.01 (2004/2022) (adopts NAIC buyer's guide by reference).
Arkansas		054-00-98 ARK. CODE R. (2009).	
California	NO CURRENT ACTIVITY		
Colorado		3 COLO. CODE REGS. § 702-4:4-1-12 (2006/2019).	BULLETIN B-4.67 (2014).
Connecticut			CONN. AGENCIES REGS. § 38a-432a-5 (2005/2021).
Delaware			18 DEL. ADMIN. CODE 1214-4.0 (2021); APP. A (2021).
District of Columbia	NO CURRENT ACTIVITY		
Florida		FLA. STAT. § 627.4554 (2013/2022).	FLA. STAT. § 626.99 (1982/2013) (requires delivery of model buyer's guide).

ANNUITY DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. COMP. R. & REGS. 120-2-73 (1996/2015); BULLETIN 15-EX-1 (2015).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431:10D-601 to 431:10D-605 (2006/2010).
Idaho		IDAHO CODE ANN. §§ 41-1940 to 1943 (2010/2021) (portions of model); BULLETIN 21-05 (2021).	
Illinois	NO CURRENT ACTIVITY		
Indiana			IND. CODE 27-1-12.6-6 (1977).
Iowa	IOWA ADMIN. CODE r. 191-15.61 to 191-15.69 (2003/2021).		BULLETIN 2013-3 (2013).
Kansas	NO CURRENT ACTIVITY		
Kentucky		806 KY. ADMIN. REGS. 12:150 (2007/2021).	806 KY. ADMIN. REGS. 12:131 (1991/2007) (annuity used to fund preeneed funeral contracts).
Louisiana	NO CURRENT ACTIVITY		
Maine		02-031 ME. CODE R. § 915 (2004/2015).	BULLETIN 389 (2013).
Maryland			MD. CODE REGS. 31.15.04.01 to 31.15.04.07 (1980).
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. COMP. LAWS ANN. 500.4155 (2006/2020).
Minnesota			MINN. STAT. ANN. § 72A.2032 (2013/2022).
Mississippi	NO CURRENT ACTIVITY		

ANNUITY DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri		MO. CODE REGS. ANN. tit. 20, §§ 400-5.800 (2016); BULLETIN 2017-01 (2017) (SUNSETTED 2018).	
Montana		MONT. ADMIN. R. 6.6.801 to 6.6.807 (1998/2001).	
Nebraska		NEB. REV. ST. § 44-8106 (2006/2021).	
Nevada			NEV. ADMIN. CODE §§ 688A.110 to 688A.180 (1980/2006).
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. §§ 306.02 to 306.08 (1983/2018).	
New Jersey			BULLETIN 2009-6 (2009); BULLETIN 2014-5 (2014).
New Mexico		N.M. CODE R. § 13.9.12 (1997/2000).	
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 40.0 to 40.6 (Regulation 139) (1990/2013); §§ 53-1.1 to 53-1.6 (Regulation 74) (1997/2003).
North Carolina		N.C. GEN. STAT. §§ 58-60-120 to 58-60-145 (2005).	
North Dakota			BULLETIN 2002-1 (2002).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE § 3901-6-14 (2007/2018).	
Oklahoma		OKLA. ADMIN. CODE §§ 365:25-19-1 to 25-19-9 (2005/2007).	LH BULLETIN 2013-02 (2013).
Oregon		OR. ADMIN. R. 836-051-0900 to 836-051-0925 (2008).	OR. ADMIN. R. 836-051-005 to 836-051-0020 (1978/2006).

ANNUITY DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			31 PA. CODE §§ 85.38 to 85.39 (1978).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		230 R.I. CODE R. §§ 20-25-6.1 to 20-25-6.9 (2018).	
South Carolina			S.C. CODE ANN. REGS. 69-39 (1986/2010).
South Dakota			S.D. COD. LAWS § 58-33A-16.5 (2022).
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 3.9701to 3.9712 (2011).
Utah		UTAH ADMIN. CODE R590-229-1 to R590-229-10 (2004/2021).	
Vermont			8 VT. STAT. ANN. § 3841 (2009).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE § 5-41-40 (2012).
Washington			WASH. ADMIN. CODE §§ 284-23-300 to 284-23-370 (1980).
West Virginia		W. VA. CODE R. §§ 114-11E-1 to 11E-7; App. A (2015).	
Wisconsin			WIS. ADMIN. CODE INS. § 2.15 (1982/1989).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2021

ANNUITY DISCLOSURE MODEL REGULATION (#245)

1. Description of the Project, Issues Addressed, etc.

The *Annuity Disclosure Model Regulation* (#245) was revised to address its application to participating income annuities.

2. Name of Group Responsible for Drafting the Model and States Participating

The Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Mike Yanacheak, Chair	Iowa
Chris Struk	Florida
Julie Holmes and Craig VanAalst	Kansas
Adewole Odumade	Maryland
John Robinson	Minnesota
Frank Stone	Oklahoma
Sarah Neil/Matt Gendron	Rhode Island
Doug Danzeiser/Phil Reyna	Texas

3. Project Authorized by What Charge and Date First Given to the Group

In 2016, the Life Insurance and Annuities (A) Committee adopted a charge for the Annuity Disclosure (A) Working Group to: "Review and revise, as necessary, Section 6—Standards for Annuity Illustrations in the *Annuity Disclosure Model Regulation* (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace."

At the 2017 Summer National Meeting, the Executive (EX) Committee and Plenary adopted a Request for NAIC Model Law Development "to revise Section 6—Standards for Illustrations in the *Annuity Disclosure Model Regulation* (#245) to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or addressed adequately in the current standards."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Annuity Disclosure (A) Working Group met six times to discuss an issue identified under its charge: that the model prohibits the illustration of "non-guaranteed elements," which could be construed to include participating income annuities because of the formula used to calculate the dividend scale.

New York Life had been working with state insurance regulators since 2015 to develop language for inclusion in Model #245 to allow for the illustration of participating income annuities. The Working Group heard presentations explaining the issue and discussed a proposal forwarded by New York Life. The Working Group reviewed, discussed and revised the proposal. All drafts and comments were posted on the NAIC website. On March 2, 2018, the Working Group adopted draft revisions addressing participating income annuities.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Annuity Disclosure (A) Working Group met Nov. 22, 2016; Dec. 14, 2017; March 9, 2017; April 13, 2017; Feb. 15 2018; March 2, 2018; and June 4, 2018. All drafts and comments were posted to the NAIC website. The Working Group adopted the revisions addressing participating income annuities on March 2, 2018, and the Life Insurance and Annuities (A) Committee adopted the revisions during the 2018 Summer National Meeting. These revisions were adopted and held by the Committee pending resolution of an additional issue that the Working Group identified. The Working Group did not end up making any additional revision to the model. During the 2021 Spring National Meeting, the Committee agreed to disband the Working Group once these revisions to Model #245 were considered by the Membership.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

During its Feb. 15 meeting, the Working Group discussed concerns that the American Academy of Actuaries (Academy) raised with the participating income annuity proposal. The Academy was concerned that the proposal deviated from the current standard in its use of projected improvements and that it did not apply the change consistently across product types. New York Like explained that the proposal was purposefully narrow in scope to address a particular issue with a particular product; only participating income annuities include the potential for additional income in the form of dividends based on the divisible surplus of the company. New York Life also worked with Missouri to revise the proposal to include additional disclosures about future rate assumptions, and it included a requirement that consumers are shown an additional, more conservative illustrated scale when current interest rates are less than the long-term interest rates.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2015

ANNUITY DISCLOSURE MODEL REGULATION (#245)

1. Description of the Project, Issues Addressed, etc.

The *Annuity Disclosure Model Regulation* (#245) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Adding a drafting note to clarify that the requirement to provide a Buyers Guide would not be appropriate for CDAs unless, or until such time as, the NAIC adopts a Buyers Guide that specifically addresses CDAs.

- Adding to Section 4. Definitions: Registered product means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933, with a drafting note stating that registered products include, but are not limited to, CDAs.

2. Name of Group Responsible for Drafting the Model and States Participating

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Ted Nickel, Chair	Wisconsin	Roger A. Sevigny/Keith Nyhan	New Hampshire
Robert Chester	Connecticut	Joseph Torti III/Elizabeth Dwyer	Rhode Island
Jim Mumford	Iowa	Michael Humphreys	Tennessee
Jason Lapham	Kansas	Tomasz Serbinowski	Utah
Bruce R. Ramge	Nebraska		

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions to the *Annuity Disclosure Model Regulation* (#245) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association of Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

There were concerns that using the term "CDAs" when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and using drafting notes to clarify that the terms are intended to include CDAs.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

PROJECT HISTORY - 2011

ANNUITY DISCLOSURE MODEL REGULATION (#245)

1. Description of the Project, Issues Addressed, etc.

The following is a list of the major changes to the *Annuity Disclosure Model Regulation* (#245) adopted by the working group:

- The Buyer's Guide was separated from being an appendix to the model.
- The scope of the model was broadened to include variable annuities and other registered products to make its scope comparable to the *Suitability in Annuity Transactions Model Regulation* (#275). As in that model, this model also contains a safe harbor for SEC and FINRA approved disclosure documents, although it will disappear if the SEC and/or FINRA do not develop some shortened disclosure form for variable annuities by January 2013. Variable annuity illustrations are excluded from coverage because FINRA has extensive rules governing variable annuity illustrations. The safe harbor does not cover delivery of a Buyer's Guide for the sale of variable annuities so any sale of any kind of fixed deferred, indexed deferred or variable annuity requires that an Annuity Buyer's Guide be delivered.
- In the requirements for the disclosure document, provisions clarifying certain aspects of how indexed annuities should be disclosed were added. Clarifications of other sections were also made although no major substantive modifications were made to these provisions.
- An entirely new section entitled "Standards for Annuity Illustrations" was added. It includes the following major requirements.
    - It is a supplement to the disclosure document.
    - The use of an illustration is not mandatory either by the carrier or the producer and can be used for the initial sale or for subsequent contacts with the owner.
    - If it is used, it has to be prepared by the carrier or by a third party authorized by the carrier prior to its use and subject to a system of control by the carrier over its use.
    - It contains several limitations on the use of assumptions, terms, benefits, riders, etc. but the major limitation on the illustration of nonguaranteed values is the use of current conditions and not any assumed future conditions.
    - It contains several specific requirements and limitations relating to indexed annuity illustrations.
    - It contains several specific requirements and limitations relating to illustrations of annuities with market value adjustments.
    - It adds an optional section for recordkeeping similar to *the Suitability in Annuity Transactions Model Regulation* (#275).

2. Name of Group Responsible for Drafting the Model and States Participating

The Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Jim Mumford, Chair	Iowa	Robert Commodore/Paul Hanson /Tamara Kopp	Minnesota
Steve Ostlund	Alabama	Thomas B. Considine	New Jersey
Dan Honey	Arkansas	Gail Keren/Martin Schwartzman	New York
Peg Brown/Paula Sisneros	Colorado	Michelle Brugh	Ohio
Mary Ellen Breault	Connecticut	Betsy Jerome	Utah
Mary Beth Senkewicz	Florida	Fred Nepple	Wisconsin
Marlyn Burch	Kansas		

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2008 by the following charge: Review and consider changes to the *Annuity Disclosure Model Regulation* (#245) to improve the disclosure of information provided for annuity products, both generally and specifically, and to provide insurers uniform guidance in developing disclosure information and documents and monitoring distribution thereof in order to better inform annuity consumers about the annuity product purchased and how it works. The Executive (EX) Committee approved the model law request for revising the *Annuity Disclosure Model Regulation* (#245) at the 2008 Fall National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC Web site. The Working Group adopted a draft of proposed revisions at the 2010 Fall National meeting on Oct. 18, 2010, which was then forwarded to the Committee.

All drafts were distributed to over 200 interested parties and posted on the NAIC Web site. Numerous interested parties participated, including industry representatives, such as the American Council of Life Insurers (ACLI), the National Association for Fixed Annuities (NAFA), and the Insured Retirement Institute (IRI); insurance producer representatives, such as the National Association for Insurance and Financial Advisors (NAIFA); consumer representatives, such as Brenda Cude (University of Georgia) and Karroll Kitt (University of Texas) and The Academy of Actuaries (AAA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group has met at every National Meeting since 2008 Fall National Meeting and held intermittent conference calls. Since the 2010 Summer National Meeting, the Working Group was able to have 5 conference calls and make substantial progress in revising the model.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

The industry supported regulatory oversight for annuity illustrations to assure a level playing field for companies and producers. The insurance industry, consumer representatives and the AAA all worked together on revising the model regulation.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

VARIABLE ANNUITY MODEL REGULATION

Table of Contents

Section 1. Authority

Pursuant to authority given by Section [insert applicable section] of the Insurance Laws of [insert state], the Insurance Commissioner, after due notice and publication and after affording interested persons opportunity to present written data, views and arguments, does hereby make and promulgate the following rules and regulations to be applicable to insurance companies delivering or issuing for delivery in this state variable annuities as defined in Section 2B, pursuant to Section [insert applicable section] of the insurance laws of this state.

Editor's Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

These regulations shall become effective [insert date].

Drafting Note: This section will obviously depend on the existing provisions under a given state's insurance code with respect to the method for adopting rules and regulations.

Section 2. Definitions

A. "Agent," as used in this regulation, means a person, corporation, partnership or other legal entity that under the laws of this state is licensed as a life insurance agent, solicitor, general agent or life insurance broker.

Drafting Note: States should make the necessary changes in terminology to conform with statutory language describing those persons eligible to be licensed to sell life insurance.

B. "Variable annuity," as used in this regulation, means a policy or contract that provides for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract, as provided for in Section [insert applicable section] of the laws of this state.

Drafting Note: The objective is to define the contracts covered by the regulations to include all forms of annuity contracts where the benefits vary according to the investment experience of a separate account authorized by the enabling statute, including group and individual, variable accumulation and variable benefit, etc. Exclusion of particular kinds of contracts from sections of the regulation that may be inapplicable is handled in those sections.

Section 3. Qualification of Insurance Companies To Issue Variable Annuities

A. A company shall not deliver or issue for delivery variable annuities within this state unless it is licensed or organized to do a life insurance or annuity business in this state and the commissioner is satisfied that its condition or method of operation in connection with the issuance of these contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable annuities.

B. If the company is a subsidiary of an admitted life insurance company, or affiliated with a company by common management or ownership, it may be deemed by the commissioner to have satisfied the provisions of Subsection A(2) if either it or the admitted life company satisfies the provisions of Subsection A(2). Companies licensed and having a satisfactory record of doing business in this state for a period of at least three (3) years may be deemed to have satisfied the commissioner with respect to Subsection A(2) above.

C. Before any company shall deliver or issue for delivery variable annuities within this state it shall submit to the commissioner:

(1) A general description of the kinds of variable annuities it intends to issue;

(2) If requested by the commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable annuities; and

(3) If requested by the commissioner, biographical data with respect to officers and directors of the company on the NAIC uniform biographical data forms.

Drafting Note: Subsection C suggests the type of submission which might be appropriate to afford a basis for determining that a company meets the test in Subsection A(2). The NAIC biographical data regulation and forms appear in the 1967 *Proceedings of the NAIC* II 382-385 and 1974 *Proceedings of the NAIC* I 120-123.

Some state statutes provide seasoning requirements for the licensing of foreign life insurance companies; these statutes presumably will also apply to companies seeking to be licensed to sell variable annuities. The drafters do not believe that there is a need for seasoning requirements for companies writing variable annuities beyond those required for life companies generally. If, however, an additional seasoning requirement for companies writing variable annuities is considered desirable, such a requirement should be specifically provided by statute and the drafters recommend that the statute expressly require consideration of the experience of a parent or affiliated company. See Subsection B above.

If there are specific capital and surplus requirements for companies writing variable annuities these should be the same as those for life insurance companies generally. If stricter capital and surplus requirements are considered necessary, these should be specifically provided by statute and it is strongly recommended that the statute permit waiver of these requirements pursuant to regulations adopted by the commissioner. A provision to accomplish this purpose might read as follows:

> "The commissioner may waive any or all the requirements set forth in Section [insert applicable section] if by reasons of a company's capital structure, surplus, amount of business in force and plan of operations, it substantially conforms to these requirements, or, in the opinion of the commissioner, otherwise affords adequate protection to contractholders."

Section 4. Separate Account

A domestic company issuing variable annuities shall establish one or more separate accounts pursuant to Section [insert applicable section] of the insurance laws of this state, subject to the following provisions:

A. (1) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Subsection A(2):

(a) Amounts allocated to a separate account and its accumulations may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; and

(b) The investments in the separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(2) Reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest may be maintained in a separate account if a portion of the assets of the separate account at least equal to the reserve liability is invested in accordance with the laws and regulations of this state governing the investments of life insurance companies. That portion of the assets also shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(3) With respect to seventy-five percent (75%) of the market value of the total assets in a separate account a company shall not purchase or otherwise acquire the securities of an issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after the purchase or acquisition the market value of the investment, together with prior investments of the separate account in the security taken at market, would exceed ten percent (10%) of the market value of the assets of the separate account. The commissioner, may waive this limitation if, in the opinion of the commissioner, the waiver will not render the operation of the separate account hazardous to the public or policyholders in this state.

(4) Unless otherwise permitted by law or approved by the commissioner, a company shall not purchase or otherwise acquire for its separate accounts the voting securities of an issuer if, as a result of the acquisition, the insurance company and its separate accounts, in the aggregate, will own more than ten percent (10%) of the total issued and outstanding voting securities of the issuer. This shall not apply with respect to securities held in separate accounts where the voting rights are exercisable only in accordance with instructions from persons having interest in the accounts.

(5) The limitations provided in Paragraphs (3) and (4) of this subsection shall not apply to investments with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, if the investments of the investment company comply in substance with Paragraphs (3) and (4).

Drafting Note: Virtually all statutes contain the broad language in Subsection A(1) permitting investments without regard to investment limitations with respect to life insurance companies. Subsection A(3) would impose a quantitative limitation to promote diversification and limit investment risk. It should be noted that while separate accounts registered under the 1940 Act will be subject to the 5% rule under that Act, there would appear to be sound reasons for permitting greater flexibility, up to 10%, with respect to separate accounts not subject to the 1940 Act. It is further provided that the commissioner may waive this limitation where it would not render the operation of the account hazardous.

Subsection A(4) would prohibit the acquisition by the separate account of the securities of an issuer if the acquisition would result in the ownership of more than 10% of the voting securities of the issuer, with the holdings by the company and all of its separate accounts aggregated, except when there is a pass-through of voting rights to contractholders.

Subsection A(6) is intended primarily to permit the operation of a separate account as a unit investment trust under the 1940 Act, with all of its assets being invested in the securities of a registered investment company. It should be noted, however, that the commissioner would retain indirect control since the exception from the application of Subsections A(3) and A(4) would not apply if the investments of the investment company did not comply with these subsections.

Basic authority for exemption from investment limitations, as well as the quantitative limitations in Subsections A(3) and A(4) and the exemption from these limitations in Subsection A(5), should probably be covered by statute.

B. Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account. Unless otherwise approved by the commissioner, the portion, if any, of the assets of the separate account equal to the company's reserve liability with regard to the benefits and funds referred to in Subsection A(2) shall be valued in accordance with the rules otherwise applicable to the company's assets.

Drafting Note: In the case of variable annuities involving a 1940 Act registered account and in many group contracts the procedure for valuing assets will be stated in rules of the separate accounts or in a separate applicable written agreement, and the regulation is drafted to permit this.

C. To the extent provided under the applicable contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

Drafting Note: To achieve effective insulation of certain assets held in separate accounts from claims of general creditors it is probably necessary, as a matter of general corporate law, that the insulation be specifically authorized by statute.

D. (1) Notwithstanding any other provisions of law, a company may:

(a) With respect to a separate account registered with the Securities and Exchange Commission as a unit investment trust, exercise voting rights in connection with securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the company; or

(b) With respect to a separate account registered with the Securities and Exchange Commission as a management investment company, establish for the account a committee, board or other body, whose members may or may not be otherwise affiliated with the company and may be elected to membership by the vote of persons having interests in the account ratably as determined by the company. The committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage the separate account and the investment of its assets.

(2) A company, committee, board or other body may make other provisions in respect to a separate account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect if the commissioner approves the provisions as not hazardous to the public or the company's policyholders in this state.

Drafting Note: Certain separate accounts are registered with the Securities and Exchange Commission under the Investment Company Act of 1940, and contractholders in these separate accounts must be given voting rights, principally in connection with the management of the assets of the account. Subsection D(1) is intended to provide for a separate account registered with the SEC as a unit investment trust, under which all of the assets of the account are invested in a separate mutual fund. In this connection, see also Subsection A(6). Subsection D(1) would permit a pass-through of voting rights in the shares of the underlying mutual fund to the contractholders.

Where a separate account is registered under the 1940 Act as a management investment company, the contractholders have the right to elect a committee with power to manage the account and invest its assets, as provided in Subsection D(2).

As with the insulation provision in Subsection C, it would probably be wise in most states to provide authority for the above regulation by statute, since many states require that the assets of an insurer may be managed by its board of directors.

E. (1) No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in the case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless the transfer, whether into or from a separate account, is made:

(a) By a transfer of cash; or

(b) By a transfer of securities having a valuation which could be readily determined in the marketplace, if that transfer of securities is approved by the commissioner.

(2) The commissioner may authorize other transfers among such accounts, if, in his opinion, such transfers would not be inequitable.

Drafting Note: This provision, common to many existing statutes and regulations, is intended to prevent unfair or discriminatory transfer among accounts. Regular cash flow should permit those transfers to and from the general account necessary to the operation of the variable annuity business to be made in cash.

F. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as may otherwise be approved by the commissioner.

Drafting Note: This section varies from a number of existing regulations that provide that assets shall be equal to reserves. The drafters agreed that a deficit should not be permitted, but that build-up of surplus within the separate account should not be prohibited as it would apparently be under the existing regulations referred to.

G. Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflict of interest shall also apply to members of a separate accounts committee, board or other similar body. No officer or director of the company nor a member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of the separate account.

Section 5. Filing of Contracts

The filing requirements applicable to variable annuities shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate. Contract form filings shall also include a certification by a member of the American Academy of Actuaries as to the compliance with Section 7.

Section 6. Variable Annuity Contracts

A. A variable annuity providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of variable benefits. A contract, including a group contract and a certificate in evidence of variable benefits issued under the contract, shall state that the dollar amount will vary to reflect investment experience and shall contain on its first page a clear statement to the effect that the benefits of the contract are on a variable basis.

B. Illustrations of benefits payable under any variable annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience. Nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits.

C. No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which in the opinion of the commissioner are more favorable to the holders of contracts:

(1) A provision that there shall be a grace period of thirty (30) days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which grace period the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which a payment received during the grace period shall be applied to produce the values arising under the contract; and

(2) A provision that, at any time within [insert number] years from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover overdue payments and indebtedness shall be applied to produce the values arising under the contract.

Drafting Note: The drafters recommend inclusion of provisions dealing with grace and reinstatement only if the law of a particular state requires these for individual fixed dollar deferred annuities. Several companies issuing variable annuity contracts do not require contractholders to make periodic stipulated payments. If a contractholder ceases making payments he or she may resume doing so at any time. It is assumed that Subsection C(1) would be inapplicable to these contracts since the provisions described above would be regarded as more favorable to the contractholders than a 30-day grace period.

D. (1) A variable annuity contact delivered or issued for delivery in this state shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder, and may guarantee that expense and mortality results shall not adversely affect the dollar amounts.

In the case of an individual variable annuity contract under which the expense and/or mortality results may adversely affect the dollar amount of benefits.

(a) The expense and mortality factors used in computing the dollar amount of variable benefits or other contractual payments or values shall be stipulated in the contract.

(b) Actual emerging expense and mortality results may be reflected in the dollar amount of benefits only through a mortality and expense charge that may vary only within a specified range indicated in the policy.

(2) In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(a) The annual net investment increment assumption shall not exceed five percent (5%) except with the approval of the commissioner.

(b) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity 2000 Mortality Table, or any modification of that table not having a lower life expectancy at any age, or any annuity mortality table adopted after 1996 by the National Association of Insurance Commissioners that is approved by the commissioner for this purpose.

(3) "Expense" as used in this subsection, may exclude some or all taxes, as stipulated in the contract.

E. The reserve liability for variable annuities shall be established pursuant to the requirements of Section [insert citation of Standard Valuation Law] in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Section 7. Nonforfeiture Benefits

Drafting Note: This section should be included if the Standard Nonforfeiture Law for Individual Deferred Annuities has been adopted in this state.

A. This section shall not apply to any:

(1) Reinsurance;

(2) Group annuity contract purchases in connection with one or more retirement plans or plans of deferred compensation established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, or other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended;

(3) Premium deposit fund;

(4) Investment annuity;

(5) Immediate annuity;

(6) Deferred annuity contract after annuity payments have commenced;

(7) Reversionary annuity; or

(8) To any contract which is to be delivered outside this state through an agent or other representative of the company issuing the contract.

B. To the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account before the annuity commencement date, the contract shall contain provisions that satisfy the requirements of Section [insert citation to the Standard Nonforfeiture Law for Deferred Annuities] and shall not otherwise be subject to this section.

Drafting Note: For the purpose of demonstrating that the minimum nonforfeiture amounts under the fixed portion of the contract comply with the Standard Nonforfeiture Law for Deferred Annuities, the company should assume that 100% of the considerations are allocated to the fixed account. If the contract provides for transfers between the fixed and variable accounts, the transaction charge may not exceed the charge for transfers to another separate account or to another investment division within the same separate account, as determined in Subsection D of this section.

C. In the case of a contract issued on or after [insert operative date of this section which should be at least 18 months after adoption] no variable annuity contract, except as stated in Subsections A and B, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan described in the contract that complies with Subsection G. The description will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of the contract at or prior to the commencement of annuity payments, the company will pay in lieu of a paid-up annuity benefit a cash surrender benefit described in the contract that complies with Subsection H. The contract may provide that the company reserves the right, at its option, to defer the determination and payment of a cash surrender benefit for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists that may make determination and payment impractical.

(3) A statement that a paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

D. (1) The minimum values as specified in this section of paid-up annuity, cash surrender or death benefits available under a variable annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this subsection.

(2) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest equal to the net investment return (as hereinafter defined) of the net considerations (as defined in Subsection E) paid prior to that time, decreased by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest equal to the net investment return;

(b) An annual contract charge of $50, accumulated at rates of interest equal to the net investment return;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest equal to the net investment return; and

Drafting Note: The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken.

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(3) "Net investment return" means that the rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in the contract, or in the case of a contract issued by a nonprofit corporation under which the contractholder participates fully in the investment, mortality and expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract shall be determined at least monthly.

E. The net considerations for a given contract year used to define the minimum nonforfeiture amount in Subsection D shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

F. Demonstration that a contract's nonforfeiture amounts comply with this section shall be based on the following assumptions:

(1) Values should be tested at the end of each of the first twenty (20) contract years;

(2) A net investment return of seven percent (7%) per year should be used;

(3) If the contract provides for transfers to another separate account or to another investment division within the same separate account, one transfer per contract year should be assumed;

(4) In determining the state premium tax applicable to the contract, the state of residence should be assumed to equal the state of delivery;

(5) With respect to contracts providing for periodic considerations, monthly considerations of $100 should be assumed for each of the first 240 months;

(6) With respect to contracts providing for a single consideration, a $10,000 single consideration should be assumed; and

G. Any paid-up annuity benefit available under a variable annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

H. For variable annuity contracts that provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount computed after the request for surrender is received by the company. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

I. A variable annuity contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the annuity commencement date shall include a statement in a prominent place in the contract that these benefits are not provided.

J. Notwithstanding the requirements of this section, a variable annuity contract may provide under the situations specified in Paragraph (1) or (2) of this subsection that the company, at its option, may cancel the annuity and pay the contractholder its accumulated value and by such payment be released of any further obligation under the contract:

(1) If, at the time the annuity becomes payable, the accumulated value is less than $2,000, or would provide an initial income of less than $20 per month; or

(2) If, prior to the time the annuity becomes payable under a periodic payment variable annuity contract, no considerations have been received under the contract for a period of two (2) full years and the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and the accumulated value amount to less than $2,000.

K. For a variable annuity contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of SubsectionD of this section, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 8. Required Reports

A. A company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his or her last address known to the company, a statement or statements reporting the investments held in the separate account. The company shall submit annually to the insurance commissioner a statement of business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners.

Drafting Note: The drafters intended to leave this language sufficiently flexible to apply in the event that the separate account statement is combined with the regular life annual statement blank.

B. A company issuing individual variable annuities shall mail to the contractholder at least once in each contract year after the first at his or her last address known to the company a statement reporting as of a date not more than four (4) months previous to the date of mailing. In the case of an annuity contract under which payments have not yet commenced, the statement shall contain:

(1) The number of accumulation units credited to the contract and the dollar value of a unit; or

(2) The value of the contractholder's account.

Section 9. Foreign Companies

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public substantially equal to that provided by these regulations, the commissioner, to the extent deemed appropriate by the commissioner, may consider compliance with that law or regulation as compliance with these regulations.

Drafting Note: This blanket provision would permit a commissioner to waive any or all of these requirements applicable to foreign companies in cases where the quality of regulation in the state of domicile is such that he or she would have every reason to expect that the company would be adequately regulated.

Section 10. Qualifications of Agents for the Sale of Variable Annuities

A. (1) A person may not sell or offer for sale in this state any variable annuity contract unless the person is an agent and has filed with the commissioner, in a form satisfactory to the commissioner, evidence that the person holds any license or authorization that may be required for the solicitation or sale of variable annuity contracts by any federal or state securities law.

(2) Any examination administered by the Department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation and sale of variable annuity contracts as the commissioner deems appropriate.

B. A person qualified in this state under this section to sell or offer to sell variable annuity contracts shall immediately report to the commissioner:

(1) Any suspension or revocation of his or her agent's license in any other state or territory of the United States;

(2) The imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him or her by any national securities exchange, or national securities association, or any federal, state or territorial agency with jurisdiction over securities or variable annuity contracts;

(3) Any judgment or injunction entered against him or her on the basis of conduct deemed to have involved fraud, deceit, misrepresentation or violation of any insurance or securities law or regulation.

C. The commissioner may reject an application or suspend or revoke or refuse to renew an agent's qualification under this section to sell or offer to sell variable annuity contracts upon any ground that would bar the applicant or agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable annuity contracts.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1975 Proc. I 2, 6, 573, 752, 755-760 (adopted).
1980 Proc. I 29, 38, 406, 516, 540, 545-555 (amended and reprinted).
2006 Proc. 2nd Quarter 39, 55-61 (amended).

VARIABLE ANNUITY MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VARIABLE ANNUITY MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-38-1 to 27-38-6 (1975).
Alaska		ALASKA ADMIN. CODE tit. 3, §§ 28.010 to 28.190 (1973/2011) (all variable contracts).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-2631 to 20-2638 (1996).	
Arkansas		CODE ARK. R. 054.00.6 (1970).	
California		CAL. CODE REGS. tit. 10, §§ 2525 to 2533.1 (1972).	
Colorado		COLO. CODE REGS. § 4-1-1 (1994/2010).	
Connecticut	NO CURRENT ACTIVITY		
Delaware		18 DEL. CODE REGS. § 1201 (1969/2003) (all variable contracts).	
District of Columbia			D.C. MUN. REGS. tit. 26, § 1004 (1961).

VARIABLE ANNUITY MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. ADMIN. CODE ANN. r. 69O-162.001 to 69O-162.016 (1974/2017).
Georgia		GA. COMP. R. & REGS. 120-2-22 (1969).	
Guam	NO CURRENT ACTIVITY		
Hawaii			MEMORANDUM 2012-2 (2012).
Idaho		IDAHO ADMIN. CODE r. 18.03.03 (2019).	
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1551.20 to 15.100 (2001) (portions of model).		
Indiana			760 IND. ADMIN. CODE 1-7-1 to 1-7-8 (1971/2013).
Iowa		IOWA ADMIN. CODE r. 191-31.1 to 191-31.7 (1968/2007).	
Kansas		KAN. ADMIN. REGS. §§ 40-15-1 to 40-15-8 (1969/1986).	
Kentucky		806 KY. ADMIN. REGS. § 15:010 (1975/1984).	
Louisiana		LA. ADMIN. CODE tit. 37 §§ XIII.7701 to XIII.7715 (Regulation 28) (1969/2009).	
Maine			02-031 ME. CODE R. § 310 (1984).
Maryland			MD. CODE REGS. 31.09.04.01 to 31.09.04.09 (1965/1988).
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. ADMIN. CODE r. 500.621 to 500.629 (1971/1978); BULLETIN 2009-15-INS (2009).
Minnesota	NO CURRENT ACTIVITY		

VARIABLE ANNUITY MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi		19 CODE MISS. R. Pt. 2, R. 4.01 to 4.09 (2012).	
Missouri		20 MISS. CODE R. § 400-1.020 (1969/1985).	
Montana	NO CURRENT ACTIVITY		
Nebraska			NEB. REV. STAT. ANN. §§ 44-2201 to 44-2221 (1969).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. CODE ADMIN. R. INS. 401.10 (2017) (portions of model).		
New Jersey			N.J. ADMIN. CODE §§ 11:4-44.1 to 11:4-44.4 (1996/2001) (all variable contracts); § 11:4-43.3 (2000/2006).
New Mexico			N.M. CODE R. § 13.9.3 (1997).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 50.1 to 50.11 (Regulation 47) (1971/2000).
North Carolina	NO CURRENT ACTIVITY		
North Dakota		N.D. ADMIN. CODE 45-04-02-01 to 45-04-02-18 (1974/1986).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-9-10 to 365:10-9-18 (1969).	
Oregon	NO CURRENT ACTIVITY		
Pennsylvania		31 PA. CODE §§ 85.01 to 85.40 (1978/1981).	
Puerto Rico	NO CURRENT ACTIVITY		

VARIABLE ANNUITY MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	NO CURRENT ACTIVITY		
South Carolina		S.C. CODE ANN. REGS. 69-12 (Part A) (1976/1988).	
South Dakota		S.D. ADMIN. R. 20:06:07:01 to 20:06:07:07 (1978/1986).	
Tennessee		TENN. COMP. R. & REGS. 0780-1-17 (1974/1978) (all variable contracts).	
Texas			28 TEX. ADMIN. CODE §§ 3.701 to 3.706 (1985).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, §§ 3855 to 3859 (1971).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		14 VA. ADMIN. CODE 5-20-10 to 5-20-110 (1969).	
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 2.13 (1981/2009) (portions of model) (all variable contracts).		
Wyoming	WYO. ADMIN. CODE 044.0002.66 (2016).		

PROJECT HISTORY - 2006

VARIABLE ANNUITY MODEL REGULATION (#250)

1. Project Description

In late 2003, the Life Insurance and Annuities (A) Committee asked the Life and Health Actuarial Task Force to review the following models and make a recommendation as to whether they should be amended, deleted, or left unchanged the Model Variable Annuity Regulation and the Interest-Indexed Annuity Contracts Model Regulation. At that time, the Task Force also undertook a review of the Modified Guaranteed Annuity Model Regulation because of the many similarities between it and the other models.

These amendments to this model are primarily designed to achieve consistency with the revisions to the Standard Nonforfeiture Law for Individual Deferred Annuities. In addition, the Task Force also looked at differences between the variable annuity regulation and the modified guaranteed annuity model and the current requirements pertaining to variable annuity products in the Interstate Compact Standards. The "Significant Issues Raised" section contains a list of some differences that were identified between the compact standards and this model.

2. Group Responsible for Drafting Model and States Participating

The 2006 members of the Life and Health Actuarial Task Force were: New Mexico (Chair), Kansas (Vice-Chair), Alabama, Alaska, Arkansas, California, Connecticut, Florida, Kentucky, Minnesota, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Texas, and Utah.

3. General Description of Drafting Process

This project was discussed at several of the Task Force's quarterly meeting between March 2004 and March 2006. In addition, the Task Force held one conference call on this topic during each quarter over that period, except the third quarter of 2004 and the first quarters of 2005 and 2006. All quarterly meetings and conference calls were open to industry personnel. Notice of each conference call was posted on NAIC's Web site and e-mailed to approximately 300 interested parties, including representatives of the American Council of Life Insurers (ACLI).

4. Significant Issues Raised

1. The mortality table used was changed from the Annuity Mortality Table for 1949, Ultimate to the Annuity 2000 Mortality Table.

2. The minimum nonforfeiture amount computations were simplified and to account for amounts paid by the company in premium taxes.

3. The Interstate Compact Standards Pertaining to variable annuities contain this requirement pertaining to contracts with "bail-out" provisions:

   > If the contract provides for a benefit waiving surrender charges contingent on a declared interest rate, the company shall provide a certification that the owner will be provided a timely notification when the declared interest rate declines to a point at which the waiver of surrender charge benefit is available.

   The variable annuity model contains no such provision. The Task Force concluded that this is more a disclosure issue than an actuarial matter, and therefore was beyond the scope of its assignment.

4. The Standards contain this requirement pertaining to actuarial certifications:

   > Certification by a member of the American Academy of Actuaries as to the compliance with Section 7 of the NAIC Model Variable Annuity Regulation, model #250.

   The proposed changes to the model include a certification of compliance with the relevant standards.

5. Implications of this Project for Accreditation and Codification

Portions of the model are included in Appendix A-250 of the NAIC Accounting Practices and Procedures Manual.

MODIFIED GUARANTEED ANNUITY MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to provide rules for a modified guaranteed annuity, a variable annuity whose assets are placed in a separate account.

Section 2. Authority

This rule is issued pursuant to the authority vested in the Commissioner of Insurance of the State of [insert state] under [insert cite to state's separate account law]. This rule will take effect on [insert date].

Section 3. Applicability and Scope

This regulation shall apply to:

A. The qualifications of agents who sell modified guaranteed annuity contracts in this state;

B. The qualification of insurers who issue these contracts;

C. The required contract form and provisions for issue of this coverage in this state; and

D. The manner in which separate account assets, supporting these issued contracts, are to be maintained and reported.

Section 4. Definitions

As used in this regulation, the following terms and phrases shall mean:

A. "Modified guaranteed annuity" means a deferred annuity contract, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. The contract contains nonforfeiture values that are based upon a market-value adjustment formula if held for shorter periods.

This formula may or may not reflect the value of assets held in the separate account. The assets underlying the contract shall be in a separate account during the period or periods when the contract holder can surrender the contract.

B. "Interest credits" means all interest that is credited to the contract.

C. "Separate account" means a separate account established pursuant to Section [insert section], or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

D. "Commissioner" means the Insurance Commissioner of [insert state].

Section 5. Authority of Insurers

The following requirements apply to all insurers either seeking or having authority to issue modified guaranteed annuities in this state.

A. Licensing and Approval to do Business.

(1) No company shall deliver or issue for delivery modified guaranteed annuities within this state unless it is licensed or organized to do life insurance or annuity business in this state. The commissioner must be satisfied that its condition or method of operation in connection with the issuance of these contracts will not render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things, the history and financial condition of the company; the character, responsibility and fitness of the officers and directors of the company; and the law and regulation under which the company is authorized in the state of domicile to issue these annuities.

(2) If the company is a subsidiary of an admitted life insurance company, or affiliated with such a company by common management or ownership, it may be deemed by the commissioner to have satisfied the provision of Paragraph (1) if either the subsidiary or the admitted life company satisfies the provisions of Paragraph (1). Companies licensed and having a satisfactory record of doing business in this state for a period of at least three (3) years may be deemed to have satisfied the commissioner with respect to Paragraph (1) above.

(3) Before a company shall deliver or issue for delivery modified guaranteed annuities within this state, it shall submit to the commissioner a general description of the kinds of annuities it intends to issue. If requested by the commissioner, the following shall be submitted:

(a) A copy of the statutes and regulations of its state of domicile under which it is authorized to issue modified guaranteed annuities; and

(b) Biographical data with respect to officers and directors of the company on the NAIC uniform biographical data forms.

B. Use of Sales Materials.

(1) An insurer authorized to sell modified guaranteed annuities in this state shall not use any sales material, advertising material or descriptive literature or other materials of any kind in connection with the sale of modified guaranteed annuities in this state that is false, misleading, deceptive or inaccurate.

(2) Illustrations of benefits payable under a modified guaranteed annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience; except that hypothetical assumed interest credits may be used to illustrate possible levels of benefits.

(3) Before an insurer shall deliver or issue for delivery a modified guaranteed annuity contract in this state, the commissioner may require the filing of a copy of any prospectus or other sales material to be used in connection with the marketing of the insurer's modified guaranteed annuity contract. The sales material shall clearly illustrate that there can be both upward and downward adjustments due to the application of the market value adjustment formula in determining nonforfeiture benefits.

C. Reports. An insurer authorized to transact the business of modified guaranteed annuities in this state shall submit to the commissioner:

(1) A separate account annual statement, which shall include the business of its modified guaranteed annuities; and

(2) Such additional information concerning its modified guaranteed annuity operations or separate accounts as the commissioner shall deem necessary.

D. Authority of Commissioner to Disapprove.

Any material required to be filed with and approved by the commissioner shall be subject to disapproval if at any time it is found by the commissioner not to comply with the standards established by this regulation.

Section 6. Filing of Contracts

The filing requirements applicable to modified guaranteed annuities shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate. Filings shall include a demonstration in a form satisfactory to the commissioner that the nonforfeiture provisions of the contracts comply with Section 7B of this regulation, as well as a certification by a member of the American Academy of Actuaries as to the compliance with Section 7B.

Section 7. Modified Guaranteed Annuity Contract Requirements

A. Mandatory Contract Benefit and Design Requirements.

(1) A modified guaranteed annuity contract delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of nonforfeiture benefits.

(2) A modified guaranteed annuity contract calling for the payment of periodic stipulated payments shall not be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(a) A provision that there shall be a grace period of thirty (30) days or one month during which the contract shall remain in force and, within which any payment due to the insurer other than the first may be made. The contract may include a statement of the basis for determining the date as of which any such payment received during the grace period shall be applied to produce the values under the contract.

(b) A provision that, at any time within one year from the date of default, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and of all indebtedness to the insurer on the contract, including interest. Reinstatement may not occur if the cash value has been paid. The contract may include a statement of the basis for determining the date as of which the amount to cover the overdue payments and indebtedness shall be applied to produce the values under the contract.

(c) A provision that, to the extent set out in the contract, the portion of the assets of any separate account that equal the reserves and other contract liabilities of the account shall not be chargeable with liabilities arising out of any other business of the company.

(3) The market-value adjustment formula, used in determining nonforfeiture benefits, shall be stated in the contract and shall be applicable for both upward and downward adjustments. When a contract is filed, it shall be accompanied by an actuarial statement indicating the basis for the market-value adjustment formula and that the formula provides reasonable equity to both the contract holder and the insurance company.

Drafting Note: To achieve effective insulation of certain assets held in separate accounts from claims of general creditors it is probably necessary, as a matter of general corporate law, that the insulation be specifically authorized by statute.

B. Nonforfeiture Benefits.

(1) This section shall not apply to any of the following:

(a) Reinsurance;

(b) Group annuity contracts purchased in connection with one or more retirement plans or deferred compensation plans established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code;

(c) Premium deposit fund;

(d) Investment annuity;

(e) Immediate annuity;

(f) Deferred annuity contract after annuity payments have commenced;

(g) Reversionary annuity; or

(h) Any contract which is to be delivered outside this state by an agent or other representative of the company issuing the contract.

(2) A modified guaranteed annuity contract shall not be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(a) When premium payments cease under a contract, the insurer will grant a paid-up annuity benefit on a plan described in the contract that complies with Paragraph (7) of this subsection. The provision will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(b) If a contract provides for a lump sum settlement at maturity or at any other time, upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay, in lieu of a paid-up annuity benefit, a cash surrender benefit as described in the contract that complies with Paragraph (8) of this subsection. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefore with surrender of the contract after making written request and receiving written approval of the commissioner.The request shall address the necessity and equitability to all policyholders of the deferral.

(3) The minimum values, as specified in this section, of any paid-up annuity, cash surrender or death benefits available under a modified guaranteed annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this paragraph. The unadjusted minimum nonforfeiture amount on any date prior to the annuity commencement date shall be an amount equal to the net considerations (as specified in Paragraph (6) of this subsection) increased by the interest credits defined in Section 4 allocated to the net considerations, which amount shall be reduced to reflect the effect of Subparagraphs (a), (b), (c), and (d) below:

(a) Any prior withdrawls from or partial surrenders of the contract increased by the interest credits defined in Section 4;

(b) An annual contract charge of $50, increased by the interest credits defined in Section 4;

(c) Any premium tax paid by the company for the contract, increased by the interest credits defined in section 4; and

Drafting Note: The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken.

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(4) Guaranteed interest credits in each year for any period of time for which interest credits are guaranteed shall be reasonably related to the average guaranteed interest credits over that period of time.

Drafting Note: The requirement that guaranteed interest credits be reasonably related to their average over any period is intended to preclude the use of patterns of interest credits that are not based on economic reality in order to manipulate unadjusted minimum nonforfeiture amounts.

(5) The minimum nonforfeiture amount shall be the unadjusted minimum nonforfeiture amount adjusted by the market-value adjustment formula contained in the contract.

(6) The net considerations for a given contract year used to define the minimum nonforfeiture amount in Paragraph (3) shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

(7) Any paid-up annuity benefit available under a modified guaranteed annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(8) For modified guaranteed annuity contracts that provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount next computed after the request for surrender is received by the insurer. The death benefit under these contracts shall be at least equal to the cash surrender benefit.

(9) Any modified guaranteed annuity contract which does not provide cash surrender benefits, or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the annuity commencement date shall include a statement in a prominent place in the contract that these benefits are not provided.

(10) Despite the requirements of this section, a modified guaranteed annuity contract may provide under the situations specified in Subparagraph (a) or (b) below that the insurer, at its option, may cancel the annuity and pay the contract holder the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforfeiture amount, and by this payment be released of any further obligation under the contract:

(a) If, at the time the annuity becomes payable, the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforfeiture amount is less than $2,000, or would provide an income the initial amount of which is less than $20 per month; or

(b) If, prior to the time the annuity becomes payable under a periodic payment contract, no considerations have been received under the contract for a period of two (2) full years and both the total considerations paid prior to that period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforteiture amount is less than $2,000.

(11) For any modified guaranteed annuity contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Despite the provisions of Paragraph (2) of this subsection, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all these additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of these additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Drafting Note: This regulation is not intended to prevent the application of variable annuity regulations or the individual nonforfeiture laws if and to the extent that modified guaranteed annuity benefits are combined in the same contract with (1) variable annuity benefits that vary directly with the value of the assets in the separate account, and (2) traditional fixed annuity benefits, or (3) life insurance benefits.

C. The Application. The application for a modified guaranteed annuity shall prominently set forth language substantially stating that amounts payable under the contract are subject to a market value adjustment prior to a date or dates specified in the contract. The statement shall be placed immediately above the signature line.

Section 8. Reserve Liabilities

A. Reserve liabilities for modified guaranteed annuities shall be established in accordance with actuarial procedures that recognize:

(1) That assets of the separate account are based on market values;

(2) The variable nature of benefits provided; and

(3) Any mortality guarantees.

B. As a minimum, the separate account liability will equal the surrender value based upon the market value adjustment formula contained in the contract. If that liability is greater than the market value of the assets, a transfer of assets will be made into the separate account so that the market value of the assets at least equals that of the liabilities. Also, any additional reserve that is needed to cover future guaranteed benefits will also be set up by the valuation actuary.

C. The market value adjustment formula, the interest guarantees and the degree to which projected cash flow of assets and liabilities are matched must also be considered. Each year, the valuation actuary shall provide an opinion on whether the assets in the separate account are adequate to provide all future benefits that are guaranteed.

Section 9. Separate Accounts

The following requirements apply to the establishment and administration of modified guaranteed annuity separate accounts by a domestic insurer:

A. Establishment and Administration of Separate Accounts. A domestic insurer issuing modified guaranteed annuities shall establish one or more separate accounts pursuant to Section [insert section providing for separate accounts].

B. Amounts in the Separate Account. The insurer shall maintain in each separate account assets with a market or other value comporting to standards set out in Section [insert section] at least equal to the valuation reserves and other contract liabilities respecting such account.

C. Valuation of Separate Account Assets. Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value, or pursuant to standards contained in Section [insert section].

D. Investment Laws. Unless otherwise approved by the commissioner, separate accounts relating to modified guaranteed annuities will be subject to investment laws applicable to the insurer's general asset account.

Section 10. Reports to Policyholders

A company shall annually provide its contractholders with a report showing both the account value and the cash surrender value. The report should clearly indicate that the account value is prior to the application of any surrender charges or market value adjustment formula. It should also specify the surrender charge and market value adjustment used to determine the cash surrender value.

Section 11. Foreign Companies

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public that is substantially similar to that provided by these regulations, the commissioner may consider compliance with the law or regulation as compliance with this rule to the extent deemed appropriate by him or her.

Section 12. Authorization of Agents

A person, corporation, partnership, or other legal entity may not sell or offer for sale in this state any modified guaranteed annuity contract unless licensed to sell variable annuities under the insurance laws of this state.

Section 13. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1985 Proc. II 11, 23, 552, 556-561, 607 (adopted).
1990 Proc. II 7, 15-16, 565, 582, 897 (amended and reprinted).
2006 Proc. 1st Quarter 36, 39-43 (amended).

MODIFIED GUARANTEED ANNUITY REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODIFIED GUARANTEED ANNUITY REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	054-00-59 ARK. CODE R. §§ 1 to 13 (1994).		
California	CAL. CODE REGS. tit. 10, §§ 2534.20 to 2534.32 (1992/2006).		CAL. INS. CODE § 10506.3 (1992); BULLETIN 92-7 (1992); BULLETIN 92-7 (revised) (1993).
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. AGENCIES REGS. tit. 38a, §§ 433-12 to 433-22 (1986).		BULLETIN PF-19 (1990).
Delaware	NO CURRENT ACTIVITY		
District of Columbia			D.C. CODE ANN. § 31-4442 (1934/2003).
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		

MODIFIED GUARANTEED ANNUITY REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1410.10 to 1410.80 (1997/2001) (portions of model).		BULLETIN 2013-20 (2013); BULLETIN 2014-12 (2014); BULLETIN 2015-11 (#2) (2015); BULLETIN 2016-9 (2016).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. COMP. LAWS §§ 500.4101 to 500.4127 (1991/1993).		
Minnesota	MINN. R. §§ 2751.0100 to 2751.1300 (1992).		BULLETIN 91-2 (1991).
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.150 (1990/2003).		BULLETIN 2008-03 (2008).
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		

MODIFIED GUARANTEED ANNUITY REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, § 99.4 (2001); N.Y. COMP. CODES R. & REGS. tit. 11, § 99.9 (2001/2009).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania			NOTICE 1994-12 (1994) (separate account modified guaranteed annuity); NOTICE 1994-11 (1994) (general account modified guaranteed annuity).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-25-7.1 to 20-25-7.13 (2001).		
South Carolina			BULLETIN 10-2003 (2003).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 1116.001 to 1116.003 (2011).
Utah			UTAH CODE ANN. § 31A-5-217.5 (1992/2010); UTAH ADMIN. CODE r. R590-227 (2004/2016); BULLETIN 2002-9 (2002); BULLETIN 2011-2 (2011).

MODIFIED GUARANTEED ANNUITY REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-107.1 (1992); § 38.2-1443.1 (2008); § 38.2-3113.1 (1992).
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. ADMIN. CODE INS. §§ 2.13(8) to 2.13(9) (1990/2009).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2006

MODIFIED GUARANTEED ANNUITY MODEL REGULATION (#255)

1. Project Description

In late 2003, the Life Insurance and Annuities (A) Committee asked the Life and Health Actuarial Task Force to review the following models and make a recommendation as to whether they should be amended, deleted, or left unchanged the Model Variable Annuity Regulation and the Interest-Indexed Annuity Contracts Model Regulation. At that time, the Task Force also undertook a review of the Modified Guaranteed Annuity Model Regulation because of the many similarities between it and the other models.

These amendments to this model are primarily designed to achieve consistency with the revisions to the Standard Nonforfeiture Law for Individual Deferred Annuities. In addition, the Task Force also looked at differences between the variable annuity regulation and the modified guaranteed annuity model and the current requirements pertaining to variable annuity products in the Interstate Compact Standards. The "Significant Issues Raised" section contains a list of some differences that were identified between the compact standards and this model.

2. Group Responsible for Drafting Model and States Participating

The 2005 members of the Life and Health Actuarial Task Force are: New Mexico (Chair), Minnesota (Vice-Chair), Alabama, Alaska, Arkansas, California, Connecticut, Florida, Kansas, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, and West Virginia.

3. General Description of Drafting Process

This project was discussed at several of the Task Force's quarterly meeting between March 2004 and December 2005. In addition, the Task Force held one conference call on this topic during each quarter over that period, except the third quarter of 2004 and the first quarter of 2005. All quarterly meetings and conference calls were open to industry personnel. Notice of each conference call was posted on NAIC's Web site and e-mailed to approximately 300 interested parties, including representatives of the American Council of Life Insurers (ACLI).

4. Significant Issues Raised

1. The Interstate Compact Standards Pertaining to variable annuities contain this requirement pertaining to contracts with "bail-out" provisions:

> If the contract provides for a benefit waiving surrender charges contingent on a declared interest rate, the company shall provide a certification that the owner will be provided a timely notification when the declared interest rate declines to a point at which the waiver of surrender charge benefit is available.

The modified guaranteed annuity model contains no such provision. The Task Force concluded that this is more a disclosure issue than an actuarial matter, and therefore was beyond the scope of its assignment.

2. The Standards contain this requirement pertaining to actuarial certifications:

> Certification by a member of the American Academy of Actuaries as to the compliance with Section 7 of the NAIC Model Variable Annuity Regulation, model #250.

The proposed changes to the model include a certification of compliance with the relevant nonforfeiture standards.

3. Section 3A(2) of the Standard Nonforfeiture Law for Individual Deferred Annuities contains this language: "The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral." The proposed change to the MGA incorporates this language.

5. Implications of this Project for Accreditation and Codification

Portions of the model are included in Appendix A-255 of the NAIC Accounting Practices and Procedures Manual.

VARIABLE CONTRACT MODEL LAW

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Section 1. Domestic Companies

A domestic life insurance company may establish one or more separate accounts, and may allocate amounts to it (including without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life insurance or annuities (and incidental benefits), payable in fixed or variable amounts or both, subject to the following:

A. The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the company.

B. Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Subsection C:

(1) Amounts allocated to a separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; and

(2) The investments in the separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

C. Except with the approval of the commissioner and under such conditions as to investments and other matters as the commissioner may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration, and funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account.

Drafting Note: Wherever "commissioner" is referred to in this Act, "director" or "superintendent" should be substituted where applicable.

Drafting Note: It is intended that separate account investments except as to conditions imposed by the commissioner under Subsection C, should be exempt from the laws of the state governing the investments of life insurance companies. In some states it may be necessary to provide for the exemption by reference to the appropriate sections or to a particular article or chapter. Some states, however, may not want to provide an exemption from all investment laws applicable to domestic companies, but merely from some specific sections establishing requirements or restrictions on the quantity of investments, such as a limit on the amount of common stocks which may be held by the company. These states may want to require that separate account investments meet certain of the qualitative requirements of the investment laws. In this event, the exemption must refer to specific sections, which will have to be carefully selected. If certain qualitative restrictions are retained, it then may become necessary, in order to recognize the "unit investment trust" approach to variable contract business, to specifically provide that all of the assets of a separate account may be invested "in the shares of an open-end investment company or companies registered under the federal Investment Company Act of 1940."

D. Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account; provided that, unless otherwise approved by the commissioner, the portion, if any, of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in Subsection C shall be valued in accordance with the rules otherwise applicable to the company's assets.

E. Amounts allocated to a separate account in the exercise of the power granted by this Act shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to these amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

F. No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless the transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that the transfer of securities is approved by the commissioner. The commissioner may approve other transfers among the accounts if, in his or her opinion, the transfers would not be inequitable.

G. To the extent the company deems it necessary to comply with any applicable federal or state laws, the company, with respect to a separate account, including without limitation any separate account that is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account.

Drafting Note: Certain separate accounts are registered with the Securities and Exchange Commission under the Investment Company Act of 1940, and variable annuity contractholders in the separate accounts must be given voting rights, principally in connection with the management of the assets of the account. The foregoing provision is accordingly recommended since many states require that the assets of an insurer be managed by its Board of Directors.

Section 2. Contract Statement Required

A contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of the variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that the dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

Section 3. License Required

A. A company shall not deliver or issue for delivery within this state variable contracts unless it is licensed or organized to do a life insurance or annuity business in this state, and the commissioner is satisfied that its condition or method of operation in connection with the issuance of the contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts. The state of entry of an alien company shall be deemed its place of domicile for this purpose.

B. If the company is a subsidiary of an admitted life insurance company, or affiliated with such company through common management or ownership, it may be deemed by the commissioner to have met the provisions of this section if either it or the parent or the affiliated company meets the requirements.

Section 4. Power of Commissioner

Notwithstanding any other provision of law, the commissioner shall have sole authority to regulate the issuance and sale of variable contracts, and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this Act.

Section 5. Applicability

Except for Sections [insert applicable sections] of the Insurance Law in the case of a variable annuity contract and Sections [insert applicable sections] in the case of a variable life insurance policy and except as otherwise provided in this Act, all pertinent provisions of the Insurance Law shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract, delivered or issued for delivery in this state shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract.

Drafting Note: Wherever this Act refers to the "Insurance Law," any necessary changes in reference should be made to indicate the applicable statute or statutes.

The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Drafting Note: Insert appropriate section numbers above to make inapplicable any provisions in the Insurance Law requiring (i) grace, reinstatement and nonforfeiture provisions for either annuity contracts or life insurance policies, (ii) policy loans, (iii) tables of installment payment of contract proceeds, (iv) that annuity contracts be participating, and (v) any other provisions relating to annuities or insurance which require either elimination or modification for variable contracts, such as any provision requiring that the policy stipulate the dollar amount of benefits under the policy. If the law of a particular state requires provisions dealing with grace, reinstatement or nonforfeiture in individual fixed-dollar deferred annuities, the second sentence of this section should be modified by inserting the words "or annuity" after the word "insurance." If the law of a particular state requires any such provision with respect to a group contract, a new sentence should be added specifying that the provision, appropriate to a variable group contract, shall be required.

Section 6. Effective Date

This Act shall take effect [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1970 Proc. I 300, 344, 367-370, 379 (adopted).
1972 Proc. I 15, 16, 555, 607 (amended).

VARIABLE CONTRACT MODEL LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VARIABLE CONTRACT MODEL LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-38-1 to 27-38-6 (1971/1986).		
Alaska	ALASKA STAT. § 21.42.315 (1968/1980).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-2661 to 20-2662 (2007).
Arkansas	ARK. CODE ANN. §§ 23-81-401 to 23-81-405 (1975).		
California	CAL. INS. CODE § 10506 (1963/2002).		BULLETIN 97-2 (1997).
Colorado	COLO. REV. STAT. §§ 10-7-402 to 10-7-405 (1971/2003).		
Connecticut	CONN. GEN. STAT. § 38a-433 (1967/1983).		
Delaware	DEL. CODE ANN. tit. 18, § 2932 (1995).		
District of Columbia			D.C. CODE § 31-4442 (1981/1993).
Florida			FLA. STAT. §§ 627.801 to 627.807 (1961/1982).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. § 33-11-66 (2009/2013).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:10D-118 (1988).		MEMORANDUM 2012-2 (2012).
Idaho	IDAHO CODE ANN. §§ 41-1936 to 41-1939 (1969/1971).		
Illinois	215 ILL. COMP. STAT. 5/245.21 to 5/245.25 (1977/2013).		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA CODE §§ 508A.1 to 508A.5 (1973).		
Kansas			KAN. STAT. ANN. §§ 40-436 to 40-438 (1967/1972).
Kentucky	KY. REV. STAT. ANN § 304.15-390 (1970/1986).		
Louisiana	LA. REV. STAT. ANN. § 22:781 (1966/1976).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2537 (1970/1973).		
Maryland			MD. CODE ANN., INS. §§ 16-601 to 16-603 (1970/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 132F (1982).
Michigan			MICH. COMP. LAWS § 500.925 (1963/1974); BULLETIN 2016-07-INS (2016).
Minnesota			MINN. STAT. §§ 61A.13 to 61A.21 (1967/1978).
Mississippi	MISS. CODE ANN. §§ 83-7-27 to 83-7-49 (1978).		

VARIABLE CONTRACT MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. REV. STAT. § 376.309 (1963/1983).		
Montana	MONT. CODE ANN. §§ 33-20-601 to 33-20-606 (1989).		
Nebraska			NEB. REV. STAT. §§ 44-2201 to 44-2221 (1969).
Nevada	NEV. REV. STAT. § 688A.390 (1971).		
New Hampshire			N.H. REV. STAT. ANN. §§ 408:23 to 408:26 (1967/1977).
New Jersey			N.J. REV. STAT. §§ 17B:28-1 to 17B:28-15 (1971/1981).
New Mexico	N.M. STAT. ANN. § 59A-20-30 (1985).		
New York			N.Y. INS. LAW § 4240 (1984).
North Carolina	N.C. GEN. STAT. § 58-7-95 (1965/2001).		
North Dakota	N.D. CENT. CODE §§ 26.1-33-13 to 26.1-33-17 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3911.011 (1969).
Oklahoma	OKLA. STAT. tit. 36, § 6061 (1967/1973).		
Oregon	OR. REV. STAT. §§ 733.220 to 733.230 (1973).		
Pennsylvania	40 PA. STAT. ANN. § 506.2 (1963).		
Puerto Rico	NO CURRENT ACTIVITY		

VARIABLE CONTRACT MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS §§ 27-32-1 to 27-32-9 (1966/2002).		
South Carolina	S.C. CODE ANN. §§ 38-67-10 to 38-67-50 (1988).		
South Dakota	S.D. CODIFIED LAWS §§ 58-28-13 to 58-28-31 (1966/1971).		
Tennessee	TENN. CODE ANN. §§ 56-3-501 to 56-3-509 (1967/1970).		
Texas			TEX. INS. CODE ANN. §§ 1152.001 to 1152.151 (2003); 28 TEX. ADMIN. CODE §§ 3.701 to 3.706 (1985).
Utah	UTAH CODE ANN. § 31A-5-217.5 (1992/2010).		
Vermont	VT. STAT. ANN. tit. 8, §§ 3855 to 3859 (1971/1981).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-3113 to 38.2-3113.1 (1986/1992).
Washington	WASH. REV. CODE ANN. §§ 48.18A.010 to 48.18A.900 (1969/2013).		
West Virginia	W. VA. CODE §§ 33-13A-1 to 33-13A-5 (1977).		
Wisconsin			WIS. STAT. § 611.25 (1971); § 632.45 (1975/1979).
Wyoming	WYO. STAT. ANN. § 26-16-502 (1967/1983).		

VARIABLE LIFE INSURANCE MODEL REGULATION

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Section 1. Authority

The following regulations applicable to variable life insurance policies are promulgated under the authority of Section [insert applicable section] of the Insurance Laws of [insert state], and are effective [insert date].

Section 2. Definitions

As used in this regulation:

A. "Affiliate" of an insurer means a person, directly or indirectly, controlling, controlled by, or under common control with the insurer; a person who regularly furnishes investment advice to the insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner or employee of the insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

B. "Agent" means a person, corporation, partnership or other legal entity that is licensed by this state as a life insurance agent.

C. "Assumed investment rate" means the rate of investment return that would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

D. "Benefit base" means the amount to which the net investment return is applied.

E. "Commissioner" means the insurance commissioner of this state.

Editor's Note: Insert the title of the chief insurance regulatory official whenever the term "commissioner" appears.

F. "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than ten percent (10%) of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing to all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

G. "Flexible premium policy" means any variable life insurance policy other than a scheduled premium policy as specified in Subsection O of this section.

H. "General account" means all assets of the insurer other than assets in separate accounts established pursuant to Section [insert applicable section] of the insurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

I. "Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to, accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income or term riders.

J. "May" is permissive.

K. "Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

L. "Net investment return" means the rate of investment return in a separate account to be applied to the benefit base.

M. "Person" means an individual, corporation, partnership, association, trust or fund.

N. "Policy processing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

O. "Scheduled premium policy" means a variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

P. "Separate account" means a separate account established pursuant to Section [insert section] of the insurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Q. "Shall" is mandatory.

R. "Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

S. "Variable life insurance policy" means an individual policy that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to the policy, pursuant to Section [insert applicable section] of the insurance laws of this state or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Section 3. Qualification of Insurer to Issue Variable Life Insurance

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having authority to issue variable life insurance in this state.

A. Licensing and Approval to do Business in This State. An insurer shall not deliver or issue for delivery in this state any variable life insurance policies unless:

(1) The insurer is licensed or organized to do a life insurance business in this state;

(2) The insurer has obtained the written approval of the commissioner for the issuance of variable life insurance policies in this state. The commissioner shall grant written approval only after the commissioner has found that:

(a) The plan of operation for the issuance of variable life insurance policies is not unsound;

(b) The general character, reputation and experience of the management and those persons or firms proposed to supply consulting, investment, administrative or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this state; and

(c) The present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things:

(i) The history of operation and financial condition of the insurer;

(ii) The qualifications, fitness, character, responsibility, reputation and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative or custodial services to the insurer;

(iii) The applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(iv) If the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meets these standards.

B. Filing for Approval to do Business in This State. The commissioner may, at his discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with the department the following information for the consideration of the commissioner in making the determination required by Subsection A(2) of this section:

(1) Copies of and a general description of the variable life insurance policies it intends to issue;

(2) A general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer;

(3) With respect to any separate account maintained by an insurer for a variable life insurance policy, a statement of the investment policy the issuer intends to follow for the investment of the assets held in the separate account and a statement of procedures for changing the investment policy. The statement of investment policy shall include a description of the investment objectives intended for the separate account;

(4) A description of any investment advisory services contemplated as required by Section 6H;

(5) A copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies;

(6) Biographical data with respect to officers and directors of the insurer on the National Association of Insurance commissioners Uniform Biographical Data Form; and

(7) A statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

C. Standards of Suitability. Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the standards of suitability to be used by the insurer. The standards of suitability shall specify that no recommendation shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant on the basis of information furnished after reasonable inquiry of the applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or the agent making the recommendation.

D. Use of Sales Materials. An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive or inaccurate. Variable life insurance sales material, advertising material and descriptive literature shall be subject to the additional requirements of [insert citation to the state life insurance advertising rules].

E. Requirements Applicable to Contractual Services. Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the commissioner with any information or reports in connection with the services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations, and any other applicable law or regulations.

F. Reports to the Commissioner.

(1) An insurer authorized to transact the business of variable life insurance in this state shall submit to the commissioner, in addition to any other materials that may be required by this regulation or any other applicable laws or regulations:

(a) An annual statement of the business of its separate account or accounts in such forms as may be prescribed by the National Association of Insurance Commissioners; and

(b) Prior to the use in this state any information furnished to applicants as provided for in Section 7; and

(c) Prior to the use in this state the form of any of the reports to policyholders as provided for in Section 9; and

(d) Such additional information concerning its variable life insurance operations or its separate accounts as the commissioner shall deem necessary.

(2) Any material submitted to the commissioner under this section shall be disapproved if it is found to be false, misleading, deceptive or inaccurate in any material respect and, if previously distributed, the commissioner shall require the distribution of amended material.

G. Authority of Commissioner to Disapprove. Any material required to be filed with and approved by the commissioner shall be subject to disapproval if at any time it is found by him or her not to comply with the standards established in this regulation.

Section 4. Insurance Policy Requirements

A. Policy Qualification. The commissioner shall not approve any variable life insurance form filed pursuant to this regulation unless it conforms to the requirements of this section.

B. Filing of Variable Life Insurance Policies. All variable life insurance policies, and all riders, endorsements, applications and other documents that are to be attached to be made a part of the policy and which relate to the variable nature of the policy, shall be filed with the commissioner and approved by him or her prior to delivery or issuance for delivery in this state.

(1) The procedures and requirements for filing and approval shall be, to the extent appropriate and not inconsistent with this regulation, the same as those otherwise applicable to other life insurance policies.

(2) The commissioner may approve variable life insurance policies and related forms with provisions the commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by this regulation.

C. Mandatory Policy Benefit and Design Requirements. Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements.

(1) Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

(2) For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid (subject to the provisions of Subsection E of this section);

(3) The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer shall demonstrate that the reflection of investment experience in the variable life insurance policy is actuarially sound.

(4) Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

(5) Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

(6) The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other nonforfeiture benefits, as described either in the policy or in a statement filed with the commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation shall be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values to the minimum values required by Section [insert applicable section of the standard nonforfeiture law of this state] for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Nonforfeiture Law of this state. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the Standard Nonforfeiture Law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not limited to, a guarantee that the amount payable at death or maturity shall be least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

(7) The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the commissioner.

D. Mandatory Policy Provisions. Every variable life insurance policy filed for approval in this state shall contain at least the following:

(1) The cover page or pages corresponding to the cover page of each policy shall contain:

(a) A prominent statement in either contrasting color or in bold-faced type that the amount or duration of death benefit may be variable or fixed under specified conditions;

(b) A prominent statement in either contrasting color or in bold-faced type that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(c) A statement describing any minimum death benefit required pursuant to Subsection C (2) of this section;

(d) The method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death;

(e) To the extent permitted by state law, a captioned provision that the policyholder may return the variable life insurance policy within ten (10) days of receipt of the policy by the policyholder and receive a refund equal to the sum of the difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy and the value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent. Until such time as state law authorizes the return of payments as calculated in the preceding sentence, the amount of the refund shall be the total of all premium payments for such policy.

(f) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

(2) (a) For scheduled premium policies, a provision for a grace period of not less than thirty-one (31) days from the premium due date which shall provide that when the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(b) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. The grace period shall end on a date not less than sixty-one (61) days after the mailing date of the Report to Policyholders required by Section 9C.

(c) The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than three (3) times the charges that were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day.

(3) For scheduled premium policies, a provision that the policy will be reinstated at any time within two (2) years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(a) All overdue premiums with interest at a rate not exceeding [insert number] percent per annum compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding [insert number] percent per annum compounded annually; or

(b) 110 percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding [insert number] percent per annum compounded annually.

(4) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

(5) A provision designating the separate account to be used and stating that:

(a) The assets of the separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

(b) The assets of the separate account shall be valued at least as often as any policy benefits vary but at least monthly.

(6) A provision specifying what documents constitute the entire insurance contract under state law;

(7) A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his or her behalf, shall be considered as representations and not warranties;

(8) An identification of the owner of the insurance contract;

(9) A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation;

(10) A statement of any conditions or requirements concerning the assignment of the policy;

(11) A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

(12) A provision that the policy shall be incontestable by the insurer after it has been in force for two (2) years during the lifetime of the insured. However, any increase in the amount of the policy's death benefits subsequent to the policy issue date, which occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after the increase has been in force, during the lifetime of the insured, for two (2) years from the date of issue of increase;

(13) A provision stating that the investment policy of the separate account shall not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the commissioner of this state;

(14) A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(a) For up to six (6) months from the date of request, if the payments are based on policy values which do not depend on the investment performance of the separate account; or

(b) Otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical;

(15) If settlement options are provided, at least one option shall be provided on a fixed basis only;

(16) A description of the basis for computing the cash value and the surrender value under the policy shall be included;

(17) Premiums or charges for incidental insurance benefits shall be stated separately;

(18) Any other policy provision required by this regulation;

(19) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation; and

(20) A provision for nonforfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any nonforfeiture insurance options will not be available.

E. Policy Loan Provisions. Every variable life insurance policy, other than term insurance policies and pure endowment policies delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than a provision for policy loans after the policy has been in force for [insert number] full years which provides the following:

(1) At least seventy-five percent (75%) of the policy's cash surrender value may be borrowed.

(2) The amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law.

(3) Any indebtedness shall be deducted from the proceeds payable on death.

(4) Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit.

(5) For scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within thirty-one (31) days after the date of mailing of notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following policy processing day exceed the amounts available under the policy to pay the charges, a report must be sent to the policyholder containing the information specified by Section 9C.

(6) The policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase the variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110 percent of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request.

(7) The policy may specify a reasonable minimum amount that may be borrowed at any time but the minimum shall not apply to any automatic premium loan provision.

(8) No policy loan provision is required if the policy is under extended insurance nonforfeiture option.

(9) The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

(10) Amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

F. Other Policy Provisions. The following provision may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

(1) An exclusion for suicide within [insert "two" or other number of years] years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within two (2) years of any increase in death benefits which result from an application of the owner subsequent to the policy issue date;

(2) Incidental insurance benefits may be offered on a fixed or variable basis;

(3) Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options:

(a) The amount of the dividend may be credited against premium payments;

(b) The amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(c) The amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(d) The amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(e) The amount of the dividend may be deposited as a variable deposit in a separate account.

(4) A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under Subsection E of this section, except that a restriction that no more than two (2) consecutive premiums can be paid under this provision may be imposed;

(5) A provision allowing the policyholder to make partial withdrawals; and

(6) Any other policy provision approved by the commissioner.

Section 5. Reserve Liabilities For Variable Life Insurance

A. Reserve Liabilities Under Standard Valuation Law. Reserves liabilities for variable life insurance policies shall be established under [insert citation to the standard valuation law] in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

B. Reserve Liabilities for the Guaranteed Minimum Death Benefit. Reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall not be less than the greater of the following minimum reserves:

(1) The aggregate total of the term costs, if any, covering a period of one full year from the valuation date or, if less, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account, on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets in the separate account followed by a net investment return equal to the assumed investment rate; or

(2) The aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue," as described in Subparagraph (a) below, of the prior year's "attained age level" reserve on the contract, with any such "residue," increased or decreased by a payment computed on an attained age basis as described in Subparagraph (b) below.

(a) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to the prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of a guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(b) The payment referred to in this paragraph shall be computed so that the present value of a level payment of that amount each year over the future period for which charges for this risk will be collected under the contract, is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any "residue," as described in Subparagraph (a), of the prior year's "attained age level" reserve on such variable life insurance contract. If no future charges for this risk will be collected under the contract, the payment shall equal (A) minus (B) minus (C). The amounts of the future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate or the valuation interest but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in Paragraph (1) and (2) of this subsection shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserves, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

C. Incidental Insurance Benefit. Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shallbe maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to the benefit.

Section 6. Separate Accounts

The following requirements apply to the establishment and administration of variable life insurance separate accounts by a domestic insurer:

A. Establishment and Administration of Separate Accounts. A domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to Sections [insert appropriate sections] of the insurance laws of this state.

(1) If no law or other regulation provides for the custody of separate account assets and if the insurer is not the custodian of the separate account assets, all contracts for custody of these assets shall be in writing and the commissioner shall have authority to review and approve of both the terms of the contract and the proposed custodian prior to the transfer of custody.

(2) The insurer shall not without prior written approval of the commissioner employ in any material connection with the handling of separate account assets any person who:

(a) Within the last ten (10) years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341, 1342 or 1343 of Title 18, United States Code; or

(b) Within the last ten (10) years has been found by any state regulatory to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit or knowing misrepresentation; or

(c) Within the last ten (10) years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit or knowing misrepresentation.

(3) All persons with access to the cash, securities, or other assets of the separate account shall be under bond in the amount of not less than $[insert appropriate amount].

(4) The assets of separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

B. Amounts in the Separate Account. The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for these policies.

C. Investments by the Separate Account.

(1) No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(a) In case of transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(b) The transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(2) The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

D. Limitations on Ownership.

(1) A separate account shall not purchase or otherwise acquire the securities of an issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after the purchase or acquisition the value of the investment, together with prior investments of the account in the security valued as required by these regulations, would exceed ten percent (10%) of the value of the assets of the separate account. The commissioner may waive this limitation in writing if the commissioner believes the waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

(2) No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of the acquisition the insurer and its separate accounts in the aggregate, will own more than ten percent (10%) of the total issued and outstanding voting securities of the issuer. The commissioner may waive this limitation in writing if he or she believes the waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of these securities.

(3) The percentage limitation specified in Paragraph (1) of this subsection shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of Subsection C of this section and other applicable portions of this regulation.

E. Valuation of Separate Account Assets. Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

F. Separate Account Investment Policy. The investment policy of a separate account operated by a domestic insurer filed under Section 3B(3) shall not be changed without first filing the change with the insurance commissioner.

(1) Any change filed pursuant to this section shall be effective sixty (60) days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of the sixty-day period of his or her disapproval of the proposed change. At any time the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to this section.

(2) The commissioner may disapprove the change if he or she determines that the change would be detrimental to the interests of the policyholders participating in the separate accounts.

G. Charges Against Separate Account. The insurer shall disclose in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account, including, but not limited to, the following:

(1) Taxes or reserves for taxes attributable to investment gains and income of the separate account;

(2) Actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(3) Actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

(4) Charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(5) A charge, at a rate specified in the policy, for mortality and expense guarantees;

(6) Any amounts in excess of those required to be held in the separate accounts; and

(7) Charges for incidental insurance benefits.

H. Standards of Conduct. Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees and affiliates with respect to the purchase or sale of investments of separate accounts. The standards of conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17j under the Investment Company Act of 1940 and its applicable rules and regulations shall satisfy the provisions of this section.

I. Conflicts of Interest. Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

J. Investment Advisory Services to a Separate Account.

(1) An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(a) The person providing advice is registered as an investment adviser under the Investment Advice Act of 1940; or

(b) The person providing advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

(c) The insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(i) The name and form of organization, state of organization, and its principal place of business;

(ii) The names and addresses of its partners, officers, directors and persons performing similar functions or, if the investment advisory is an individual, of the individual;

(iii) A written standard of conduct complying in substance with the requirements of Subsection H of this section which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

(iv) A statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(I) Has been convicted within ten (10) years of a felony or misdemeanor arising out of the person's conduct as an employee, salesman, officer or director of an insurance company, a banker, an insurance agent, a securities broker or an investment advisor involving embezzlement, fraudulent conversion or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of United States Code;

(II) Has been permanently or temporarily enjoined by an order, judgment or decree of a court of competent jurisdiction from acting as an investment advisor, underwriter, broker or dealer, or as an affiliated person or as an employee of an investment company, bank or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(III) Has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under these laws; or

(IV) Has been censured, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(d) The investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty (60) days' written notice to the investment advisor.

(2) The commissioner may, after notice and opportunity for hearing, by order require the investment advisory contract to be terminated if the commissioner deems continued operation under the contract to be hazardous to the public or the insurer's policyholders.

Section 7. Information Furnished To Applicants

An insurer delivering or issuing for delivery in this state a variable life insurance policy shall deliver the following to the applicant for the policy, and obtain a written acknowledgment of receipt from the applicant coincident with or prior to the execution of the application. The requirements of this section shall be deemed to have been satisfied to the extent that a disclosure containing information required by this section is delivered, either in the form of a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

A. A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors that affect the variation. The explanation shall include notices of the provision required by Sections 4D(1)(e) and 4D(6);

B. A statement of the investment policy of the separate account, including:

(1) A description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(2) Any restrictions or limitations on the manner in which the operations of the separate account are intended to be conducted;

C. A statement of the net investment return of the separate account for each of the last ten (10) years or such lesser period as the separate account has been in existence;

D. A statement of the charges levied against the separate account during the previous year;

E. A summary of the method to be used in valuing assets held by the separate account;

F. A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary; and

G. Illustrations of benefits payable under the variable life insurance contract. The illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investments experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that the assumed rates are hypothetical only.

Section 8. Applications

The application for a variable life insurance policy shall contain:

A. A prominent statement that the death benefit may be variable or fixed under specified conditions;

B. A prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees); and

C. Questions designed to elicit information that enables the insurer to determine the suitability of variable life insurance for the applicant.

Section 9. Reports to Policyholders

An insurer delivering or issuing for delivery in this state a variable life insurance policy shall mail to each variable life insurance policyholder at his or her last known address the following reports:

A. Within thirty (30) days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to Section 4E under the policy computed as of the policy anniversary date. However, the statement may be furnished within thirty (30) days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty (60) days prior to the mailing of the notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the statement, the statement shall be modified to so indicate. For flexible premium policies, the report shall contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report shall show the projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that planned periodic premiums, if any, are paid as scheduled; guaranteed costs of insurance are deducted; and the net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message shall be included that states that the policy may be in danger of terminating without value in the next twelve (12) months unless additional premium is paid.

B. Annually, a statement or statements including:

(1) A summary of the financial statement of the separate account based on the last annual statement filed with the commissioner;

(2) The net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five (5) years when available;

(3) A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the commissioner;

(4) Any charges levied against the separate account during the previous year; and

(5) A statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment advisor of the separate account.

C. For flexible premium policies, a report shall be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report shall indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Section 10. Foreign Companies

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public that is substantially similar to that provided by these regulations, the commissioner to the extent deemed appropriate by the commissioner in his or her discretion, may consider compliance with such law or regulation as compliance with these regulations.

Section 11. Qualifications Of Agents For The Sale Of Variable Life Insurance

A. Qualification to Sell Variable Life Insurance

(1) A person shall not sell or offer for sale in this state any variable life insurance policy unless the person is an agent and has filed with the commissioner, in a form satisfactory to the commissioner, evidence that the person holds a license or authorization that may be required for the solicitation or sale of variable life insurance.

(2) An examination administered by the Department for the purpose of determining the eligibility of a person for licensing as an agent shall, after the effective date of this regulation, include questions concerning the history, purpose, regulation and sale of variable life insurance as the commissioner deems appropriate.

B. Reports of Disciplinary Actions. A person qualified in this state under this Act to sell or offer to sell variable life insurance shall immediately report to the commissioner:

(1) Any suspension or revocation of the agent's license in any other state or territory of the United States;

(2) The imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension or revocation of or denial of registration, imposed upon him or her by any national securities exchange, or national securities association, or any federal, state or territorial agency with jurisdiction over securities or variable life insurance; and

(3) Any judgment or injunction entered against him or her on the basis of conduct deemed to have involved fraud, deceit, misrepresentation or violation of any insurance or securities law or regulation.

C. Refusal to Qualify Agent to Sell Variable Life Insurance: Suspension, Revocation, or Nonrenewal of Qualification. The commissioner may reject an application or suspend or revoke or refuse to renew an agent's qualification under this Act to sell or offer to sell variable life insurance upon any ground that would bar the applicant or agent from being licensed to sell other life insurance contracts in this state. The rules governing a proceeding relating to the suspension or revocation of an agent's license shall also govern a proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable life insurance.

Section 12. Separability

If any provision of this regulation or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1974 Proc. I 12, 14, 405, 461-462, 463-485 (adopted).
1974 Proc. II 8, 10, 456, 538, 541-547 (adopted report as an interpretive guideline).
1975 Proc. I 2, 6, 573, 752, 761-786 (amended and reprinted)
1975 Proc. I 792-852 (commentary adopted).
1978 Proc. I 13, 15, 348, 578, 579 (amended).
1983 Proc. I 6, 35, 448, 583, 587-642 (amended commentary and regulation and all reprinted).
1989 Proc. I 9, 23-24, 642, 670-671, 674 (amended).

COMMENTARY TO
VARIABLE LIFE INSURANCE MODEL REGULATION

Section 2. Definitions

Note: Each definition should be reviewed to assure that the definition corresponds to the actual language used by the statutes of the particular state. Additional definitions may be necessary.

Subsection A. Affiliate

Source: NAIC Model Holding Company Act Section lA, 1969 *Proceedings of the NAIC* II 739.

Comment: The circumstances in which a person becomes an affiliate must remain flexible, and depend on the particular facts of each case. However, a person would presumptively be affiliated if: (1) they owned more than 10 percent of the voting securities; (2) they furnished regular investment advice; (3) they were in control of, were controlled by, or were in common control with; or (4) were a director, employee, officer, partner of such a person or a member of that person's immediate family. It should be noted that a separate account in not a severable legal entity but rather is an integral part of the insurer. Therefore, it cannot be an affiliate of anyone.

The definition of an affiliate contains no percentage limitation. Therefore the definition of "control" (Section 2F) takes on added significance.

The definition of affiliate has been expanded from the NAIC Model Holding Company Act to include those persons (investment advisers, directors, partners, employees and relatives) who might obtain personal or corporate gain at the expense of variable life insurance policyholders. A finding of affiliation is significant because it (1) triggers the conflict of interest provisions (Section 6I), (2) imposes minimum standards of conduct (Section 6H), and (3) subjects the entire corporate structures of insurers to scrutiny by the commissioner relating to its variable life insurance operations (see Section 3A(2)(c)(iv) concerning those who would otherwise be non-affiliated persons).

The inherent close relationship of the insurer's general account and separate account, the nature of the insurer's obligation, and the ownership of separate account assets would have made application of the interested person concept (see 15 USC 80a-2(19) and 15 USC 80a-10(a)) not only inappropriate, but contradictory to the nature of variable life insurance. Because of the nature of an insurer's variable life insurance operations, the committee found no beneficial effect in requiring a separate account to have a management which was independent of the insurer. As a matter of fact, they expressly held the insurer's board responsible in a management context for all acts of the insurer involving its separate account. It was expected, however, that separate account operations would be carefully scrutinized (see, e.g., Section 6I).

Otherwise independent investment advisers who furnish regular investment advice are incorporated within the definition of affiliate in order to place protection against overreaching in general, and potential conflicts of interest within the scope of the regulation.

The definition purposely limits its application to those otherwise independent advisers who regularly furnish investment advice for which a specific fee is charged. This is done in order to avoid the possible construction that a broker who, as part of his normal brokerage commission gives incidental investment advice, would be an affiliate.

Subsection B. Agent

Note: Those states that have life insurance brokers or solicitors should modify the definition of agent to include them.

Source: NAIC Model Variable Contract Regulation Article II, Section 2, 1970 *Proceedings of the NAIC* II 1185.

Comment: See NAIC Agents and Brokers Licensing Model Act Section 4A(2)(a)(1) as amended by the NAIC in December, 1973 consistent with the recommendation contained in 1973 *Proceedings of the NAIC* II 383.

C. Assumed Investment Rate

Comment: This is the hypothetical rate of investment return, after the enumerated deductions, specified by the insurer in defining the plan of insurance benefits. In a variable whole life policy, for example, it is the rate of investment return at which the variable death benefit (Section 2R) will at all times equal the initial death benefit. It is the rate of investment return at which nonforfeiture benefits must be tested for conformity with those required by the Standard Nonforfeiture Law (see Section 4C(6)).

A low assumed investment rate will increase the net premium while simultaneously increasing the likelihood that the net investment return will exceed the assumed investment rate. That is, for a given net premium, a low assumed investment rate would produce a lower initial face amount, but a greater probability that subsequent variable death benefits would increase. Thus, there may be sound actuarial and marketing reasons for a lower than average assumed investment rate. However, too low an assumed investment rate would make premiums uncompetitively high.

On the other hand, a high assumed investment rate would produce a higher initial face amount, but with a greatly reduced chance of subsequent increases in the death benefit. In addition, it should be noted that the higher the assumed investment rate, the more costly any initial face value guarantees will become to the insurer. The Subcommittee was concerned with the possibility that excessive assumed investment rates could be deceptive in suggesting unrealistic policyholder expectations, and could impinge adversely on the insurer's solvency. The fourth sentence of Section 4C(6), limiting this rate to the maximum rate permitted under the Standard Nonforfeiture law, was included to prevent this.

Subsection D. Benefit Base

Comment: Prior to the 1983 amendments, the model regulation defined benefit base as the "amount . . to which the difference between the net investment return and the assumed investment rate is applied in determining the variable benefits of the policy." In some of the early drafts of the model regulation, the Committee utilized the term "attributed fund." The term "benefit base" was substituted therefor as more descriptive and to specifically avoid the unintended connotation of individual policyholder proportionate ownership of identifiable assets being read by some into the term "attributed fund."

The 1983 amendments recognize that the benefit base of a flexible premium variable life insurance policy is the policy's cash value and that the concept of an assumed investment rate is not meaningful in the context of these products.

Thus, the definition of benefit base, as changed by the 1983 amendments, defines the amount for both flexible premium and scheduled premium policies. For this reason, for example, the 1983 amendments deleted the previous formulations which correlated the benefit base computation to the difference between the net investment return and the assumed investment rate. In addition, the cross-reference to Section 6B, which sets forth the benefit base computation, has been deleted to correspond to the deletion of the latter provision.

Subsection E. Commissioner

Note: Each state should modify the term "commissioner" so that it corresponds to the correct title of the insurance regulatory official in the state where this regulation is adopted.

Source: NAIC Health Maintenance Organization Model Act Section 2D, 1973 *Proceedings of the NAIC* I 205.

Subsection F. Control

Source: NAIC Model Holding Company Act Section lC, 1969 *Proceedings of the NAIC* II 739.

Comment: This section closely parallels its source, but the percentage of ownership before control would be presumed was slightly amended from "ten percent (10%)" to "more than ten percent (10%)." This was done to eliminate an internal inconsistency with Section 6D that allows ownership of up to 10% of the securities of any one issuer in funding the variable life insurance separate account.

The term control (and therefore affiliate) is defined in terms of the ability to direct or cause the direction of the management of another person whether or not through stock ownership. Thus, control can in fact be found regardless of the absence of a presumption of control. The criteria for making such a finding are clearly contained within the definition, to wit, the ability to direct management.

There is no reverse presumption of a lack of control when 10% or less is owned. Rather, the burden would still always be on the person claiming no control to demonstrate this to the commissioner.

The facts of each particular case in determining control must be judged on their own merits. It is for this reason that the model regulation attempts to preserve maximum flexibility for the commissioner in order not to bind him or her in the future to decisions which lack relevance to the actual facts of a particular case. Nonetheless, it would seem that the percentage of stock ownership in question, as well as the existence or nonexistence and size of any other organized factions of shareholders, would be relevant inquiries in determining control.

The finding of control would in turn automatically establish an affiliate relationship and trigger the conflict of interest (Section 6I) and standards of conduct (Section 6H) provisions of the regulation notwithstanding the absence of a presumption of control. The last sentence of this section would also allow the commissioner to determine that control of or by persons without voting securities exists in fact.

The question of notice and procedure is designed to be governed by the administrative law and procedure of the particular state in question. In most instances, this would be a question that would be handled by the state of domicile (see also comment to Section 3E).

Subsection G. Flexible Premium Policy

Comment: A flexible premium variable life insurance policy is defined by reference to a scheduled premium variable life insurance policy as defined in Section 2. The demarcation between scheduled and flexible premium policies is a fundamental underpinning of the 1983 amendments to the model regulation. The classification of a product as a flexible premium or scheduled premium policy is, for example, determinative of important distinctions in the applicability and scope of mandatory policy benefit and design requirements and mandatory policy provisions (see, e.g., Sections 4C(2), 4D(2) and 4D(3)).

Structurally, the model regulation defines a flexible premium variable life insurance policy broadly as any variable life insurance policy other than a scheduled premium policy as defined in Section 2. Accordingly, if either the amount or timing of premium payments under a variable life insurance policy is not fixed by the insurer (see Section 2), or if both amount and timing have not been so fixed, then the policy is a flexible premium variable life insurance policy within the scope of Subsection G.

Subsection H. General Account

Comment: The general account of an insurer may not be an account as such but rather consists of all the assets of the insurer that are available to satisfy its overall obligations. The general account does not include any separate account of the insurer. However, to the extent that a particular separate account's assets may exceed separate account liabilities, they are of course available to satisfy obligations of the general account (see Section 4D(5)(a)). Separate accounts include variable annuity and any other separate accounts permitted by law. The reference to separate accounts established pursuant to the laws of the promulgating state should be interpreted to include the equivalent authorizing section of the insurer's state of domicile.

Subsection I. Incidental Insurance Benefit

Comment: This definition is intended to include all those riders and policy benefits, other than the variable death benefit and associated nonforfeiture benefits and any minimum death benefit, that are sold as a part of or in conjunction with the variable life insurance policy. Benefits are within this definition regardless of whether they also may be sold to variable life insurance purchasers as separate policies or whether the premiums are separately stated or determined. For example, disability waiver of premium and guaranteed insurability options are not normally offered as a separate policy but are offered as a part of a permanent fixed benefit policy and would therefore be incidental insurance benefits to the variable life insurance policy. Accidental death benefits may be purchased as a separate policy but are also normally sold as part of a permanent fixed benefit life policy and would also be incidental insurance benefits to a variable life policy. Incidental insurance benefits would also include incidental minimum guarantees (see Section 4C(6)).

Prior to the 1983 amendments, the model regulation precluded an insurer from offering incidental insurance benefits on a variable basis. This restriction was clear from the text of the prior definition, which referred, in part, to fixed benefit term riders, and from the statement in the original commentary that incidental insurance benefits must be fixed. The deletion of the reference to fixed benefit term riders is designed to be indicative of the intention to permit insurers to offer variable incidental benefits.

Subsection K. Minimum Death Benefit

Comment: Reserves underlying any minimum death benefit guarantee must be maintained in the general account (see Section 5). The minimum death benefit guarantee, if any, is not what makes this product life insurance.

Subsection L. Net Investment Return

Comment: The 1983 amendments revised the definition of net investment return by deleting the clause that had specified the permissible deductions to be utilized in computing the net investment return. Prior to the 1983 amendments, Section 6G limited permissible deductions from the separate account to the categories that were specifically enumerated in that section. Section 6G was amended in 1983 to require the insurer to disclose all deductions that are made from the separate account. The categories of charges set out in Section 6G were retained as illustrative of the charges that must be disclosed; permissible charges, however, were no longer limited to the specified categories. The amendment to the definition of net investment return corresponds to the revisions in Section 6G.

Subsection M. Person

Source: NAIC Model Holding Company Act Section lF 1969 *Proceedings of the NAIC* II 740.

Comment: This section was intended to include all forms of business enterprise no matter what their organization. It includes affiliates, and if applicable, governmental entities. An insurer's separate account by itself could not be a person (see comment to Section 2A).

Subsection N. Policy Processing Day

Comment: The definition of policy processing day was added by the 1983 amendments. As explained more fully in the discussion of Sections 4 and 9, the policy processing day plays a central role in triggering the grace period for flexible premium variable life insurance policies and in measuring the length of the grace period once it is so activated (see Section 4D(2)(b) and Section 9C).

Subsection O. Scheduled Premium Policy

The definition of a scheduled premium policy was added by the 1983 amendments to the model regulation. It is intended to establish the perimeters of contemporary traditional variable life insurance policies. Specifically, a variable life insurance policy is classified as a scheduled premium policy if the insurer has established (or fixed) both the amount of required premium payments and the times at which they are to be paid. Typically, under a scheduled premium policy, if a premium is not paid in accordance with the schedule that has been fixed by the insurer, and if the non-payment of premium is not remedied within the applicable grace period, the policy lapses, triggering the operation of nonforfeiture options.

It should be noted that a policy would not necessarily be classified as a scheduled premium policy simply because the specifications page might set forth a planned premium (a concept characteristic of current universal life insurance policies). This is because the planned premium, in most cases, is set by the insured, not the insurer.

Subsection P. Separate Account

Comment: See comments to Section 2G. The blank space in this section should be completed with the section of the Variable Contract Law authorizing separate accounts. The reference to the law of the promulgating state authorizing the establishment of a separate account should be interpreted as including the equivalent in the insurer's state of domicile. Prior to the 1983 amendments, this definition limited separate accounts to those established for variable life insurance. In 1983, the limiting phrase for variable life insurance was deleted to dispel the inference, present by implication in the prior definition, that a separate account may be established solely for variable life insurance, and to afford insurers the flexibility to utilize the same separate account to fund a variety of products, e.g., both variable life insurance and variable annuities. This desired flexibility is reflected in amendments that were made in 1983 to other portions of the model regulation (see, e.g., Section 4D(5)(a)).

Subsection R. Variable Death Benefit

Comment: For scheduled premium policies, when the net investment return of the separate account (see Section 2L) is greater than the assumed investment rate (or the net investment return minus assumed investment rate is positive), the variable death benefit will reflect the full application of this difference (after the necessary adjustments for policy loans) to the benefit base under the terms and design of the policy, and the variable death benefit payable to the policyholder will to that extend exceed the initial face amount or minimum death benefit (see Section 4C(4)). Section 4C(3) provides that the policy shall reflect the full net investment experience of the separate account.

Conversely, when the net investment return under a scheduled premium policy is less than the assumed investment rate, the variable death benefit will decrease and, depending on past performance, may become less than the minimum death benefit. In this situation, of course, assuming premiums have been duly paid, the insurer will be obligated to pay the initial face amount of the policy (minimum death benefit). Thus, for scheduled premium policies, the insurer is always obligated to pay the greater of the minimum death benefit or the variable death benefit.

For scheduled premium policies, the variable death benefit, even when it is less than the minimum death benefit, is a useful figure to policyholders in conjunction with various hypothetical investment returns as a disclosure device for the purpose of cost and benefit comparison of policies. It can illustrate the level of performance required to return above the minimum death benefit as well as the receptivity of the variable death benefit to market fluctuations and therefore the significance of the minimum death benefit guarantee.

Prior to the 1983 amendments, the variable death benefit was defined as the amount of death benefit payable in the absence of the minimum death benefit. The 1983 amendments revised the definition of variable death benefit to refer to any minimum death benefit instead of *the* minimum death benefit. This revision corresponds to the model regulation's divergent approach to the minimum death benefit that an insurer must afford under scheduled premium and flexible premium variable life insurance policies. As amended in 1983, the model affords insurers considerable flexibility in formulating death benefit guarantees for flexible premium products, in that a flexible premium policy need not afford a death benefit in an amount at least equal to the initial face amount of the policy (compare Section 4C(2) with Section 4D(2)(b)). An unequivocal reference to the minimum death benefit in this Subsection R might have been inconsistent with this flexible approach. Accordingly, the substitute language was inserted, essentially as a conforming amendment.

Subsection S. Variable Life Insurance Policy

Source: This section is derived from the NAIC Model Variable Contract Regulation, Article II Sections 1, 2b, 1970 *Proceedings of the NAIC* II 1185.

Comment: Prior to the 1983 amendments, the definition of variable life insurance policy generally corresponded to the generic description in which benefits fluctuate with the separate account's investment experience.

The 1983 amendment was intended to clarify an interpretive question that could have arisen under the original definition. Specifically, the original definition's reference to *"life insurance which varies*" according to the investment experience of the separate account could have been construed to mandate that the amount of the death benefit under a variable life insurance policy vary to reflect investment experience. Such an interpretation would not necessarily be compatible with flexible premium variable life insurance product design. Under a flexible premium variable life insurance policy, insurance coverage would continue as long as the amounts available under the policy are sufficient to support deductions for the cost of insurance and other charges. Thus, it may be the *duration* of the insurance coverage, rather than the amount of the death benefit, which varies with investment experience. Accordingly, in 1983 the definition of variable life insurance policy was expanded to encompass "any individual policy which provides for life insurance *the amount or duration* of which varies" in accordance with investment experience.

The definition does for the present specifically limit variable life insurance to individual policies. A master contract and certificate of enrollment relationship would not be permitted.

The blank space in this section should be completed in the same manner as described in the comment to Subsection P.

Section 3. Qualifications of Insurer to Issue Variable Life Insurance

Subsection A. Licensing and Approval to do Business in This State

Source: Derived from the original NAIC Model Variable Contract Regulation (see 1968 *Proceedings of the NAIC* II 777).

Comment: In Paragraph (1) the word organized can be read domiciled. Therefore, the insurer must be either an admitted or a domestic life insurer in the state promulgating the regulation.

Prior to the 1983 amendments this section required that the state of domicile of the insurer provide for substantially similar regulation of permissible investments and changes in investment policy as a condition to receipt of approval by the commissioner. While it is anticipated that there will be significant uniformity in all phases of the model regulation, the requirement of substantially similar regulation of permissible investments and changes in investment policy was deleted in the 1983 amendments.

As discussed at greater length in connection with Section 6, the deleted requirement reflected the hope of the insurance industry and the state insurance regulators at the time the model was originally adopted that this provision and the provisions of Section 6 would be considered an adequate substitute for the federal securities law provisions regarding investment policy. The fact that variable life insurance was ultimately found to be subject to the federal securities laws substantially changes the assumptions on which the existing model's provisions regarding investment policy were based prior to the 1983 amendments. Not only is extensive disclosure of separate account investment policy required by the federal securities laws, but restrictive regulations and limitations are imposed with regard to investment policies of separate accounts and procedures for changing such policies.

Under Subsection A(2)(c)(iii) the insurer must demonstrate to the insurance department that the laws and regulations of its state of domicile are not likely to render its operation hazardous to the public or the policyholders in the state. This requirement establishes adequate protection of the public interest as the principal consideration and renders unnecessary the mischievous substantially similar requirement.

Paragraph (2) requires the insurer wishing to write variable life insurance to obtain the written approval of the insurance commissioner. It also includes the standards that the commissioner must apply and the considerations that must apply in making a determination of whether to grant or deny approval.

As an introduction to this requirement it is instructive to consider generally some of the concerns and approaches taken by the (C4) Subcommittee in developing this portion of the regulation.

The NAIC Model Variable Contract Law requires, in Section 3, that before a company can deliver or issue for delivery in any state a variable life contract, it must satisfy the commissioner that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. This requirement has been broken down primarily into the three paragraphs of Paragraph (2) and is not significantly different from the standard presently applied by insurance departments when considering a license application by a new company. However, there are a number of different factors to be considered by the departments before variable life authority should be granted:

i. **Capital and surplus requirements.** All states presently have capital and surplus requirements for admission of foreign life insurers. The Subcommittee found no persuasive reason why higher capital and surplus requirements should be necessary for authority to write variable life insurance so long as the present standards adequately measure the stability of the company. Of course, the insurer, regardless of minimum capital and surplus requirements, must still demonstrate to the commissioner's satisfaction that its plan of operation is not unsound (see Section 3A(2)(a)). The Subcommittee also recommended that each state reexamine its capital and surplus requirements to assure their adequacy for variable life insurance operations. Until more experience is obtained, it appears advisable that each company either has a minimum earned surplus, or, in the alternative, is willing to submit to close monitoring by the insurance department as to premiums written, investments and operating costs. To some extent, the earned surplus requirement may discourage entry of new firms into the variable life market. However, the monitoring approach offers an alternative. Any special reporting requirements might be lifted once the department is confident of its regulatory system as it relates to variable life and the condition of a particular company indicates that such a move is responsible.

ii. **Repeated violation of insurance laws**. There are many insurance laws and department regulations covering life insurance marketing. These laws and regulations, to the extent they are applicable and not inconsistent with the model variable life insurance regulation, will, of course, apply to variable life insurance. It can be anticipated that of the regulatory problems with variable life insurance, many will spring from its marketing side. Thus, a company's record in abiding by present life insurance marketing laws is crucial.

iii. **Extra seasoning**. The Subcommittee considered the desirability of recommending that companies seeking variable life insurance authority be required to have a longer history of operations than a company seeking fixed benefit life authority. However, they found no persuasive reasons to make such a recommendation. Nevertheless, they strongly recommend that company management be closely examined as required by Paragraphs (2)(b) and (c), and that the financial stability of the company be closely examined.

iv. **Management qualities**. It appears that most life insurers presently contemplating variable life insurance intend to invest the assets of the separate account in varied investments. Therefore, the Subcommittee recommends that each insurance department examine the investing experience, familiarity and expertise of the management of insurers requesting authority to write variable life insurance.

The commissioner is required to make the affirmative findings delineated Subparagraphs (a) to (c) in order to grant approval under Paragraph (2). If he or she does make these findings, the regulation requires the commissioner to give approval. However, in order to make the determination required, he or she should carefully consider the material required to be submitted by Section 3B as well as any other material that the commissioner deems relevant to the inquiries presupposed by the required findings of this section.

In order to grant approval under Paragraph 2(a) the commissioner must find that the insurer's plan of operation for the issuance of variable life insurance is not unsound.

There is no uniform consensus on what constitutes a plan of operation. A presentation to the commissioner pursuant to this section, however, should include a comprehensive examination of the reasonably expected impact of the insurer's proposed variable life insurance operations on the insurer, its policyholders within the state, and the general public. At a minimum it would seem to require a description of expected policy designs, the financial impact (including the impact on surplus), the insurer's proposed standards of suitability, standards of conduct (see Section 3C and Section 6H), and methods of operation (i.e., names of service companies, the nature of internal and adviser operations). Other information including sales projections may also be desirable. Since the need for approval to do business is continuous, this section implies a continuing obligation for the insurer to notify the commissioner when and if information that was relied upon in giving approval changes in any substantial degree (see also Section 6J). This would include key changes in either internal or external personnel.

In Paragraph (2)(a) the meaning of the words "not unsound" was intended to be flexible, and have a much broader interpretation than merely being actuarially sound. Rather, the term was intended to include a determination that the proposed plan is not fundamentally unfair or inequitable to any class of the insurer's policyholders or the general public. For example, a finding of unsoundness could result from a policy's design, benefit structure, possible impact on the insurer as a whole, or any other fact which indicates adverse impact on the public, including actuarial infirmity. This subparagraph contemplates a review of whether or not the plan is fundamentally fair and equitable to the public. An example of such unsoundness might be a policy design so inherently deceptive, unfair or confusing that even proper disclosure would not be likely to result in understanding by a prospective purchaser as to what he is buying.

Reference to the Unfair Trade Practices Act might be helpful in interpreting the term unsound in this context.

A separate account provides an accounting mechanism to measure the level of benefits the insurer owes to its variable life policyholders. In many cases assets of the insurer in addition to those underlying the separate account stand behind the insurer's obligation, including the assumption of mortality and expense risks and any guaranteed minimum death benefit. Consequently, state insurance regulators have the responsibility to examine closely the investment practice and management of the entire insurer and, where necessary, step in to protect the policyholders.

Paragraph (2)(a) could be utilized to require an insurer to participate in a guaranty fund to the extent of risks not assumed by the policyholders.

Paragraph (2)(b) requires the commissioner to examine the character and, in general, the qualifications of the management of both the insurer and those various organizations that are proposed to handle significant aspects of the insurer's methods of operation on a contractual basis.

Paragraph (2)(c), with the exception of Item (iv), is an expansion of portions of the original Model Variable Contracts Regulation. Thus, in addition to making the findings required by Subparagraphs (a) and (b), the commissioner must, after considering the information delineated by Items (i) through (iv) inclusive, be satisfied that the present and prospective financial condition of the insurer and method of operation will not be hazardous to the public.

The inquiry of Paragraph (2)(c) is basically one of financial soundness and the ability to satisfy all the obligations imposed on the insurer by variable life insurance operations. For example, one alternative requirement of Section 5 requires, under certain circumstances, reserves which anticipate an immediate one-third drop in the value of separate account assets. In order to satisfy the requirements of this section, the insurer must demonstrate that in a period of sharply declining values it has the surplus needed to meet these obligations without jeopardizing the public or any class of its policyholders. Thus the term policyholders means all policyholders of the insurer and not just variable life insurance policyholders.

Paragraph (2)(c)(i) is self-explanatory and relates to the previous discussion concerning seasoning, chronic insurance law violation, capital and surplus requirements and the willingness of the insurer to be subject to close insurance department monitoring.

While Paragraph (2)(c)(ii) may appear to repeat requirements contained in Paragraph (2)(b) of this section it should be noted that while Paragraph (2)(b) is itself a required finding of the commissioner, Paragraph (2)(c)(ii) is only one factor which must be considered in determining the prospective financial condition of the insurer. Of course, this item refers to both internal and external investment advisers, and the previous discussion relating to the relative investment expertise of insurers is clearly a consideration which should be made in this context (see also comment to Section 6A(1) relating to custody).

Under Paragraph (2)(c)(iii) the insurer must be able to demonstrate that the laws and regulations of its state of domicile are such as to protect the financial interests of the policyholders in the promulgating state. This item requires that the insurer seeking to do business in a state is under an obligation to convince the commissioner that the entire regulatory scheme of the insurer's domicile is not likely to be hazardous to the admitting state's policyholders.

Item (iv) obligates the commissioner to examine the possible effect of any affiliation by the insurer on the prospective financial condition of the insurer and the effect on the policyholders. As previously discussed, this aspect relates to management experience, the ability of the insurer to meet its obligations and the favorable or unfavorable experience that the insurance department has had with the insurer's corporate family in supervising compliance with applicable insurance laws and regulations. This section may also be useful in determining potential conflicts of interest.

Subsection B. Filing for Approval to do Business in This State

Source: Portions of this subsection are derived from the original NAIC Model Variable Contract Regulation (see 1969 *Proceedings of the NAIC* II 777).

Comment: This section permits the commissioner, at his or her discretion, to require filing with the insurance department of certain specified information before the insurer can deliver or issue for delivery a variable life insurance policy. Prior to the 1983 amendments; the section required that certain information be filed and permitted the commissioner to request other information. Under the section as currently drafted, if the information is already available to the department, or the commissioner feels that certain information is unnecessary, the commissioner can give the approval required by Subsection A without requiring the filing of that information by the insurer.

The 1983 amendments made two other significant changes in this section. A discussion of the methods of distribution of variable life insurance policies was added as a specified element of the description of methods of operation which the commissioner may require be filed pursuant to Paragraph (2). This change reflects the recognition that the methods of selling variable life insurance products may differ significantly from the methods of selling more traditional life insurance products and that commissioners may take a particular interest in these sales activities.

Paragraph (7) is new. As a result of the 1983 amendments, many of the traditional guarantees are no longer mandatory elements of variable life insurance policies (see Section 4C). This makes possible varied and innovative policy designs that allocate mortality and investment risks in ways not permitted under prior regulations. Under these circumstances, it is anticipated that commissioners may wish to obtain a statement from the insurer's actuary describing the mortality and expense risks that the insurer will bear under the policy.

Naturally, Subsection B, as well as Section 3F were not intended to be exclusive and these sections do not prohibit the commissioner from requiring additional relevant information that may be required to make determinations required by this regulation as well as other applicable laws and regulations. Subsection B implies a continuing obligation to amend as necessary any report made to the commissioner when the circumstances underlying the original report have changed.

Paragraph (1) relates to the findings under Section 3A(2)(a) and (c), as well as Section 4A.

Paragraph (2) relates to Section 3A(2)(a), (b), and (c)(ii) and (iv), as well as Section 3E and Section 6A and J.

Paragraph (3) relates to Section 3A(2) and Section 6F. A statement pursuant to this paragraph would include specific descriptions of the investment goals of the separate account (e.g., long term growth), the means by which these goals are to be met (e.g., primarily common stocks) and any internal investment restrictions (see Section 7B).

Paragraph (4) goes hand in hand with Paragraph (3) and relates to Section 3A(2).

Subsection C. Standards of Suitability

Source: Portions of this subsection are derived from the NAIC Model Regulation on Deceptive Practices Section 5(g), 1973 *Proceedings of the NAIC* II 542, Securities and Exchange Commission (SEC) Rule 15b 10-3, and the holding in *Anderson* v. *Knox,* 297 F.2d 702 (9th Cir.), *cert. denied,* 370 U.S. 915 (1961).

Comment: This section imposes a duty on both the insurer and its agents to make a good faith, reasonable inquiry as to the facts and circumstances concerning a prospect's insurance and financial needs and to make no recommendation that a prospect purchase variable life insurance when such a purchase is not reasonably consistent with the information that is known or reasonably should be known to the insurer or agent. The substantive standard set forth is:

> that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

Some of the factors which would presumably be considered are: age, earnings, marital status, number and age of dependents, the value of savings and other assets, and current life insurance program.

The substantive standard set forth above is derived from the federal securities laws. The genesis of the suitability doctrine is the ethical guidelines of the National Association of Securities Dealers (NASD). Article III, Section 2 of the NASD Rules of Fair Practice provides:

> In recommending to a customer the purchase, sale or exchange of any security a member shall have reasonable grounds for believing that the recommendation is suitable for such customer upon the basis of the facts, if any, disclosed by such customer as to his other security holdings and as to his financial situation and needs.

New York Stock Exchange Rule 405 and American Stock Exchange Rule 411 place suitability limitations upon the members of those exchanges. The SEC has adopted Rule 15b 10-3 under the Securities Exchange Act of 1934 (the 1934 Act) to govern the suitability of recommendations by brokers who are not members of the NASD.

The NASD rule has generally been used in disciplinary actions involving flagrantly unethical or illegal conduct, and no reported case has involved violation of Rule 15b 10-3. However, the SEC has frequently sought to enforce suitability by incorporating the concept into the fraud provisions of the federal securities laws, particularly Rule 10b-5 under the 1934 Act. The development of suitability as a fraud concept has, however, received its greatest impetus from the courts in cases not arising under the federal securities laws. For example, in *Anderson v. Knox,* 297 F.2d 702 (9th Cir.), *cert. denied,* 370 U.S. 915 (1961), the U.S. Court of Appeals for the Ninth Circuit held that an insurance agent who had induced a client to purchase excessive amounts of bank financed insurance was liable for damages in common-law fraud because the policies were not suitable to the plaintiff's needs.

The 1983 amendments made changes in this section to achieve a more practical application of the suitability concept to sales of variable life insurance. While the concept originally set forth in this section was substantially similar to that utilized in the federal securities laws, the application of the concept was exaggerated as part of the effort to avoid SEC regulation of variable life insurance. For example, prior to the 1983 amendments, the section required that the insurer adopt the standards of suitability by formal action of its board of directors. This requirement of board adoption was found to be unprecedented in NAIC model insurance statutes and unnecessary to the application of the suitability concept to sales of variable life insurance. Similarly, the standards of suitability were "applicable to and binding on the insurer's officers, directors, employees, affiliates and agents with respect to the suitability of variable life insurance for the applicant." The potential for mischief of this broad requirement was considerable, raising, for example, the possibility of liability for violations of the suitability standards being imposed on individual officers, directors, employees or agents who never even knew of the transaction involved. These provisions were deleted in the 1983 amendments.

The duty to make a good faith reasonable inquiry must be stressed since an insurer or agent cannot continually seek to avoid the obligations imposed by this section by claiming that a prospect refused to divulge information sufficient to make a professional evaluation of the suitability of variable life insurance to particular circumstances.

At its June 1974 Meeting the NAIC adopted a staff report concerning this provision 1974 *Proceedings of the NAIC* II 540). This report emphasizes three basic areas of ideal suitability:

(1) needs perceived by the insured; (2) needs perceived by the agent; and (3) persistency. The report also included interpretive rules. It was adopted as an interpretive guide to this section and offers (p. 547) the following language as an informal consensus as to the meaning of suitability in the model variable life insurance regulation.

Definition.

"Suitability" means the likelihood that the purchase of variable life insurance is reasonably consistent with:

(1) The expressed insurance objectives and needs as perceived by the prospective insured;

(2) The reasonable objectives and needs of the prospective insured as determined objectively by a professional agent after a diligent reasonable inquiry into relevant financial, family and other background information concerning the prospective insured; and

(3) The potential that the prospective insured will persist with the policy for such a period of time that the insurer's acquisition costs are amortized over a reasonable period of time.

General Rules of Interpretation.

1. When variable life insurance meets characteristics (1) and (3) or (2) and (3), it is probably still "suitable" in most instances.

2. Variable life insurance is clearly "unsuitable" when it meets none of the three characteristics for a given prospect.

3. Variable life insurance is probably "unsuitable" in the absence of extraordinary factors when it does not meet characteristic (3).

4. Other situations must be judged on their individual facts.

In adopting the 1983 amendments, the NAIC recognized that the proliferation of variable life insurance product designs anticipated as a result of those amendments might make suitability, and particularly factors (1) and (2), even more important. On the other hand, it was understood that the possibility of more variable life insurance products designed to compete with investment oriented products of other financial institutions will make factor (3) less significant because policyholders will be more likely to move among competing financial institution products for reasons such as rate of return, tax considerations and economic conditions. As a result, persistency will be less and less relevant as a measure of suitability.

This section requires the insurer to formally adopt its suitability standards. Earlier drafts of this section specifically required that the insurer establish and file with the commissioner guidelines or profiles of applicants and situations in which variable life insurance would not generally be suitable. This specific requirement was deleted.

As to the potential legal implications of adopting standards of suitability, it is not unlikely in those jurisdictions where the doctrine of implied rights of action is accepted, that the theory would give rise to an enforceable obligation to the insured (see, e.g., *Anderson v. Knox,* 297 F.2d 702 (9th Cir. 1961)). Furthermore, it is probable that the commissioner would have the authority (either formal or informal) to reverse an unsuitable sale upon the request of the policyholder. This would be in addition to the full range of sanctions available to him.

It was the intention of the Subcommittee that the requirements of this subsection would not be applicable with respect to each individual employee involved in a noncontributory pension plan situation.

Prior to the 1983 amendments, the section included provisions pursuant to which lapse rates were to be utilized as indicators of suitability. These provisions were based upon the realization that suitability is a difficult area to police and the hope that lapse rates, by indicating persistency, would be an accurate yardstick for suitability. The 1983 amendments eliminated references to lapse rates as measures of suitability. With regard to conventional insurance policies, lapse rates, even those reflecting experience over a very long period of time, are suspect as an indicator of whether or not sales of insurance were suitable when made. Lapse rates are even less relevant to the suitability of sales of variable life insurance. Lapse rates are affected by a variety of factors, the most significant of which ordinarily is changes in the policyholder's perception of the attractiveness of the policy due to changes in the general economy and in the economic circumstances of the policyholder. In the case of variable life insurance, an additional important factor is the performance of the separate account relative to other financial alternatives. Because of the significance of these factors, the use of lapse rates as a measure of suitability was found

to be inappropriate.

It should be noted that Section 8C requires that variable life insurance applications contain questions designed to elicit suitability information from applicants.

Subsection D. Use of Sales Materials

Comment: This subsection requires that the insurer may not use false, misleading, deceptive or inaccurate sales materials, advertising materials or descriptive literature.

The primary purpose of the section is to prevent the use of sales materials that will intentionally or unintentionally mislead the public as to what they are purchasing and how much it is costing them. It is within this context that the determination of what is "false, misleading, deceptive, or inaccurate" must be made. The section was intended to reach any material that is designed for ultimate presentation to a prospective purchaser in attempting to convince him to purchase variable life insurance. The comments to this section prior to the 1983 amendments indicate that the NAIC was concerned with reconciling SEC and NAIC policies with regard to advertising and sales materials. Therefore, this section required that all variable life insurance advertising and agent training materials be submitted to the commissioner. This was considered an interim measure only and was not intended to modify the commissioner's authority to regulate the dissemination of sales materials in the state.

At the time of the 1983 amendments, it was determined that mandatory filing of sales materials imposed an unnecessary burden on insurance departments. There was concern that approval of sales materials might be implied if materials were filed and the commissioner failed to act to prevent their use. Also, insurance departments wished to avoid the unnecessary cost and inconvenience of retention and storage of filed sales material.

Because the commissioner has the authority under state law to obtain all sales materials upon request (see, e.g., NAIC Rules Governing the Advertising of Life Insurance), it was determined that incorporation of that authority into this regulation would be adequate to permit the insurance department to police variable life insurance advertising.

The use of false or misleading sales material could give rise to the full extent of powers at the disposal of the commissioner. These would range from license revocations (for both the insurer and agents), fines and cease and desist orders, to informal disciplinary sanctions. Furthermore, the activities described would violate the state unfair trade practices acts. In addition, the commissioner as a practical matter probably possesses the power to rescind a sale based on a material misrepresentation. Common law fraud causes of action, as well as implied rights of action, also may exist depending on the law of each individual state.

Subsection E. Requirements Applicable to Contractual Services

Comment: This subsection was added to give the commissioner control over contracts for material variable life insurance services performed for the insurer by a third party. Since these material operations are functions which would normally be carried on by the insurer itself, and thus would be subject to the commissioner's direct control, the Subcommittee inserted this subsection in order to assure that the interests of the public and the policyholders would be protected. This subsection, therefore, indirectly regulates service companies through the regulation of service contracts under which a variable life insurer is to be obligated. The subsection requires the contract to be in writing and requires the service company to subject itself to examination and to furnish the commissioner with information sufficient to determine whether or not the service operations conducted for the insurer are consistent with the relevant portions of both the model regulation and other applicable laws and regulations.

The word material was inserted so that functions that were not relevant to the welfare of the policyholders or the public were not required to be covered by this subsection. Naturally, the question of materiality must ultimately be answered by the commissioner. However, the contracts referred to in this subsection were not intended to include traditional agency compensation agreements and normal reinsurance treaties.

Service company operations are a significant part of the insurer's plan of operation (Section 6A(2)(a)). Therefore, the insurer is under an obligation to notify the commissioner of any change. The commissioner was felt to possess the inherent power to terminate a service contract which he or she felt to be hazardous to the public or the insurer's policyholders.

It is impossible to speculate in the absence of actual facts as to what particular circumstances might give rise to control of an insurer by a service company. The Subcommittee intended that the commissioner should have flexibility in making this decision.

The performance of services in the absence of stock ownership would not by itself seem to constitute control, since this would not appear to give rise to the ability to direct the management of the insurer. That is, if a service company performed all or substantially all of the administrative functions associated with the variable life insurance contracts, advised the insurer as to regulatory requirements associated with the contracts, managed to investment company in which all or substantially all of the separate account's assets were invested, and reinsured all or substantially all of the risks under the variable contracts, it would not necessarily be in control. However, the furnishing of regular investment advice would give rise to an affiliation between the insurer and the service company pursuant to Section 2A.

Subsection F. Reports to the Commissioner

Source: Portions of this subsection are derived from the original Model Variable Contract Regulation (see 1968 *Proceedings of the NAIC*, II 777).

Comment: This subsection was not intended to include all of the material that must be filed or reported to the commissioner of each state in which the insurer is doing business. Additional sections separately impose specific requirements (see, e.g., Section 3C and D and Section 4B).

Furthermore, as provided in Paragraph (1)(d), the commissioner may require such additional information concerning an insurer's variable life insurance operations as he or she deems necessary.

Paragraph (1)(a) is not intended to imply that a separate account is a severable distinct entity.

Paragraph (2) requires the commissioner to disapprove the material filed under this subsection if he or she finds it to be materially false, misleading, deceptive or inaccurate, and further requires distribution of amended material. Naturally, this distribution would be to those who received the defective report; however, some flexibility was intended for the commissioner.

The filing of an amended report is not the limit of sanctions that could be imposed on the insurer for defective reports. Rather, the full range of sanctions at the disposal of the commissioner delineates the potential liability of the insurer. This could include, depending upon the seriousness of the violation involved, informal disciplinary proceedings all the way up to and including revocation of an insurer's license.

Since a substantial amount of the material required to be filed under this subsection must be filed prior to its distribution, the Subcommittee hoped to lessen the problem of purchase in reliance upon disapproved material.

Subsection G. Authority of Commissioner to Disapprove

Source: NAIC Model Variable Contract Regulation (see 1968 *Proceedings of the NAIC* II 777).

Comment: This subsection is similar to Section 3F(2) and the comments made there are applicable here.

This subsection was added to deal with any material which is required to be filed and approved by law or provisions of the regulation other than Section 3F.

Section 4. Insurance Policy Requirements

Subsection B. Filing of Variable Life Insurance Policies

Source: Portions of this subsection are derived from the original NAIC Model Variable Contract Regulation (1968 *Proceedings of the NAIC* II 777).

Comment: This subsection requires specimens of all variable life insurance policies, riders endorsements, applications, and other related documents that are to be attached to or made part of the policy to be filed with the commissioner and approved prior to the use of that form in a particular state.

Prior to the 1983 amendments, Subsection B required the commissioner to approve variable life insurance policies and other forms in writing prior to delivery in the state. The 1983 amendments deleted this requirement, thereby subjecting variable life insurance policies to the same rules and procedures governing approval of other forms of life insurance in the state.

It was felt that perpetuating a separate requirement of written approval for variable life insurance was anachronistic and unnecessary. In the years that have elapsed since the promulgation of the original model regulation, state insurance departments have developed increased familiarity with the variable life insurance product and its regulation. Moreover, the commissioner possesses significant control over the issuance of variable life insurance in the state by virtue of Section 3A(2), which requires that the commissioner scrutinize the insurer's plan of operation, financial condition and other factors prior to granting written approval for the issuance of variable life insurance in the state.

The term "related forms" in the introductory paragraph of this subsection does not include either information to applicants required by Section 7 or reports to policyholders provided for in Section 9. However, these are also subject to approval prior to use (see Section 3F and G).

Paragraph (2) gives the commissioner the authority to approve policies and forms which he or she deems to be not less favorable to the policyholder and beneficiary than those required by the model.

Paragraph (2) is intended to allow companies to include provisions more favorable to the insured. This may be desirable for the insurer in order to promote uniformity of policy forms. For example, assume that State X allowed a two-year suicide exclusion and State Y allowed a one-year exclusion. The one-year exclusion is more favorable to the policyholder. Thus, this paragraph would enable the commissioner of State X to approve a company's form which contained the more favorable one-year exclusion, thus permitting the insurer to have the same form in both states. The commissioner of State X could not, pursuant to the model, impose the one-year exclusion on the insurer.

The determination of when a benefit is more favorable can be a very subjective determination. For example, a one-year "free look" would be a benefit to those who chose to take advantage of it. Those who had no intention of ever exercising such a provision and would be forced to bear the extra cost involved would be unlikely to look at this change as a benefit. Thus, what may be a benefit for some would be merely an extra mandated cost for others. Flexibility by individual commissioners in this area was intended to be preserved.

Prior to 1983, Paragraph (3) provided an exemption from several policy design and policy form requirements for policies sold to qualified pension, profit sharing and retirement plans. Because of the enhanced overall flexibility in product design envisaged by the 1983 amendments, and because of the deletion or amendment of the sections of the prior model to which it refers, Paragraph (3) was deleted.

Subsection C. Mandatory Policy Benefit and Design Requirements

Comment: The 1983 amendments substantially revised Section 4 to afford insurers the necessary flexibility to offer flexible premium variable life insurance and variations on more traditional forms of variable life insurance. The amendments were premised upon the recognition that the strictures embodied in the original version of Section 4 were adopted in the context of a regulatory atmosphere that no longer prevails in an effort on the part of the NAIC to avert dual (i.e., federal and state) regulation of variable life insurance. The revisions also spring from the conviction that the restrictive criteria reflected in the original model were unnecessary impediments to the development of innovative flexible premium products. It was felt that these limitations could be relaxed without impairing the thoroughness and efficacy of state insurance regulation of flexible premium variable life insurance.

The requirement of lifetime insurance coverage which originally appeared in Paragraph (1) was inserted in an attempt to convince the SEC of the predominant insurance nature of variable life insurance and thereby to avoid dual regulation of the product. The evolution of the federal role in variable life insurance regulation has rendered this limitation anachronistic. The requirement that coverage be provided "for the lifetime of the insured" was deleted in 1983 as an unnecessary impediment to the development of innovative flexible premium product designs. In this regard, it should be noted that the commentary to the original model clearly reflects the NAIC Subcommittee's assumption that the "whole of life" limitation would be applicable for the time being only.

Paragraph (1) has been further revised to read as follows: "Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract." The purpose of this language is to indicate clearly that the insurer bears the mortality and expense risks under a variable life insurance policy. The charges for those risks cannot exceed the maximum which the insurer establishes in the policy.

Prior to 1983, Paragraph (2) provided that "[g]ross premiums for death benefits shall be a level amount for the duration of the premium payment period." This limitation resulted from the Committee's concern that it might be difficult for the public properly to understand the operation of variable premium–variable benefit policies and to evaluate the comparative cost of this type of product.

The registration of variable life insurance products with the SEC will help ensure thorough disclosure concerning the operation of these products and other varied policy designs. The enhanced familiarity and regulatory expertise that state insurance departments have developed with respect to variable life insurance will also aid in effectively protecting the public. In addition, it is noteworthy that traditional, fixed policies are not subject to any similar requirement.

Thus, the current regulatory structure has substantially weakened the original premise for this limitation. Accordingly, this restriction was deleted in 1983 to accommodate the flexibility in amount and timing of premium payments which is the cornerstone of the flexible premium variable life insurance product. The deletion will accommodate flexible premium products while permitting traditional forms of variable life insurance to continue to be written.

Reserve liabilities for any guaranteed minimum death benefit must be maintained in the general account (see Section 5B and C).

Prior to 1983, the model required that a variable life insurance policy provide a "minimum death benefit ... in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid." The minimum death benefit contemplated by the original model was "an initial stated amount of death benefit," to be paid (assuming duly paid premiums) in the event that the stated amount exceeded the variable death benefit.

The Committee recognized that the minimum death benefit guarantee that the prior model Regulation mandated could not be required under a product design that is characterized by non-level premiums that are paid on an irregular basis. The minimum death benefit guarantee was premised on the assumption that the insurer would establish level periodic premiums that would have to be paid by the insured at the times specified by the insurer. As the commentary to the previous model regulation indicated, the minimum death benefit was required only so long as premiums were duly paid. In a flexible premium variable life policy, this required minimum death benefit may not be appropriate. The insured, not the insurer, controls the timing and the amount of each premium payment. In addition, in many of the anticipated policy designs, it will be the duration of the coverage, and not the amount that will vary. Accordingly, the minimum death benefit requirement was amended in 1983 to differentiate between the minimum death benefit that must be offered under scheduled premium policies, and the applicability of such a requirement to flexible premium policies. Under the amendment, the minimum death benefit guarantee contained in the original model is limited to *scheduled* premium variable life insurance policies. A minimum death benefit guarantee for flexible premium policies is addressed in the context of a new provision governing grace periods for flexible premium policies (see commentary to Section 4D(2)(b)).

The minimum death benefit under a scheduled premium policy is only required to be applicable so long as premiums are duly paid. This would include situations in which a policy was properly reinstated. Thus, assuming duly paid premiums, the death benefit payable at any time under a scheduled premium policy is the greater of the variable death benefit or the minimum death benefit adjusted by any policy loans, withdrawals or surrenders.

The model regulation does not require a minimum death benefit paid-up variable whole life insurance since the minimum death benefit guarantee under a scheduled premium policy is required only when premiums are duly paid. Early drafts of the model regulation required a minimum death benefit guarantee in this situation. However, it was determined that the cost of providing such a benefit was too great in relation to the corresponding benefit. This is because a relatively small decline in the value in the separate account portfolio could have a relatively great impact on the death benefit of a paid-up policy. Furthermore, such a guarantee on a reduced paid-up policy could expose the insurer to risks not present under the original policy. In fact, with variable life insurance it is not at all unlikely that the traditional reduced paid-up insurance could in

reality be increased paid-up insurance. After a period of good investment performance, it is possible that the guaranteed death benefit under a reduced paid-up policy could exceed the initial death benefit guarantee, thereby exposing the insurer to an unanticipated risk and giving rise to solvency concerns. It became clear that the imposition of a required minimum in this instance would in all probability have meant that such a nonforfeiture option would merely not have been offered.

In the situation where participating policy dividends are used to purchase additional paid-up variable life insurance additions (Section 4F(3)(b), the amount payable on death was intended to be increased by the then current amount of death benefit provided by these dividend options. Thus, it would equal the greater of the minimum death benefit or the variable death benefit adjusted for indebtedness plus the current amount of additions. The minimum death benefit itself would not be applicable to Section 4F(3)(c) (see comments to Section 4F(3)(c))).

While "initial face amount" as utilized in Section 4C(2) is an undefined term, it should not be interpreted to include the amounts of any incidental insurance benefits.

See also comments to Section 2K.

The minimum multiples that appeared in the model regulation prior to 1983 attempted to establish a relationship between the amount of death benefit and gross annual premiums. The 1983 amendments deleted the minimum multiples as another vestige of the ultimately unsuccessful attempt to avert dual regulation of variable life insurance. The minimum multiples are absent from the variable life insurance regulations of several states,* suggesting that they are not a necessary ingredient of effective state regulation of variable life insurance. It was also recognized that there is no similar requirement applicable to traditional fixed life insurance policies. Thus, it was concluded that the minimum multiples are a significant but unnecessary impediment to the development of designs for flexible premium variable life insurance products.
* e.g., Georgia, Massachusetts, Michigan, Minnesota, New York, North Carolina, and Pennsylvania.

Prior to 1983, Subsection C(3) required that excess investment performance (either positive or negative) be applied only to provide policy benefits, and defined the only methods by which such application could be made. The effect of this paragraph was to limit policy designs to those that applied excess investment performance to provide adjustments to the amount of insurance, and further limited the types of insurance that could be offered. To temper the rigidity of this paragraph and its attendant inhibiting effect on the development of flexible premium variable life insurance product designs, the Committee deleted the requirement that investment experience be reflected in the variable death benefit. Thus, investment experience could, for example, be used to increase cash value or the duration of coverage.

In addition, the portion of this subsection that prescribed and delimited the manner in which excess investment performance was to be applied has been deleted. In lieu of these detailed requirements, the 1983 amendments substituted a less specific provision requiring the insurer to demonstrate to the commissioner "that the reflection of investment experience in the variable life insurance policy is actuarially sound." It is intended that this demonstration will pay particular attention to the manner in which the policy operates under both favorable and unfavorable investment conditions, and to the matching of current liabilities under the policy to the market value of assets.

Since the net investment return is a rate, the word "amount" in Paragraph (4) refers to the product of the net investment return times the benefit base.

Paragraph (5) requires death benefit determination to be at least annually. Paragraph (6) requires cash values to be determined at least monthly while Section 6A(4) (as well as Section 4D(5)(b)) requires underlying separate account assets to be valued at least as frequently as benefits are determined but in any event at least monthly. The comments to these sections refer to the Committee's thinking with regard to the frequency of the valuations covered thereby.

Sections 4C(6) and 4D(3)(b) in combination require all policy benefits to commence varying according to the terms of the policy not later than the next separate account valuation date after a maximum interval of one month from the effective date of the policy. Paragraph (5), therefore, would permit a policy design under which the first change in the variable death benefit may not occur until as late as the first policy anniversary and subsequent changes may occur as infrequently as each anniversary thereafter.

Depending on separate account investment experience, less frequent death benefit valuation can be advantageous or disadvantageous. Certainly benefits will not achieve a high level of dollar cost averaging. However, there is a possible advantage which might arise out of the certainty that for the next full valuation period (up to one year for death benefits) the entire risk of either adverse or favorable separate account performance is shifted to the insurer and benefits will be as stated on the last determination date. There may be a number of counterbalancing reasons why persons might not wish to purchase a policy in which death benefits were valued annually. The Committee, however, decided that prospective purchasers of variable life insurance should not be precluded from purchasing such policies as a matter of law.

Comment: Subsection C(6) requires cash values (nonforfeiture benefits) to be determined at least monthly.

Either the policy or a statement filed with the commissioner of the state in which the policy is to be delivered must describe the method of computation of such values. The method of computation is required to be in accordance with actuarial procedures that recognize the variable nature of the policy. It is expected that insurers will make every effort to describe the process in as simple a manner as possible. Naturally, if the insurer opts to file its statement with the commissioner, a technically oriented description would be more acceptable than would be the case if the same description were placed in the policy. An insurer choosing to file with the commissioner would be obligated to call the filing to the policyholders' attention in the policy. In any event a technical benefit base description, if not placed in the policy, must be filed separately with the commissioner (see Subsection 3A(2)). Furthermore, the filing route would not relieve the insurer from its obligation to disclose the operation of the policy in general terms (see Section 3C; Section 4D(1), 4D(4), and Section 7A).

The most important portion of this subsection requires that policy benefits be designed in such a manner that the Standard Nonforfeiture Law is satisfied with necessary modifications for variable benefits. The NAIC recommends that a guideline be developed to assist the states in administering the standard nonforfeiture law as it applies to flexible premium variable life insurance.

Prior to 1983, Section 4C(6) required that the method of computation of cash values and other non-forfeiture benefits rest in all cases on the assumption "that at all times during the life of the policy the full net investment return ... exactly equals the assumed interest rate." (commentary of NAIC Subcommittee). The 1983 amendment added a sentence to Section 4C(6) to embody the recognition that flexible premium variable life insurance products might not contain an assumed investment rate. In that event, it is contemplated that, in lieu of an assumed investment rate, the calculation is to be based upon the maximum interest rate permitted under the Standard Nonforfeiture Law.

Prior to 1983, the model regulation was designed to provide effective protection for variable life insurance policyholders against the possibility of an insurer's acquisition costs becoming too high with the resulting premium being unreasonable in relationship to the benefits provided. The approach reflected the conclusion that the only form of control that would provide meaningful safeguards to purchasers was one which was applicable to the total premium charged rather than to an artificial subdivision. The Committee considered and rejected any approach that attempted to regulate the expenses of the insurer since this would not necessarily affect the premiums charged the policyholder. This approach, in effect, required vastly increased nonforfeiture benefits if a premium that exceeds the conditional maximum was charged. This approach was chosen by the Committee rather than direct premium rate regulation—a concept alien to the life insurance industry in the United States. The Committee deleted this subsection in 1983 on the rationale that it is unnecessary to the regulation of variable life insurance by state insurance departments. Deletion was also supported by the fact that traditional fixed life insurance is not subject to any similar requirement.

Prior to 1983, the model regulation limited the deductions that could be made in determining net investment return to four of the categories of charges enumerated in Section 6G. The 1983 amendments modified Section 6G so that the specifically enumerated categories no longer limit permissible charges, but merely illustrate charges which must be disclosed in writing prior to or contemporaneously with delivery of the variable life insurance policy. Because Section 4 provisions were obsolete in view of the restructuring of Section 6, the Committee has deleted it.

Subsection D. Mandatory Policy Provisions

Source: Portions of Paragraph (1) are derived from the original Model Variable Contracts Regulation.

Comment: The primary purpose of this subsection is disclosure in order to assure that the policyholder is aware of the risks that both he and the insurer are assuming. This subsection requires that the mandated statements be prominently displayed on the cover page of the policy (see also Section 8).

Paragraphs (1)(a) and (1)(b) require that the cover page of the policy contain a prominent statement highlighting the variable nature of death benefits and cash values respectively. These paragraphs were revised in 1983 by deleting the requirement that these statements by set forth in type at least four points larger than the typesize used in the text of any provision on the page. The statements required by these paragraphs will be adequately distinguishable from the surrounding text since they must in any event be set forth either in contrasting color or boldface type.

The 1983 amendments also made several changes of an editorial nature in Subsection D(1). New matter was added in Paragraphs (1)(a) and (1)(c) to conform those paragraphs, respectively, to the amended definition of "variable life insurance policy" (Section 2S) and to the bifurcated approach to the minimum death benefit guarantee for scheduled premium and flexible premium policies (Section 4C(2) and Section 4D(2)(b)).

The "free look" provision incorporated in Paragraph (1)(e) was amended in two significant respects.

First, Paragraph (1)(e) as amended provides that the free-look right may be exercised only during the ten-day period following the policyholder's receipt of the policy; the 1983 amendment deleted the language in the model that provided, alternatively, that the policyholder could return the policy either within the foregoing 10-day period or within 45 days of the date of the execution of the application, whichever was later.

Second, the 1983 amendments changed the calculation of the amount that the insurer must refund upon return of the policy within the specified period. Specifically, to the extent permitted by state insurance law, the insurer is permitted to utilize a refund calculation similar to the method prevalent in computing free-look refunds for variable annuities. Thus, it is contemplated, in essence, that the amount to be refunded upon return of a variable life insurance policy during the prescribed 10-day period will equal the sum (determined as of the date on which the returned policy is received by the insurer or its agent) of (1) the amount designated as loading, plus (2) "value of the amounts allocated to any separate accounts under the policy," i.e., the cash value corresponding to the policy.

The 1983 amendments recognized that state insurance law may have to be amended to permit insurers to utilize the foregoing refund approach. Accordingly, Paragraph (1)(e) preserves the status quo—requiring the insurer to refund "the total of all premium payments for such policy"—until any necessary statutory amendments have been enacted.

The premise underlying the 1983 amendments to Paragraph (1)(e) was that the requirements of the former model were inequitable to insurers because their effect was to impose the entire investment risk on the insurer during the free-look period. By correlating the required refund to the value of the amounts allocated to the separate account, the 1983 amendments permit an insured to benefit from favorable investment performance during the free-look period. Conversely, the amount to be refunded will reflect the results of adverse investment performance during the prescribed period.

As already noted in discussing the minimum death benefit provisions, the 1983 amendments to the model regulation differentiate between the minimum death benefit that must be offered under scheduled premium and flexible premium policies. The required minimum death benefit for flexible premium variable life insurance is, in turn, closely intertwined with the grace period that must be afforded by such products. Paragraph (2) was accordingly amended in 1983 to achieve dual objectives: it demarcates the different grace periods and establishes the scope of the required minimum death benefit under a flexible premium product.

Prior to 1983, Paragraph (2) required that a variable life insurance policy afford "a grace period of not less than thirty-one (31) days from the premium due date..." This language applied the standard life insurance policy grace period to variable life insurance. Thus, it was contemplated that there would be no change in either variability or amount of benefits owing under the policy if premiums were paid within the grace period. Policy benefits were to be the same as if the premium were paid on the due date.

The 1983 amendments placed the thirty-one day grace period requirement in a separate paragraph and limited its applicability to *scheduled* premium policies. This was done because (1) the concept of a "premium due date" was thought to be inapposite to flexible premium policies and (2) a 31-day, "standard life insurance policy" grace period is consistent with the longer grace period that is typically required for current general account flexible premium policies.

Paragraph (2)(b), added by the 1983 amendments, requires a 61-day grace period for flexible premium variable life insurance policies, measured by reference to the "policy processing day" as defined in Section 2N. The 61-day grace period, akin to the grace period that must be provided under current universal life insurance policies in some states, begins to run on the "policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges..." The policyholder report required

by Section 9C will notify the policyholder that the amounts available under the policy are insufficient to keep the policy in force. The policyholder will thereby be afforded an opportunity to pay sufficient premiums to maintain the coverage in effect. Paragraph (2)(b) provides that the flexible premium policy grace period will terminate no sooner than sixty-one days after this warning notice is mailed.

The death benefit under a flexible premium variable life insurance policy will remain in force as long as sufficient amounts are available under the policy to support the deductions necessary to maintain the coverage in force. However, even if the amounts available are insufficient to carry the policy to the next policy processing day, Paragraph (2)(b) nonetheless mandates that an insurer provide a minimum death benefit during the grace period. The death benefit that must be paid is the death benefit that was in effect immediately prior to the grace period, less any overdue charges. Of course, nothing precludes an insurer from offering a greater minimum death benefit guarantee under a flexible premium variable life insurance policy.

Paragraph (3) is derived from the original Model Variable Contract Regulation. It was adopted from the normal fixed benefit life insurance reinstatement provision with modifications required by the nature of variable life insurance.

Paragraph (3) was amended in 1983 to limit the mandatory reinstatement privilege to scheduled premium variable life insurance policies. State insurance statutes typically require reinstatement only when (1) there has been a default in premium payments; (2) on default, the value of the policy has been applied automatically to the purchase of other insurance; and (3) other insurance is in force and the original policy has not been surrendered to the company and cancelled. Under a flexible premium variable life insurance policy, however, the concept of a default in premium payments is not meaningful; coverage remains in effect until the amounts available under the policy to support the coverage are depleted by deductions for charges in accordance with the policy's terms. Thus, it is not appropriate to require a mandatory reinstatement privilege for flexible premium policies; once the value of the policy has been fully consumed, there is nothing to reinstate. However, it should be noted that Paragraph (3) does not preclude an insurer from developing and offering a reinstatement privilege in the context of a flexible premium policy.

Just as with fixed benefit life insurance, evidence of insurability is required on reinstatement in order to protect against anti-selection. With death benefits and cash values subject to fluctuation, a fixed benefit type reinstatement would have offered an opportunity for speculation against the insurer. A policyholder could lapse his policy and, assuming he or she remained insurable, the policyholder could wait to see whether separate account performance resulted in increased or decreased benefits. If benefits decreased, he would not reinstate and could purchase a new policy. If benefits had increased, in the absence of Subparagraph (b), he or she would pay back merely the overdue premiums as interest.

While this might appear to be an attractive scenario, it would rarely be in either the policyholder's or the insurer's interest. The insured is always risking his or her insurability. More importantly, however, in lapsing and purchasing a new policy the policyholder would be paying policy acquisition costs again as well as reestablishing the suicide and incontestability clauses (see, e.g., NAIC Replacement of Life Insurance and Annuities Model Regulation, 1970 *Proceedings of the NAIC* I 345).

Reinstatement in the situation described above could also be costly to the insurer (and, in the case of an insurer issuing participating policies, other classes of policyholders). It imposes a significant investment risk. For example, in scheduled premium variable life insurance the allocation of premium to the separate account is made on a uniform basis independent of the date the premium is actually paid. Consequently, cash will have to be advanced from the general to the separate account to "purchase" the investments necessary to support the promised benefits. These advances create an investment risk for the insurer. If the premium is not paid by the policyholder, the advance from the general account must be reversed when the policy lapses, at which time the market may be depressed.

This, of course, is in addition to the normal risks of anti-selection and administrative costs of keeping the policy in suspended animation during the reinstatement period. In response to these problems, the model regulation conditions reinstatement on the payment of the greater of: (1) both overdue premiums and outstanding indebtedness at the maximum policy loan interest rate permitted by law in that state; or (2) 110% of the increase in cash surrender value resulting from the increase.

For discussion of the benefit base, see the comment to Section 4C(6). While the description of the benefit base is required elsewhere in different degrees of technicality (see e.g., Section 7A), the purpose of Paragraph (4) is to make it a contractual matter.

Paragraph (5) makes the identification of the separate account utilized a contractual matter. It was modified in 1983 by deleting Subparagraph (a), which required that the separate account be used to fund only variable life insurance benefits. This deletion was intended to afford insurers the flexibility to utilize the same separate account to fund several products, e.g., variable annuities in addition to variable life insurance. The commissioner's pervasive regulatory control over the separate account, the contents of variable life insurance policies, and the insurer's operations made it clear that continuation of this restriction was no longer essential in order to assure regulation of variable life insurance which will not be detrimental to the public or the policyholders of an insurer (see commentary to original model regulation).

Subparagraph (a) is derived from the original Model Variable Contracts Regulation, Article IV, Section 2. It has the effect of insulating the assets underlying separate account liabilities.

Prior to 1983, Paragraph (b) required that a variable life insurance policy contain a provision stating that "the policy and any papers attached thereto by the insurer, including the application if attached" comprised the "entire insurance contract under state law." This requirement was originally imposed to prevent the insurer from incorporating by reference in its policy, provisions which were contained in documents to which the insured had limited access. Paragraph (6) was amended in 1983 in response to the realization that the former language was, at best, too narrow and, at worst, misleading in that it might have been read to imply that the entire insurance contract was uniform from state to state. Accordingly, the paragraph was broadened to take account of possibly divergent statutory formulations of the documents which constitute the entire insurance contract.

This provision would not destroy a policyholder's rights as a third-party beneficiary of a contract made by the insurer for the policyholder's benefit assuming any such rights exist. The provision was designed to protect the policyholders from losing any rights, not to destroy rights arising outside the contract.

Paragraph (12) was amended in 1983 by adding a proviso to subject increases in the policy's death benefits subsequent to the policy issue date to a new 2-year contestability period. The new period of contestability applies only to the amount of the increase and only in those cases in which (1) the increased coverage is attributable to a new application or request by the owner, and (2) the insurer asked for satisfactory evidence of insurability. Thus, for example, the insurer would not be permitted to contest increased death benefits that have resulted from successful investment performance of the separate account, or from the exercise of a contractual right (e.g., a guaranteed purchase option) that was applied for, underwritten and approved at the time of original issue.

The deferral contemplated by Paragraph (14) might be necessary in times of financial difficulty when in the opinion of the insurance commissioner there might be a "run" on the insurer that would jeopardize the remaining policyholders. This might also exist in a liquidation, a situation in which the commissioner might allow death benefits, but not cash values, to be paid pending the liquidation process.

Insurers are exempted from the federal bankruptcy laws in order that liquidation can take place in a manner that will serve to protect the policyholders. This protection of all policyholders (variable and fixed) would be placed in severe jeopardy were the separate account given preferential treatment over the general account.

This provision is similar to one that is required in most states for fixed benefit life insurance in order to protect the policyholders in the instances described. This paragraph grew out of the depression economy. Although relatively few insurance companies failed during the depression, there was a concern that a run on insurance companies in a future depression could have very severe consequences not only on the insurers and their policyholders, but to the general economy (Gregg, *Life and Health Insurance Handbook*, 2nd edition, p. 1151).

Again, it is important to realize that a separate account is not a severable entity but rather an integral part of the insurer. A separate account alone could not operate a variable life insurance policy. A part of the reserve underlying a variable life insurance policy may be in the general, not the separate, account at any given time. Thus, a combination of the two may be required in order to pay benefits. Without the protection of this paragraph, the insurance commissioner might be in the position of being able to protect the policyholders in a liquidation only to the extent of the reserves in the general account.

This paragraph has particular importance to variable life insurance. Since the separate account's portfolio may consist of equity investments to a much larger extent than the general account's portfolio, determination of the proper amounts payable under a policy will be difficult during periods when the stock exchanges are closed.

The phrase "except when used to pay premiums" is intended to apply to the payment of premiums under an automatic premium loan provision as permitted in Section 4F(4) and not to any other situation.

Prior to 1983, Paragraph (15) required that every variable life insurance policy contain settlement options that shall be provided on a fixed basis only. The 1983 amendments provide that at least one settlement option must be provided on a fixed basis, but permit the insurer to provide variable settlement options.

A review of the commentary accompanying the prior version of Paragraph (15) reveals that the restriction to fixed basis settlement options was intended to ensure that no one would attempt to impose dual regulation as a result of variable settlement options. The federal role in the regulation of variable life insurance has, however, eliminated the justification for this limitation. In this connection, it should be noted that, in a memorandum dated September 9, 1976, the NAIC Counsel specifically noted that "[c]ontinuance of this provision in the event of dual SEC-state regulation would be unnecessary, and in that event its deletion is recommended." "Proposed Changes to the NAIC Model Variable Life Insurance Regulation" (September 9, 1976), Memorandum of Richard A. Hemmings, NAIC Counsel. The prior restriction imposed unnecessary costs on consumers; a policyholder or beneficiary desiring a variable settlement option was constrained to surrender the variable life insurance policy and purchase a separate variable product, incurring the costs associated with the surrender and replacement.

Prior to 1983, Paragraph (16) required that a variable life insurance policy contain a description of the basis for computing the cash surrender value under the policy and display the value in the format of a schedule of cash values. The function of these schedules was to set out the cash values under the policy at specified durations per $1,000 of variable death benefits then in force, regardless of investment performance. The schedules did not involve assumptions as to what the amount of variable death benefit or cash values would in fact be at the specified future durations.

The alternative cash value schedules that were set forth in Paragraph (16) were deleted in 1983 on the grounds that they might be, at best, meaningless, and, at worst, misleading in the context of flexible premium variable life policies characterized by nonguaranteed cash values that fluctuate in accordance with investment experience. In lieu of these alternative cash value schedules, the 1983 amendments made mandatory the furnishing of illustrations of benefits payable under variable life insurance policies.

As amended in 1983, Paragraph (16) required the insurer to describe the basis for computing the policy's cash value in addition to its cash surrender value. This requirement was added to provide the policyholder with useful information which juxtaposes the two amounts and thereby focuses the policyholder's attention on the costs, if any, associated with surrendering the policy.

Paragraph (17) was amended in 1983 to require that charges for incidental insurance benefits, in addition to premiums for the benefits, be separately stated. This language was added to indicate that while premiums for incidental death benefits could be paid directly by the policyholder, the cost of the benefits might also be deducted as charges from the separate account.

Prior to 1983, Paragraph (20) required that a variable life insurance policy afford at least one non-forfeiture benefit on a fixed basis from the due date of the premium in default, and prohibited an insurer from offering variable extended term insurance as a nonforfeiture benefit. The commentary accompanying the prior model regulation stated that the prohibition upon variable extended term insurance was being imposed "for the time being" only. Thus, it was apparently contemplated that the need for these restrictions would be reexamined.

The 1983 amendments respond to the clear incompatibility between these constraints and rudimentary design characteristics of flexible premium policies. The hallmark of flexible premium products is the latitude and discretion that the policyholder possesses over the amount and timing of premium payments. Thus, the concepts of a discrete, identifiable premium due date and of a premium in default—which are readily defined and easily applied in the context of fixed life insurance and traditional variable life products—are inadaptable to flexible premium products. Nonpayment of premiums under a flexible premium product would not necessarily result in termination of insurance coverage; instead, coverage continues until the charges necessary to keep the policy in force exceed the value of the amounts allocated to the separate accounts under the policy. In other words, if premium payments are discontinued, the duration of coverage would vary in accordance with investment performance.

The model's constraints upon the types of nonforfeiture insurance benefits that may be offered were deleted in 1983 because it was felt that they posed unnecessary obstacles to the evolving development of flexible premium products. Moreover, it was felt that sound state regulation of these products did not require that these strictures be retained.

The concluding language of Paragraph (20) allows an insurer to limit certain nonforfeiture benefits to a reasonable minimum amount. In other words, the regulation recognizes that costs associated in offering certain benefits in minute amounts may be unrelated to the size of the benefit. Therefore, it was thought unreasonable to require an insurer to absorb costs below a reasonable minimum benefit amount. The commissioner must ultimately approve of the reasonable minimum.

As amended, this provision, which was formerly included in Subsection E, is most appropriately classified as a mandatory policy provision, and therefore has been placed in Subsection D. This permits Subsection E to be devoted solely to policy loans.

Subsection E. Policy Loan Provisions

Comment: Prior to 1983, this subsection encompassed partial surrenders and partial withdrawals in addition to policy loans. In 1983, the Committee restructured Subsection E so that it addresses only policy loans. This was accomplished by deleting references to partial withdrawals and partial surrenders from Subsection E (see, e.g., former Paragraph (b)(10) and Paragraphs (9) and (10) as amended) and inserting instead, in Subsection F(5), a permissive provision that a variable life insurance policy may contain a provision allowing the policyholder to make partial withdrawals.

The original model regulation formulated the loan value by reference to the cash value of the policy. The 1983 amendments correlated the loan value to the cash surrender value of the policy to accomplish two principal objectives.

First, defining the loan value in terms of the cash surrender value conformed the model regulation to the insurance laws of most states. These statutes define the loan value as the cash surrender value and provide that when total indebtedness equals or exceeds the loan value, the policy may be terminated provided that at least thirty days' prior notice has been given to the policyholder.

Second, relating the loan value to the cash surrender value avoids disparate treatment of a policyholder who takes out a policy loan vis-a-vis a policyholder who surrenders the policy. Specifically, it was felt that if the original language were retained and a policyholder were permitted to borrow the full cash value of the policy, he or she could thereby circumvent imposition of a surrender charge and would be more favorably treated than a surrendering policyholder.

In 1983, the Committee added an exclusion for term insurance policies and pure endowment policies to the introductory language to Subsection E to make it clear that a policy loan provision is mandatory for all policy designs except term insurance and pure endowment policies. In addition, because of the unscheduled nature of premium payments characteristic of flexible premium products, it was felt that the previous introductory language which tied the availability of policy loans to payment of a specified number of full years' premiums was inapplicable. Accordingly, in 1983 this language was amended to provide that policy loans would be available after the policy has been in force for a specified period of time.

Paragraph (2) was amended in 1983 to replace the reference to a maximum permissible interest rate with language which would permit insurers to charge a variable interest rate on policy loans where permitted by state law.

Paragraph (5) requires that the insurer notify the policyholder of the insurer's intention to terminate the policy if excess indebtedness is not repaid within thirty-one days. Thus, rather than merely allowing the insurer to cancel the policy, this paragraph requires the insurer to allow the policyholder to repay immediately the excess indebtedness over the cash surrender value. The Committee fully recognized that this placed a substantial risk on the insurer during the thirty-one day period. Furthermore, the Committee was aware that in fluctuating markets the insurer could be forced to send frequent notices. However, this is the risk the insurer must take, and is one of the reasons for the 75% limitation of Paragraph (1).

Paragraph (5) was amended in 1983 to apply different notice requirements to scheduled and flexible premium policies. The 31-day notice of intention to cancel is triggered when the indebtedness exceeds the cash surrender value of the policy, rather than the policy's cash value. Finally, the word "any" was inserted in the clause "notice of <u>any</u> intent to cancel" (emphasis added) to make it clear that cancellation of the policy is not mandated by the regulation, but is to be at the option of the insurer.

Paragraph (6) was intended to allow, but not to require, the insurer to permit full restoration of benefits upon the repayment of 110% of the increase in cash value and the furnishing of evidence of insurability satisfactory to the insurer. The 110% repayment is inserted to discourage speculation against the insurer. Evidence of insurability is required to protect against anti-selection (see comment to Section 4D(3)).

Paragraph (7) is intended to prevent a policyholder from borrowing amounts that are so small as to generate high costs in administering the loan by the insurer with limited corresponding benefits to the policyholder. Of course, the commissioner must ultimately determine what will constitute a reasonable minimum amount.

Paragraphs (9) and (10) must be read together. They were inserted in order to attempt to solve problems which have long been associated with fixed benefit policy loans.

The NAIC model regulation does not specify any particular method of making policy loans. It does, however, specifically require in Paragraph (9) that the insurer shall construct policy loan provisions so that all policyholders (variable and fixed) of the insurer who have not exercised policy loan provisions are not disadvantaged by the exercise of loan provisions by other policyholders. There is no restriction as to how companies shall accomplish this result.

One method that is likely to be utilized requires the transfer of policyholder loans from the separate to the general account (again illustrating the constant interrelationship of the two) and blending of the different (variable and fixed) rates of net investment return earned by the policyholder taking the loan. As a result, only the variable life insurance policyholders actually taking policy loans receive a net investment return based on the policy loan rate on that portion. The return to nonborrowing policyholders (both variable and fixed) is unchanged. It was suggested by some, however, that loans should be required to be made from the insurer's general account because transfer of the loan amount from the separate account might, depending upon that account's investment performance, decrease the return to borrowing variable life insurance policyholders. This approach reflected little concern over the fact that such a provision would require the insurer's fixed benefit policyholders to subsidize the borrowing variable life policyholders, and, further, that the risk of poor return was no longer imposed on the borrowing policyholder, and was rejected for that reason.

This aforementioned approach, in effect, applies the difference between the net investment return based on the policy loan interest rate and the net investment return of the separate account against the policy loan indebtedness to adjust the benefits otherwise payable. Under this approach, the borrowing variable life policyholders will be credited with a net investment return based on the policy loan interest rate rather than the separate account net investment return for the purpose of calculating policy benefits. Thus, to the extent of the borrowing, variable life insurance policyholder have a policy which is totally insulated from both favorable and unfavorable separate account performance, and nonborrowing policyholders remain unaffected. Borrowing policyholders are affected only to the extend of their loans.

Subsection F. Other Policy Provisions

Source: Paragraphs (1), (4), and most of (3) are based on standard fixed benefit life insurance policy provisions.

Comment: The requirements of this subsection are optional. However, if provisions are made they must resemble in substance the mandates of this subsection. In 1983, Paragraph (3)(b) was amended to eliminate a requirement that certain forms of life insurance purchased under dividend options be paid-up. In addition, the amendment permitted forms of fixed benefit life insurance besides whole life. These changes were made to add needed flexibility to permissible dividend options.

Paragraph (1) allows a two-year suicide clause. Of course, the clause must be in conformity with applicable state law.

As amended in 1983, the suicide exclusion parallels the mandatory policy provision governing incontestability (Subsection D(12)). As with the incontestability clause, the new two-year period during which the insurer may deny liability for death resulting from suicide applies "to the extent of the increased death benefits only," i.e., only to the portion of the death benefit that resulted from a new application by the policyholder for the additional coverage. Because a misrepresentation of the insured's health is not necessary to contest liability under the suicide provision, the amendment to Paragraph (1) allows the insurer to deny liability for death resulting from suicide, within two years of the date of any increase, irrespective of whether or not evidence of insurability was supplied.

Paragraph (2) was amended in 1983 to afford insurers the flexibility to offer incidental insurance benefits on a basis other than fixed. See the discussion of the 1983 amendment to the definition of "incidental insurance benefit" in Section 2I.

Paragraph (4) allows an insurer to offer an automatic premium loan provision on an optional basis. The policyholder must elect its use in writing either in the application or later. If offered, the loan must be on a basis at least as favorable to the policyholder as Section 4E(1). The language that allows the imposition of a 2-premium limitation is for the policyholders' benefit in order to prevent a previously applied for automatic premium loan from destroying cash values without the policyholder being aware of this occurrence. If the policy holder renews his or her request for the automatic premium loan, the 2-premium period should commence running anew.

Paragraph (6) was added to the model regulation in 1983. Its intent is to make it clear that the permissive policy provisions specifically set forth in Subsection E do not, by implication, preclude the insurance commissioner, in his or her discretion, from approving other policy provisions submitted by the insurer.

Section 5. Reserve Liabilities for Variable Life Insurance

Comment: Subsection A refers to reserve liabilities arising from variable benefits and requires their being held in the separate account and determined on a basis consistent with the Standard Valuation Law.

The Standard Valuation Law is prospective in nature and requires a knowledge of future benefits. Since under variable life insurance future benefits are unknown, this subsection recognizes that the Standard Valuation Law cannot be applied without appropriate modifications. Thus, this subsection requires the application of the principles contained in the Standard Valuation Law in a manner that is actuarially consistent with the variable nature of the benefits provided.

Subsection B deals with the reserves for a minimum death benefit guarantee under a scheduled premium policy (see Section 2K and Section 4C(2)). This subsection was originally adopted by the Subcommittee in substance in December of 1972. It was modified in 1983 to limit it to scheduled premium policies. The following comments drawn from the Subcommittee's December 1972 report provide an explanation of this subsection:

> The purpose of the reserve for the minimum death benefit guarantee (MDBG) is to accumulate funds to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would have been payable in the absence of such a guarantee. The amount payable under the minimum death benefit guarantee, as referred to below, means the excess of the minimum death benefit over the death benefit that would have been payable if there were not such a guarantee. The reserve for the minimum death benefit (MDBG reserve) means the reserve for that excess death benefit. The amount payable under the minimum death benefit guarantee tends to increase if the investment earnings on the assets of the separate account funding the contract are less than the assumed investment return for the contract and vice versa.

Taking into account the purpose of the MDBG and the nature of the minimum death benefit guarantee, the Subcommittee concluded that the acceptable MDBG reserve system should have the following characteristics:

1. The MDBG reserve should be held in the general account of the company so that it will be backed by the general assets of the company, most of which are debt obligations valued at amortized cost and, therefore, are of a fixed dollar nature. It would not be proper to hold the MDBG reserve in the separate account since the reserve would not be supported by fixed dollar assets but by assets that are moving in the opposite direction from the risk, i.e., value moving downward while the risk increases and vice versa.

2. The MDBG reserve should be adequate to cover, under all but the most extreme circumstances, the MDBG death claims for the next year, so that the regulatory authorities can be assured the company will not run into financial trouble from this source before the next annual statement is filed.

3. The MDBG reserve should react slowly but steadily to an extended period of poor investment experience of the separate account.

4. The MDBG reserve should not overact and cause unnecessary fluctuations in surplus by increasing too rapidly in a sharp market downswing. Also, the reserve should not decrease too rapidly in a sharp market upswing after a period of poor market experience.

The reserve should be subject to the same valuation standards with respect to mortality and interest as any other life insurance reserve, currently the 1958 CSO mortality table and a rate of interest not in excess of 3.5%, and should not be discounted by rates of withdrawal because of their uncertain nature and a great variation in rates between one company and another. Withdrawal rates are particularly uncertain for variable life insurance since no U.S. companies have yet written such insurance.

After extensively testing the operation of many proposed reserve systems against these criteria under various assumptions as to the investment performance of the separate account, the Subcommittee decided to recommend a 3-part MDBG reserve system, consisting of (1) an accumulation of amounts allocated by the insurer to the MDBG reserve, less actual MDBG claims paid, subject to a 2-part minimum equal to the greater of, (2) a one-year term reserve to assure coverage of next year's claims, and (3) a reserve designed to protect against an extended period of poor investment experience of the separate account.

The amounts allocated by the insurer to the first part of the reserve system depend upon the design characteristics of an insurer's variable life insurance contract, the insurer's judgment of the risk it has assumed, and its assessment of the possible impact on its surplus of future changes in the 2-part minimum.

The second part of the reserve system is a requirement that the reserve be sufficient to cover all MDBG claims of the following year if there is an immediate one-third depreciation in the value of the separate account assets.

The third part of the reserve system forces an insurer to gradually increase its reserve if this is necessary to cover MDBG claims arising from an extended period of poor investment performance. The technique used is to fund the cost of future MDBG claims by level payments over the future premium paying period of the contract.

The Subcommittee's proposal also provides that suitable approximations and estimates may be used to shorten the work of computing the reserve for the minimum death benefit guarantee.

The requirements for a reserve for the MDBG originally adopted by the NAIC (1973 *Proceedings of the NAIC* I 504) included a provision that amounts be regularly allocated by insurers to be accumulated to form a reserve which would be charged with any excess of actual death benefits paid over those which would have been paid in the absence of the MDBG. This requirement was subsequently deleted from the model regulation because of the difficulty of specifying the amounts to be regularly allocated since such amounts vary depending on factors such as the plan design and the assumed investment return. The Subcommittee felt that it would be better for companies to include in their plan of operation, a specification of the amounts to be regularly allocated for this purpose (see Section 3A(2)(a)). Only the second and third parts of the reserve system are retained in the present regulation.

Subsection C requires the application of the Standard Valuation Law to incidental insurance benefits. Reserves for the variable aspects of variable incidental insurance benefits shall be maintained in a separate account; reserves for any guarantee associated with the benefits shall be maintained in the general account.

Section 6. Separate Accounts

Subsection A. Establishment and Administration of Separate Accounts

Comment: Section 6 deals generally with separate account operations and the management of the insurer. Therefore, within the context below it was expected that conduct under this section would primarily be regulated by the state of domicile.

Totally aside from the model regulation, any matter which might pertain to the insurer's ability to perform its obligations within a particular state is always subject to the scrutiny and regulation of the commissioner of that state. Thus, the commissioner of any state can always change his or her regulations or bar an insurer from doing business in the state as well as invoking all other enforcement remedies available. However, as a general proposition, the internal management of the insurer is normally regulated by the state of domicile, and in the absence of unusual circumstances, this regulation is accepted by other states in which the insurer does business. In fact, this is the reason underlying Section 3A(2)(c) and 3B(5). In 1983, the introductory language to Subsection A was expanded to make clear that the domiciliary state has exclusive jurisdiction over the establishment of separate accounts and to clarify that a commissioner may not require foreign insurers to establish separate accounts in his or her state.

Subsection A relates to the creation of separate accounts. Paragraphs (1) to (3) relate to custodianship, bonding requirements and the background of persons associated with the material handling of separate account assets.

It is important to note in any discussion of these areas that the assets of the separate account are only significant with respect to solvency. Unlike a mutual fund in which the shareholder owns a proportionate share of the assets that exist, the variable life insurance policyholder owns the right to be paid benefits according to the contract, regardless of whether the assets underlying the policy actually exist. In this regard the commissioner's sole concern as to the existence of assets is limited to solvency. The insurer's obligation exists regardless of whether or not the assets have been stolen. Misconduct has no effect on the determination of benefits owed to the policyholders. Therefore, the interest of the commissioner with respect to misappropriation is exactly the same for fixed benefit and variable life insurance—namely, the ability to pay benefits under the policy.

Paragraph (1) relates to custody of separate account assets. The laws of some states are quite specific in this regard and were intended to govern over this provision. In the normal instance, the Subcommittee certainly expected that the insurer would maintain custody over its assets including those allocated to its separate account. In this context it was recognized that an insurer is never really acting as custodian of separate account assets.

Since a variable life insurance separate account is an integral part of the insurer, the insurer is acting as custodian (really owner) of its own assets, including those which it may have internally allocated to the separate account. Neither the separate account nor the variable life insurance policyholders own any assets. As a matter of fact, the Model Variable Contract Law Section 1E provides that "amounts allocated to a separate account in the exercise of the power granted by this Act shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts."

An affiliate of the insurer holding custody of the insurer's assets would not be the same thing as the insurer itself holding them. Clearly, assuming no contradictory requirement, the model regulation provides the commissioner of the state of domicile with the authority to review and approve the terms of a custodianship contract and the custodian itself. The standards to be reviewed would presumably be (1) safety of the assets; (2) cost; and (3) the absence of a conflict of interest which might be detrimental to the policyholder.

Paragraph (2) requires the prior written approval of the commissioner in order for an insurer to employ the persons described therein in any material capacity with the handling of assets allocated to the separate account. As noted earlier, this is primarily a solvency concern. However, because the assets underlying variable life insurance separate accounts are inherently liquid in nature, they are more easily converted and this subsection was felt to be desirable.

The term "material" as it is used in this subsection is designed to cover a person who is employed in a position which would enable misappropriation of funds. It was the Subcommittee's understanding at the time the model regulation was drafted that to consent to an injunction would be an acknowledgment of a violation and, therefore, approval would be required under this subsection. The prohibition of this subsection would not define a narrower class of persons that is covered under the Investment Company Act.

As previously discussed, since the operations of the separate account would generally be regulated only by the state of domicile, approval under this subsection would not necessarily have to be obtained in every jurisdiction in which a company proposed to sell variable life insurance. However, the provisions of Section 3A(2) would still be applicable.

Paragraph (3) refers to bonding requirements for persons with access to separate account assets. Since bonding is not uncommon in state insurance regulation, the Subcommittee determined to leave the particular amount to each particular state.

Paragraph (4) should be read in conjunction with Section 4C(5) and (6) as well as Section 4D(5)(b).

The model regulation allows annual death benefit determination and monthly cash value determination. However, each can be determined much more frequently (daily is a common variation). Allowing cash value determination which was less frequent than monthly combined with "backward" valuation (see comment to Section 4C(6)) would have exposed the insurer to great speculation risks and could affect solvency. Therefore, monthly cash value determination was required. Since it would be impossible to determine benefits without valuing assets, this provision merely restates the obvious in requiring asset valuation at least as frequently as benefits are determined.

Prior to 1983, a paragraph of Subsection A had required that an insurer desiring to establish more than one separate account for variable life insurance file with the commissioner a justification for the action and obtain the commissioner's approval for the establishment of each additional separate account. The paragraph also prohibited the creation of additional separate accounts for the purpose of avoiding lower maximum charges against the separate account. This paragraph was deleted in 1983 because separate accounts funding scheduled and flexible premium variable life insurance products will be registered with the SEC under the Investment Company Act, which regulates permissible charges against registered separate accounts.

In 1983, the Committee also eliminated a provision in Subsection A that provided that a separate account, exempt from regulation under Section 3(c)(11) of the 1940 Act because of the tax qualified status of the policies funded thereby, should not be used to fund other variable life insurance policies. This provision had originally been included in the model regulation in order to prohibit companies from jeopardizing the exempt status under the Investment Company Act of Section 3(c)(11) separate accounts by placing in those accounts assets from nonexempt policies. This provision was deleted to afford insurers the flexibility to decide whether there are economies or benefits to be gained from pooling 3(c)(11) assets with nonexempt assets in one separate account.

Similarly in 1983, the Committee determined to remove another provision in Subsection A that stated that except for separate accounts exempt pursuant to Section 3(c)(11) of the Investment Company Act, variable life insurance separate accounts should not be used for variable annuities or the investment of funds corresponding to dividend accumulations or other policyholder liabilities not involving life contingencies. This provision had originally been included in the model regulation to assure that insurers not jeopardize the partially exempt 1940 Act status of variable life insurance separate accounts by pooling them with assets funding variable annuities when variable annuity separate accounts were subject to full 1940 Act regulation. The Committee eliminated this provision in 1983 in order to give insurers the option of deciding whether it is more advantageous to pool the separate account fully subject to the 1940 Act, or, on the other hand, to maintain two separate accounts, one a 1940 Act regulated variable annuity separate account and the other a variable life insurance separate account that is partially exempt from the Investment Company Act.

Subsection B. Amounts in the Separate Account

Comment: The valuation reserves underlying the variable portion of the policy measure the amount of current liabilities arising from the obligation to pay future variable benefits. Thus, thissection requires corresponding assets to be maintained in the separate account for solvency reasons since the required reserve will fluctuate in direct response to changes in variable benefits (see Section 5A).

Assets at least equal to the benefit base must be maintained in the separate account in order to assure that sufficient excess investment return exists to provide the benefits required by Section 4C(3) and 4C(4). The reference to the "valuation reserves for the variable portion of the policy" is not intended to encompass reserves for fixed nonforfeiture benefits, reserves either for dividend accumulations or for dividends applied to purchase paid-up insurance, or reserves for fixed insurance benefits.

In 1983, the Committee eliminated portions of Subsection B defining benefit base and stipulating reserves because several provisions contained in other sections of the model regulation ensure that the benefit base for variable life insurance policies will be soundly defined and that benefits generated under the policies will be adequately reserved for. For example, Section 4C(3) requires that the policy reflect the separate account investment experience and that the investment experience be reflected in an actuarially sound manner. Section 4C(4) mandates that the full net investment return applied to the benefit base is credited to the policy. Section 4C(6) requires that the method for computing nonforfeiture benefits is consistent with Standard Nonforfeiture Law. Reserve liabilities for variable life insurance policies must be established under the Standard Valuation Law, pursuant to Section 5A.

Subsection C. Investments by the Separate Account

Source: Paragraph (1) is from the original Model Variable Contract Regulation.

Comment: For various reasons the Subcommittee was concerned about the valuation of separate account assets. First, these assets form the basis for most of the reserves underlying the policy's benefits. Proper valuation is essential to assure solvency. Second, the separate account serves as the measure by which investment performance and, therefore, ultimately policy benefits are determined. Consequently, the model regulation must balance sometimes competing concerns, e.g., assuring that the insurer does not artificially inflate the appearance of its investment performance by initially undervaluing its separate account assets (and thus the basis on which investment return is calculated) vis-a-vis the traditional insurance view of conservatively valuing assets in order to assure that the insurer can meet its obligations to the policyholders.

With variable life insurance this traditional concern assumes special significance because of the interrelationship between the separate account and the insurer's general account and the resultant possibility that the general account (and indirectly the insurer's fixed benefit policyholders) will be forced to backstop any significant under valuation to the extend of any initial face value guarantee. On the other hand, too high an initial valuation will tend to artificially deflate investment performance and, therefore, inadequately credit variable policy benefits. Thus, in establishing valuation requirements, the Subcommittee sought to balance these potentially competing concerns and to minimize the potential for insurer manipulation. The Subcommittee had to be sure that valuation methods were appropriate to the nature of variable life insurance and the need to protect all—not just variable—policyholders.

The provisions of Paragraph (1) are common to many existing statutes and regulations and are intended to prevent unfair or discriminatory transfer between accounts. Regular cash flow should permit those transfers to and from the general account necessary to the question of the insurer's variable life insurance business to be made in cash. The introductory language to this paragraph recognizes that the separate account is not a separate entity and is not an affiliate of the insurer. Therefore, the transactions covered by this subsection include those between: (1) the insurer's general assets and the separate account, (2) one separate account of the insurer to another, and (3) an affiliate of the insurer to either the insurer's general assets or a separate account.

Subparagraph (a) recognizes the need of seed money to establish a separate account of adequate minimum size and further the need for the constant periodic flow of cash in the form of the valuation net premium from the general account to the separate account to support the operation of policies (see also Section 6G).

Subparagraph (b) presumes that all transfers will be in cash. However, it permits transfers of assets other than cash if approved by the commissioner in advance. A transaction that is fair and equitable to both variable and fixed benefit policyholders is, of course, the standard that must be applied in determining approval. Naturally, assets transferred into the separate account must satisfy the requirements of Paragraph (2).

This subsection does not permit interest-bearing loans by the general account to the separate account to establish the latter. Section 4C(5) makes no provision for allocating separate account earnings to amortize any indebtedness.

In 1983, the Committee revised Paragraph (2) to establish a standard providing adequate safety and liquidity for separate accounts, while also affording investment flexibility. Paragraph (2) requires that the separate account maintain in its portfolio readily marketable assets and assets producing investment income such that the total of the assets and income are sufficient to meet anticipated withdrawals under policies funded by such separate account. In other words, to determine liquidity of the account, the net income from investment plus the aggregate amount of publicly traded securities, cash items and other readily marketable assets will be compared with anticipated withdrawals to meet obligations under the policies. In this way, the standard for liquidity focuses upon the entire separate account rather than individual assets in the separate account. The Committee also concluded not to prohibit specified types of investments by the separate account in view of the liquidity standard established in Paragraph (2), which determines liquidity by reference to the aggregate separate account rather than requiring that every separate account investment meet conservative liquidity standards. Moreover, since separate accounts funding scheduled and flexible premium products will be registered under the Investment Company Act, contract holders will be protected by that act and its regulations that prohibit certain specified forms of investments. The investment restrictions deleted from the model regulation, however, were more restrictive than those contained in the Investment Company Act. The Committee determined to eliminate these more restrictive limitations so that companies would have the flexibility to design products that can compete economically with alternative products offered by other financial service institutions that are not so limited. The NAIC recommends that a guideline be formulated as soon as possible to assist states in administering Section 6C(2).

Subsection D. Limitations on Ownership

Source: Paragraphs (1) and (2) are derived from the Model Variable Contract Regulation.

Comment: Paragraph (1) provides that separate accounts cannot purchase or otherwise acquire shares in any one issuer (other than the United States) if the acquisition would result in investments in that issuer exceeding 10% of the value of assets allocated to the separate account. This quantitative limitation is imposed to promote diversification and limit investment risk. The commissioner is given authority to waive this restriction in unusual circumstances where the waiver is found not to be hazardous to the public or the policyholders.

Paragraph (2) prohibits the acquisition of the securities of an issuer if the acquisition would result in the insurer's ownership of more than 10% of the voting securities of the issuer (see Section 2F.) As in Paragraph (1), the commissioner may waive this condition where such waiver is found not to be hazardous to the public or the policyholders. However, in addition, a waiver under this paragraph must also be based on an affirmative finding that the independent operation of the issuer will not be jeopardized. In this regard, coordination with the SEC may be desirable.

Paragraph (3) was inserted in order to assure that Paragraph (1) would not preclude investment in mutual fund shares, so long as the mutual fund complied with the investment restrictions of Section 6C and 6D as well as all other applicable portions of the regulation. In 1983, Paragraph (3) was expanded to make clear that Paragraph (1) was not intended to prevent separate accounts from acquiring interests in other pools in investment assets, such as interests in a pool of real estate assets, which may not be registered under the Investment Company Act. Any such investments would also have to substantially comply with the investment restrictions of Section 6C and other applicable provisions of the model regulation.

Subsection E. Valuation of Separate Account Assets

Comment: The Subcommittee was concerned with uniform portfolio valuation for a number of reasons.

A particular security may be held by separate accounts and by life company general accounts. It would appear unreasonable for the same security, held by several different variable life insurance separate accounts, to have different values. Only uniform valuation can avoid this result.

The insurance commissioners have a vital interest in the values given assets in the separate account because of the impact on the solvency of the general account caused by minimum guaranteed death benefits, if any. In fact, it can be argued that the commissioner's interest equals that of the variable life policyholders. Thus, it is important that the commissioner be satisfied with the values given the separate account assets.

Death benefits and cash values will depend to some degree on the investment performance of the separate account. Clearly in the absence of regulation a company could change its valuation procedures to alter the separate account investment results, either up or down.

Uniform valuation of separate account assets is required by the SEC under the Investment Company Act of 1940. That Act provides that portfolio securities for which market quotations are readily available shall be valued at current market value, and that other securities and assets shall be valued at "fair value" as determined in good faith by the board of directors of the investment company. The SEC has interpreted fair value to mean the value that would be received upon the current sale of a security or asset. These valuation principles, by assuring that valuation procedures reflect current market factors, eliminate the potential for understating or overstating the value of separate account assets.

In 1983, the Committee modified Subsection E to permit separate account asset to be valued at their amortized cost if it approximates market value. This change was initiated to allow valuation consistent with the current SEC position permitting conditional use of the amortized cost method of valuation. Under this valuation method, which seeks to attain a stable net asset value. a debt security is valued at its cost and interest to be earned on the security (plus any discount received or less any premium paid upon purchase) is accrued ratably over the remaining maturity of the security.

Subsection F. Separate Account Investment Policy

Comment: In 1983, Subsection F was modified to require that changes in separate account investment policy must be filed with the insurance commissioner of the domiciliary state before they become effective. Any changes in investment policy will be deemed automatically effective 60 days after the filing date with the commissioner, unless the commissioner informs the insurer of disapproval during that period because a change is viewed as detrimental to the interests of separate account policyholders. This provision, of course, would not preclude a commissioner from also considering the interests of other policyholders of the insurer. The provision simply seeks to make the interests of separate account policyholders the principal focus of the commissioner's consideration in evaluating changes in investment policy. The automatic effectiveness provided in this subsection extends to all proposed investment policy changes and is not limited to non-material changes. In revising Subsection F, the Committee intended to make clear that commissioners are not required formally to approve all investment policy changes that are filed. Under this provision, a commissioner retains the authority to disapprove, at any time, a change in investment policy that has become effective pursuant to the deemer provision of the section. Disapproval would be subject to the requirements of notice and public hearing.

In addition to the commissioner's scrutiny of proposed changes investment policy, the Investment Company Act of 1940 provides policyholders with the right to vote upon proposed changes in investment policy.

Certain regulations under the Investment Company Act, however, provide a conditional limited exemption from shareholder voting requirements to the extent that an insurance regulator requires, pursuant to insurance law or regulation, that the separate account make certain investments that would result in changes in the subclassification or investment policies of the separate account. A similar exemption is provided to the extent that changes in the investment policy of the separate account initiated by contract holders or the separate account committee are disapproved by the life insurer under limited circumstances, provided that the disapproval was reasonable and based upon a good faith determination.

Any changes in investment policy requiring policyholder approval under the Investment Company Act, as well as those excluded from shareholder vote pursuant to the limited exemptions mentioned above, must be disclosed in the proxy statement distributed to contract holders of the variable life insurance separate account. With this mechanism, the SEC also has an opportunity to review the adequacy of disclosure regarding proposed changes in separate account investment policy.

Through the combination of procedures required under Subsection F requirements proposed by the Investment Company Act of 1940, separate account policyholders are adequately protected against adverse changes in separate account investment policy. Any proposed changes are subject to: (i) disapproval of the insurance commissioner, either within 60 days of filing or subsequently following notice and hearing; (ii) shareholder vote, unless exempt under limited regulatory conditions; and, (iii) disclosure in proxy materials filed with the SEC which are distributed to policyholders and are subject to SEC review.

Prior to 1983, the subsection provided dissenting policyholders with the right to convert to a fixed benefit policy. This provision was included in furtherance of the goal of avoiding SEC regulation, as a substitute for the voting procedures required by federal securities laws. In view of the subsequent application of the securities laws to variable life insurance and the protection from detrimental investment changes afforded by requirements enumerated in the preceding paragraph, the 1983 amendments deleted the prior paragraph.

Subsection G. Charges Against Separate Account

Comment: Prior to 1983, Subsection G set forth a restricted list of charges permitted to be deducted from the separate account. Subsection G was amended in 1983 to require written disclosure of all charges that are made against the separate account, including, but not limited to, 7 specified categories. The requirements of this provision can be satisfied by disclosing these charges either in a policy delivered to contract holders or in a prospectus distributed prior to or at the same time as the policy. All charges must be disclosed in one document or the other. Consequently, a company may not selectively disclose a portion of the charges in the policy with the remainder appearing in the prospectus. A complete listing of all separate account charges must be disclosed in the policy or in the prospectus. It was determined that permissible charges against the separate account should not be limited to those specifically enumerated in order that future product design would not be unreasonably limited.

Paragraph (1) pertains to deductions from the separate account for taxes or reserves for taxes attributable to investment gains or income attributable to the separate account. This paragraph would require disclosure of such taxes or reserves.

Paragraph (2) requires disclosure of the actual cost of brokerage fees. The conflict of interest provisions of Article VI, Section 9, of Section 17 of the Investment Company Act of 1940 and the standards of conduct in Section 6H would be relevant to prevent the insurer or its affiliates from being unfairly benefited at the expense of the variable life insurance policyholders.

Paragraph (4) requires disclosure of charges against the separate account for administrative expenses and investment management expenses. It is important to note that the term "management" is much broader than the term "advisory" services which was intentionally not utilized. The expenses for investment management consist of all costs that are necessary to secure and transact the investment obligations of the insurer. It would include advisory services as well as other associated expenses. If, for example, an outside mutual fund were utilized, sales commission, printing fees, outside directors fees, registration fees, required reports, custodian fees, etc. would all be a cost of investment management and would be included in this paragraph.

In 1983, Paragraph (4) was expanded to specifically include charges for administrative expenses in the category of investment management expense charges. Also in 1983, specific limitations on investment management expenses as a percentage of average net asset value were eliminated from Paragraph (4). This change was incorporated because the Investment Company Act of 1940, under which scheduled and flexible premium policies would be registered, regulates amounts that can be charged for investment management expenses. That Act prohibits management fees against registered separate accounts organized as either management investment companies or unit investment trust, exceeding reasonable amounts prescribed by the SEC. In addition, regulations under the Investment Company Act require that administrative expenses paid to trustees or custodians for performing bookkeeping and other services be limited to amounts that are reasonable in relation to services rendered and expenses incurred, and the SEC retains jurisdiction regarding the fees. Further, Section 36(b) of the Investment Company Act provides that investment advisers to registered investment companies have a fiduciary duty with respect to the receipt of compensation for services, and provides an express cause of action for recovery of excessive management compensation. The SEC performs its oversight regarding-the reasonableness of investment management expenses and administrative expenses both when registrations are initially declared effective and when periodically updated.

Paragraph (5) was also modified in 1983 to eliminate any specific limitation on the amounts charged for mortality and expense guarantees. This revision occurred in the interest of regulatory consistency, because regulations under the Investment Company Act stipulate that mortality and expense risk charges must be disclosed in the prospectus and shall not be less than 50% of the maximum charge for risk assumption as disclosed in the prospectus and as provided for in the contract.

Subsection G was modified in 1983 to eliminate a prohibition against investment advisory charges against the separate account that would vary in accordance with the differences between the investment performance of the separate account and any index of securities, prices or other measure of investment performance. This change was initiated because in 1970 Congress amended the Investment Advisers Act of 1940 to permit registered investment advisors to contract a limited type of performance fee with registered investment companies. Performance fees, if any, will be presented in prospectus disclosure accompanying schedule and flexible premium policies and will be evaluated by contract holders pursuant to the voting procedures required under the Investment Company Act. Also, the SEC has oversight concerning performance fees in the course of reviewing initial and periodic disclosure materials.

Subsection H. Standards of Conduct

Comment: This subsection provides the minimum standards of duty and care that are owed by the insurer to the policyholders. They can be enforced by the commissioner through the full range of methods available. In addition, the insurer itself can enforce the standards as can an individual policyholder if an implied private right of action exists.

The standards of conduct would not be required to form part of the insurance contract pursuant to Section 4D(6), although an insurer might choose to include them in the policy.

Additional items might include expressions of the nature of the quasi-fiduciary duty of management to the policyholders and the obligations of good faith under which the insurer's management is bound to operate.

The Committee modified Subsection H in 1983 to provide that codes of ethics fulfilling the requirements of Section 17(j) under the Investment Company Act of 1940 would satisfy the obligations required by this Section pertaining to standards of conduct. Rule 17(j)-1 under the Investment Company Act of 1940 would satisfy the obligations required by this Section pertaining to standards of conduct. Rule 170-1 under the Investment Company Act, 17 CFR 270.170)-1, implements the requirements of Section 170(j) and provides guidance to investment companies as to the minimum standards of conduct appropriate for a persons who have access to information regarding the purchase and sale of portfolio securities by investment companies. The rule prohibits certain activities on the part of persons affiliated with registered investment companies and their investment advisers or principal underwriters. Significantly, the rule requires those types of entities to adopt a written code of ethics containing provisions reasonably necessary to prevent fraudulent trading by persons affiliated with investment companies and their investment advisers or principal underwriters. with respect to securities held or to be acquired by the investment company. In addition, Rule 170-1 requires specified persons with access to information concerning portfolio transactions to file a report with their respective investment company, investment adviser or principal underwriter regarding personal securities transactions, including date, price, nature of transaction and execution broker or bank. Through the required code of ethics, monitoring and reporting obligations, Rule 170-1 provides a significant deterrent against fraudulent, manipulative or deceptive practices in connection with investment company portfolio transactions.

The code of ethics required by Rule 17j-1 provides a comprehensive and meaningful benchmark in fulfillment of the obligations under Subsection H regarding appropriate standards of conduct with respect to the purchase or sale of separate account investments.

Subsection I. Conflicts of Interest

Comment: Subsection I is designed to incorporate by reference and apply all state conflicts of interest laws. As such, it should be broadly interpreted.

"A separate account committee or other similar body" was intended to include any form of internal management group responsible for the operation of the separate account. For example, if an insurer did not form a variable life insurance subsidiary but rather formed a new committee of its board of directors (similar, for example, to the executive committee) to make the more day-to-day type of variable life insurance management decisions, this would be the type of group to which the model regulation refers. The intention of this subsection was clearly not to permit the insurer's board of directors to delegate the ultimate management responsibility for separate account activities to any other group, such as the policyholders, or distinct separate account management. This was in recognition of the nature of the separate account's integrated relationship with the insurer as a whole.

Furthermore, this language was meant to preclude policyholder voting for the management of variable life insurance operations. Finally, this subsection was inserted to assure no misunderstanding that the conflict of interest provisions applied to any group associated with a separate account regardless of its description.

The model regulation contains no other reference to such a body. The responsibility of the board of directors to manage the insurer including its variable life insurance operations is much broader than only those acts treated in the conflicts of interest subsection. It is spelled out in detail in state insurance laws. This responsibility would include a quasi-fiduciary duty to act in the interest of the policyholders and in compliance with the standards of conduct.

In 1983, the Committee eliminated specific prohibitions that had previously existed under Subsection I because they duplicated parallel provisions contained under Section 17 of the Investment Company Act of 1940 and its rules relating to transactions with affiliated persons and underwriters. Since separate accounts funding scheduled or flexible premium policies will be registered under the Investment Company Act and subject to the SEC's jurisdiction, the interests of policyholders will be thoroughly and adequately regulated with respect to transactions involving potential conflicts of interests on the part of the separate account, the insurer or any affiliated persons.

The Investment Company Act defines the term "affiliated person" very broadly in the Investment Company Act for purposes of the prohibitions contained in Section 17. Section 17 prohibits an affiliated person or principal underwriter for an investment company from selling securities to, purchasing securities from, or borrowing money or property from the investment company or a company it controls. Section 17(d) also prohibits affiliated persons from engaging in joint transactions with an investment company without first having been granted an order of exemption from the SEC after the SEC has thoroughly scrutinized the transaction and evaluated the basis on which the parties participate. Section 17(e) also prohibits affiliated persons of investment companies from accepting any compensation in connection with the purchase or sale of any property to or for the investment company, except in the course of brokerage transactions. In those events, the broker is prohibited from receiving commissions exceeding usual and customary brokerage commissions or 2% of the sales price in connection with secondary distributions of securities, or 1% of the sale price of other securities.

Similar to a parallel provision eliminated from Subsection I in 1983, Section 17(b) provides a mechanism for registered companies to obtain exemption from the prohibitions of Section 17 for transactions that are reasonable and fair, and do not involve overreaching and that are consistent with the policy of the company as recited in its registration statement. Any such exemptive applications must be publicly noticed in the Federal Register and would permit interested persons, such as policyholders or state insurance commissioners, to request an administrative hearing on the matter.

Subsection J. Investment Advisory Services to a Separate Account

Comment: In most instances the Subcommittee anticipated that investment advice should be performed by the insurer internally in the same manner as fixed benefit life insurance. However, the Subcommittee was aware that a substantial number of insurers might wish to utilize investment advisory services either within or outside their corporate family—hence this subsection was inserted.

It should be noted that a separate account is not a "person" and cannot contract with an investment adviser. Consistent with this philosophy, this subsection has no application to an insurer's internal investment management. Naturally, the remainder of the regulation including the standards of conduct and conflicts of interest provisions are applicable in the internal management situation (see also comment to Section 6G).

An investment advisory contract must be in writing. The adviser must be either a registered investment adviser under the Investment Advisers Act of 1940, or the insurer must file a statement in compliance with Paragraph (1)(c) of this subsection annually. This report, in effect, requires the adviser to adopt standards of conduct that are sufficient to satisfy Section 6H.

As noted above, while Paragraph (1)(c) is derived from the Investment Advisers Act, Subparagraph (c)(iv)(III) includes an additional statement of any insurance law or regulation violations.

Paragraph (1)(c) does not prohibit employment of persons noted in Subparagraph (c)(iv). However, the insurer would be placed under an extremely heavy burden to demonstrate no hazard to the public.

Paragraph (1)(d) requires an advisory contract to be in writing and terminable by the insurer without penalty on at most 60 days notice.

Under Paragraph (2), the commissioner has the authority after notice and the opportunity for hearing to compel termination of a contract which imperils the public or the policyholder of the insurer (either variable, fixed or both).

A change of investment advisers or the assignment of an advisory contract, would in all probability be a change in investment policy. As a change, it would have to be submitted to and approved by the commissioner pursuant to Section 6F. The continuing supervisory nature of Section 3A and 3B(2) would imply notification of the commissioner of a change in the plan of operation. Thus, the commissioner would have to be notified.

Section 7. Information Furnished to Applicants

Source: Subsections A and B are derived from the addendum to the original NAIC Model Variable Contracts Regulation.

Comment: This section was designed to provide information to a prospective purchaser concerning the operation and performance of a particular policy.

The question of what is adequate disclosure is quite subjective. The primary concern is, of course, that a prospect has enough information to make a reasonably informed judgment as to whether the purchase of a particular policy is consistent with the needs he or she perceives. Another important concern is that the prospective purchaser be able to compare premiums and benefits of various otherwise similar policies.

In view of this there is virtually no limit to the information which could be provided. This was revealed in the approximately 110,000 pages of data produced in the Hart Committee's inquiry into only a relatively small segment of cost comparison. Submerging the prospective purchaser with information can as a practical matter thwart the purpose of disclosure as well as failing to provide sufficient information. It was felt that at the time of sale the prospect would be overwhelmed with disclosure information required by both the states and the SEC. Therefore, an attempt was made to limit information to that which would perhaps be most understandable and relevant. For example, early drafts of the model regulation required disclosure of the percentage of premiums that made its way into the separate account. It was recognized that this figure was totally unrelated to benefits payable or the relative merits of a particular policy. Therefore, this proposal was deleted.

The question of proper "cost comparison" and disclosure, particularly with regard to variable life insurance, has never been adequately resolved. This complex issue is currently under study in connection with the proposed revision of the NAIC Life Insurance Disclosure (Solicitation) Model Regulation.

The model regulation provides in Section 3F(2) that any information furnished to applicants pursuant to Section 7 be furnished to the commissioner prior to its use in the state in question. Additionally, Section 3 requires a written acknowledgment of receipt by the applicant coincident with or prior to the execution of the application for a variable life insurance policy. The insurer is required to maintain the receipt at least until its examination in order to be able to prove compliance with this section, and probably for a longer period in order to protect itself against claims that the mandates of this section were ignored.

The commissioner will further have the market conduct portion of the examination system as well as the normal complaint mechanism to see that insurers are fulfilling their obligations pursuant to this section.

Failure to comply with this section would subject the insurer to the entire range of remedies available to the commissioner. Furthermore, rescission would presumably be available to the policyholder either as a personal equitable remedy or administratively through the commissioner.

Subsection A was intended to remain flexible and can be utilized to require proper disclosure of significant policy features. However, the commissioner may wish to amend this section to specifically require inclusion of these sections.

Subsection B refers to investment policy. Both the description of investment policy and the restrictions enumerated must, of course, comply with the regulations (see, e.g., Section 4D and E). It will be a significant factor in determining what constitutes a change or material change in investment policy since this description is what a policyholder was entitled to rely upon.

This statement should include, for example, such items as limitations on investments in particular industries as well as the expected diversification of investments allocated to the separate account.

With respect to Subsection C, the net investment referred to will not take into account policy loans if held as an asset of the separate account. It is recognized that the net investment return of the separate account is a figure that is extremely unlikely to apply to any single policy, because of differences in timing of transfers of net premiums and tabular costs of mortality, etc. This figure is intended to provide a useful indication of the general investment performance of the separate account, after deductions, for comparative purposes. It is anticipated that this figure will be shown in the NAIC annual statement and will be computed in accordance with instructions for completing the annual statement. This subsection, as well as Subsection E, does not preclude the use of figures that are not more than 16 months old. Applicants during the first 4 months of a calendar year cannot be expected to receive information for the calendar year just ended less than 4 months ago.

Prior to the 1983 amendments, the subsection required a statement describing, as an approximate percentage of an annual gross premium for each year and for the life of the policy, all commissions or other payments to be paid to all agents or other persons as a result of the proposed sale. This requirement was deleted in the 1983 amendments because it was felt that the disclosure was more likely to be misunderstood than helpful. The purpose of this disclosure was to show the interest of the agent in selling the particular product. However, because commission disclosure was not required for any other form of life insurance, the disclosure provided no basis of comparison between variable life policies and others. Also, as the commentary to the pre-1983 model regulation concedes, meaningful cost comparisons on the basis of commissions are impossible, even if the business methods of insurers were uniformly comparable. To further confuse matters, the pre-1983 model did not require disclosure of sales-related costs other than commissions and conceded that, for example, a direct mail insurer, which might have ample sales expenses but no commissions, would have a distinct advantage in this regard over an insurer doing business in the traditional agency method.

For these reasons, and because projections of this type of disclosure are difficult for flexible premium products, it was determined that it was appropriate to treat variable life insurance like other life insurance and dispense with the commission disclosure.

Prior to the 1983 amendments, the current Subsection D required a statement of the annual taxes, brokerage fees and similar costs, and the charges, expressed as an annual percentage, levied against the separate account during the previous year. The NAIC was concerned that this subsection permitted a negative inference that charges or deductions from the separate account other than those mentioned were not required to be disclosed. Therefore, Subsection D was simplified to require disclosure of all charges levied against the separate account during the previous year. These would include annual taxes, brokerage fees and all other charges.

Subsection F requires a discussion of all material federal income tax aspects of the policy to the insured, the policyholder, and the beneficiary. Prior to the 1983 amendments, only disclosure of the income tax liabilities was required. A discussion of the income tax liabilities will be subsumed in a more comprehensive discussion of the policy's tax aspects.

The subsection refers to the federal income tax aspects relative to persons insured, policyholders and beneficiaries in general and not to particular specific circumstances of each insured, etc. Opinions of counsel, if necessary in the absence of specific rulings, should be labeled accordingly.

Subsection G refers to illustrations of benefits payable under variable life insurance contracts. Prior to 1983, this section did not require the furnishing of illustrations, but merely regulated their format and content in the event they were furnished. However, since the 1983 amendments deleted the requirement that variable life insurance policies contain schedules of cash values (see comment to Section 4D(16)), the illustrations specified in this subsection were made mandatory, thereby ensuring that policyholders will receive an illustrative explanation of the way in which a policy operated under certain assumptions. The NAIC recommends that guidelines be developed as soon as possible to assist states in administering this provision and to address issues regarding guaranteed and non-guaranteed aspects of a variable life insurance policy. This subsection prohibits the projections of past investment performance into the future, or any predictions of future performance. However, past performance can be shown with appropriate caveats. The Subcommittee specifically requires all benefit illustrations to be prepared by the insurer in order that they take full responsibility and to preclude unfair, or inexact, off-the-cuff illustrations prepared at the point of sale. This subsection does require a clear identification of hypothetical rates and an indication that they are unrelated to actual performance. While no single commissioner would have the power to require uniformity in hypothetical rates of return nationwide, he or she certainly would require all the information provided to all applicants in his or her state to be identical, thereby as a practical matter allowing comparison.

Prior to the 1983 amendments, the subsection required a prominent statement in contrasting color or in bold-faced type at least 4 points larger than the type size of the largest type used in the text of any provision on the page, providing:

> "The purpose of this variable life insurance policy is to provide insurance protection for the named beneficiary.
>
> No claim is made that this variable life insurance policy is in any way similar or comparable to a systematic investment plan of a mutual fund."

These required disclosures were originally included in the regulation as part of the effort to assure that variable life insurance would be considered to be insurance not involving an investment company subject to SEC regulation. Because the insurance and securities aspects of products are now determined on the basis of the characteristics of each product, it was determined to delete these paragraphs. The first required statement is self-evident and the second statement may not be accurate in the context of certain policy designs.

Section 8. Applications

Comment: Subsections A and B should be read with reference to the comments to Section 4D(1)(a) and (b). Subsection C is referred to in the comment to Section 3C.

Section 9. Report to Policyholders

Comment: The paramount objective of Section 9 is to provide a policyholder with thorough disclosure concerning the operation of his or her variable life insurance policy and with current, reliable information concerning the status of insurance coverage. In accordance with this objective, the 1983 amendments to Section 9 expanded the information that must be included in an annual report in the case of flexible premium policies (Subsection A) and, in Section C, required insurers to provide policyholders of flexible premium policies with notice of impending expiration coverage. These amendments were both designed to alert the policyholder to the possible insufficiency of the amounts available under the policy to keep the policy in force and the corresponding need to make additional premium payments.

Subsection A. Long-range Warning Notice

Comment: In 1983, Subsection A was amended to provide the policyholder of a flexible premium variable life insurance policy with a long-range warning that his or her policy may terminate without value if additional premium is not paid. In addition to setting forth information concerning changes in the policy's cash value and cash surrender value during the preceding policy year, the expanded annual report must also contain a projection, based upon specified assumptions, of cash value and cash surrender value as of the next policy anniversary. If the projected value is less than zero, the annual report must include a warning message stating that the flexible premium policy "may be in danger of terminating without value in the next 12 months unless additional premium is paid." In order that the long-range warning notice is not misunderstood, insurers may wish to indicate that notification provided pursuant to this section is based on certain assumptions and is a projection, which should not be construed as a guarantee.

Subsection C. Notice of Impending Expiration of Coverage

Comment: Although the long-range warning notice required by Subsection A provides the policyholder with important information concerning the *possibility* that the amounts available under the policy will be insufficient to keep the policy in force, the model recognizes the need for an additional immediate notice if the amounts available under the policy are in fact insufficient to keep the policy in effect without payment of additional premium. Accordingly, as mentioned above in the commentary to Sections 2 and 4, Subsection C requires that the insurer send a report to the policyholder in the event that "the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day." The mailing of this report triggers the 61-day grace period for flexible premium policies (Section 4D(2)(b)). Subsection C requires that the report indicate the minimum payment required under the terms of the policy to keep it in force until the next following policy processing day. Thus, the policyholder is provided with prompt notice of the possible impending expiration of his or her coverage and of the correlative need to take immediate action to assure that the policy continues in effect. At the time the 1983 amendments were adopted, consideration was given to extending the Subsection C notice requirement to scheduled premium policies. Concern was expressed that future scheduled premium policy designs might be such that similar problems with the sufficiency of funds available to keep a policy in effect might result. Ultimately, Subsection C was not extended to scheduled premium policies because an insufficiency of funds resulting from a policy loan under a scheduled premium policy would trigger the 31-day notice provision of Section 4E(5). Only a scheduled premium policy that is actuarially unsound from the outset could otherwise present such a problem.

Other Aspects of Section 9

Comment: The 1983 amendments implemented several additional revisions to Section 9. In Subsection A, the requirement that the information contained in annual reports to policyholders be computed as of 45 days prior to mailing was changed to 60 days to be consistent with the corresponding time period under current SEC regulations. See 17 C.F.R. § 230.486. The portion of Subsection A that required the use of contrasting color or distinctive type to highlight the variable nature of the cash value and death benefit was deleted on the rationale that the principal function of a policyholder report, unlike a policy application, is to report information, and that Section 8 already requires that an applicant for a variable life insurance policy be provided with a prominent statement of this same information. In addition, requiring that printing be done in contrasting color imposes an unnecessary additional expense.

The required contents of the annual statement contemplated by Section 9B were also amended in 1983. First, Subsection B(2) was amended to permit an insurer, as a matter of state law, to furnish comparison of the investment rate of the separate account for more than a 5-year period. In addition, the requirement embodied in previous subsections (f) and (g) that the statement include information concerning the insurer's principal executive officer, directors, parent companies and 10% beneficial owners was deleted, on the rationale that this information will normally be provided to the policyholder pursuant to the federal securities laws. In addition, this information is not directly relevant to the more material information contained in the report concerning the policyholder's status with regard to his or her policy. Finally, a conforming amendment was made in Subsection B(4) to be consistent with the deletion of the limitations on the types of charges that may be levied against the separate account (see Section 6G and 7D).

Unlike Section 7, this section would not be satisfied by delivery of a document meeting the requirements of the Securities Act of 1933 or the Securities Exchange Act of 1934, but rather requires separate notice.

Subsection B(1) requires a summary of the financial statements of the separate account based on the annual statement last filed with the commissioner. In reality, the separate account not being an entity, has no financial statement. The assets allocated to the separate account form an integral part of the insurer's annual statement and a summary of that, including separate account information, is what is required by this subsection.

Section 10. Foreign Companies

Section 10 was added and the remaining articles renumbered by 1978 *Proceedings of the NAIC* I.

Section 11. Qualifications of Agents for the Sale of Variable Life Insurance

Source: Subsections A(1), B and C are derived from Article IX of the Model Variable Contracts Regulation.

Comment: The present division of regulatory authority over variable life insurance between the state insurance departments and the Securities and Exchange Commission has resulted in the potential dual licensing of salesmen. The states developed, for variable annuities, a special variable contract agent license which required licensing as a life insurance agent plus successful completion of a variable contracts exam given by the insurance department, plus ownership of a federal securities sales license. An alternative manner of obtaining the latter was successful completion of a federal securities examination administered by the insurance departments, developed by the NAIC, and approved by the SEC. A few years ago, the NAIC withdrew from participation in this examination procedure. Thus, at present, only a federal securities examination administered by a securities regulatory body will satisfy step 3 noted above.

Whether they are selling variable life insurance or competing against it, life insurance agents must know how variable contracts work and how they are regulated. In order to assure that they have the required knowledge, the Subcommittee believed all life agents and brokers should be examined on variable contracts just as they are examined on aspects of traditional life insurance and its regulation. The model regulation reflects this position, as does the NAIC Agents and Brokers' Licensing Model Act.

Subsection A(1) requires a person to be licensed as an agent in order to be eligible to sell variable life insurance to the public (see Section 2B). The person must provide satisfactory evidence that he or she holds any securities license that may be required for the sale of variable life insurance.

Subsection A(2) reflects the single life insurance agent licensing approach.

Subsection B requires that an agent report to the insurance commissioner any disciplinary actions against him or her by other insurance departments or by securities exchanges, associations or regulators. Upon receipt of such notification, the commissioner may find the agent ineligible for further licensing as a life insurance agent or unqualified as a variable contract agent, or the commissioner may investigate for similar violations by the agent in that state for which further disciplinary action or remedial action is needed (see Section 10C).

The difficulty with this scheme is the need for an independent source of information for the commissioners. Obviously, it is somewhat unrealistic to expect all agents to report disciplinary actions against themselves. With regard to disciplinary actions by insurance departments, an independent source is available through the monthly NAIC Agents List. The Subcommittee recommends that each state religiously report disciplinary actions through this system and utilize the resulting national monthly list.

Subsection C applies the rules and regulations applicable to fixed benefit licensing, revocations, suspensions, etc. to variable life insurance.

VARIABLE LIFE INSURANCE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VARIABLE LIFE INSURANCE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 28.010 to 28.190 (1973/2011) (all variable contracts).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-2601 to 20-2610 (1996/2002).		
Arkansas	CODE ARK. R. 054.00.33 (1984).		
California	BULLETIN 87-3 (#1) (1987/1992) (portions of model).		BULLETIN 87-3 (#2) (1987); BULLETIN 87-3 (#3) (1987); BULLETIN 95-2 (1995); BULLETIN 97-2 (1997).
Colorado	3 COLO. CODE REGS. § 702-4:4-1-3 (1994/2010).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-433-1 to 38a-433-11 (1976/2013).		
Delaware	18 DEL. CODE REGS. § 1205 (1983/2005).		

VARIABLE LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 2700 to 2799 (1995).		
Florida			FLA. STAT. 627.801 to 627.807 (1982) (separate accounts).
Georgia	GA. COMP. R. & REGS. 120-2-32 (1985/2007).		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:6-323 (1987) (separate accounts); MEMORANDUM 2012-2 (2012).
Idaho			IDAHO ADMIN. CODE 18.03.03 (1969/1999) (all variable contracts).
Illinois			ILL. ADMIN. CODE tit. 50, §§ 1551.20 to 1551.100 (1972/2014) (all variable contracts).
Indiana	760 IND. ADMIN. CODE 1-33-1 to 1-33-12 (2007/2013).		
Iowa	IOWA ADMIN. CODE r. 191-33.1 to 191-33.12 (1984/1999).		
Kansas	KAN. ADMIN. REGS. § 40-15a-1 (1975/1986) (adopted by reference with exceptions).		
Kentucky	806 KY. ADMIN. REGS. 15:030 (1984).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII. 8301 to XIII.8321 (Regulation 35) (1986).		
Maine	CODE ME. R. § 02-031 Ch. 300 (1984).		
Maryland	MD. CODE REGS. 31.09.02.01 to 31.09.02.13 (1979/2012).		

VARIABLE LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts	211 MASS. CODE REGS. 95.01 to 95.15 (1989/1996).		
Michigan	MICH. ADMIN. CODE r. 500.841 to 500.866 (1978/1997).		
Minnesota	MINN. R. 2750.0100 to 2750.4500 (1984).		
Mississippi	19 CODE MISS. R. Pt. 2, R. 5.01 to 5.15 (2012).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.030 (1985/2003).		
Montana	MONT. CODE ANN. §§ 33-20-601 to 33-20-606 (1989) (portions of model).		
Nebraska	210 NEB. ADMIN. CODE Ch. 15 (1985/1994).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. ADMIN. CODE §§ 11:4-44.1 to 11:4-44.5 (1996/2001) (all variable contracts).
New Mexico	N.M. ADMIN. CODE 13.9.8 (1985/1997).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 54.1 to 54.13 (Regulation 77) (1985/2012).		
North Carolina	11 N.C. ADMIN. CODE 12.0434 to 12.0443 (1978/2002).		
North Dakota	N.D. ADMIN. CODE §§ 45-04-04 (1984/1986).		
Northern Marianas	NO CURRENT ACTIVITY		

VARIABLE LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio	OHIO ADMIN. CODE § 3901-6-08 (1997/2014).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	31 PA. CODE §§ 82.1 to 82.91 (1978/1992).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. REGS. 69-12 (Part B) (1988).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. COMP. R. & REGS. 0780-1-17 (1974/1978) (all variable contracts).
Texas	28 TEX. ADMIN. CODE §§ 3.801 to 3.811 (1985/2013).		
Utah			UTAH CODE ANN. § 31A-22-411 (1985/1986); UTAH ADMIN. CODE r. 590-133 (1989/1994).
Vermont	4-3 VT. CODE R. § 13 (1989).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE 5-80-10 to 5-80-370 (1992).
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE R. 114-11D-1 to 114-11D-10 (2010).		
Wisconsin			WIS. ADMIN. CODE INS. § 2.13 (1981/1990) (all variable contracts).
Wyoming	WYO. ADMIN. CODE 044.0002.67 (2016).		

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

Table of Contents

Section 1. Purpose

A. The purpose of this regulation is to require producers, as defined in this regulation, to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively addressed.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation or to subject a producer to civil liability under the best interest standard of care outlined in Section 6 of this regulation or under standards governing the conduct of a fiduciary or a fiduciary relationship.

Drafting Note: The language of Subsection B comes from the NAIC *Unfair Trade Practices Act* (#880). If a state has adopted different language, it should be substituted for Subsection B.

Drafting Note: Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "*Suitability in Annuity Transactions Model Regulation*" (#275). Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.

Section 2. Scope

This regulation shall apply to any sale or recommendation of an annuity.

Section 3. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

Drafting Note: States may wish to use the *Unfair Trade Practices Act* (#880) as enabling legislation or may pass a law with specific authority to adopt this regulation.

Section 4. Exemptions

Unless otherwise specifically included, this regulation shall not apply to transactions involving:

A. Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation;

B. Contracts used to fund:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;

(3) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC; or

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

C. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

D. Formal prepaid funeral contracts.

Section 5. Definitions

A. "Annuity" means an annuity that is an insurance product under state law that is individually solicited, whether the product is classified as an individual or group annuity.

B. "Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

C. "Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs and financial objectives, including, at a minimum, the following:

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including debts and other obligations;

(4) Financial experience;

(5) Insurance needs;

(6) Financial objectives;

(7) Intended use of the annuity;

(8) Financial time horizon;

(9) Existing assets or financial products, including investment, annuity and insurance holdings;

(10) Liquidity needs;

(11) Liquid net worth;

(12) Risk tolerance, including but not limited to, willingness to accept non-guaranteed elements in the annuity;

(13) Financial resources used to fund the annuity; and

(14) Tax status.

D. "Continuing education credit" or "CE credit" means one continuing education credit as defined in [insert reference in state law or regulations governing producer continuing education course approval].

E. "Continuing education provider" or "CE provider" means an individual or entity that is approved to offer continuing education courses pursuant to [insert reference in state law or regulations governing producer continuing education course approval].

F. "FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

G. "Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

H. "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.

I. (1) "Material conflict of interest" means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.

(2) "Material conflict of interest" does not include cash compensation or non-cash compensation.

J. "Non-cash compensation" means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

K. "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

L. "Producer" means a person or entity required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. For purposes of this regulation, "producer" includes an insurer where no producer is involved.

M. (1) "Recommendation" means advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice.

(2) Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

N. "Replacement" means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy has been or is to be any of the following:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

Drafting Note: The definition of "replacement" above is derived from the NAIC *Life Insurance and Annuities Replacement Model Regulation* (#613). If a state has a different definition for "replacement," the state should either insert the text of that definition in place of the definition above or modify the definition above to provide a cross-reference to the definition of "replacement" that is in state law or regulation.

O. "SEC" means the United States Securities and Exchange Commission.

Section 6. Duties of Insurers and Producers

A. Best Interest Obligations. A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer has acted in the best interest of the consumer if they have satisfied the following obligations regarding care, disclosure, conflict of interest and documentation:

(1) (a) Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:

(i) Know the consumer's financial situation, insurance needs and financial objectives;

(ii) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

(iii) Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

(iv) Communicate the basis or bases of the recommendation.

(b) The requirements under Subparagraph (a) of this paragraph include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(c) The requirements under Subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.

(d) The requirements under this subsection do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

(e) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(f) The requirements under Subparagraph (a) of this paragraph include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.

(g) The requirements under Subparagraph (a) of this paragraph apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.

(h) The requirements under Subparagraph (a) of this paragraph do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(i) The requirements under Subparagraph (a) of this paragraph do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

(j) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

(i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(ii) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(iii) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(k) Nothing in this regulation should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

(2) Disclosure obligation.

(a) Prior to the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to Appendix A:

(i) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(ii) An affirmative statement on whether the producer is licensed and authorized to sell the following products:

(I) Fixed annuities;

(II) Fixed indexed annuities;

(III) Variable annuities;

(IV) Life insurance;

(V) Mutual funds;

(VI) Stocks and bonds; and

(VII) Certificates of deposit;

(iii) An affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:

(I) From one insurer;

(II) From two or more insurers; or

(III) From two or more insurers although primarily contracted with one insurer.

(iv) A description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary or other producer or by fee as a result of a contract for advice or consulting services; and

(v) A notice of the consumer's right to request additional information regarding cash compensation described in Subparagraph (b) of this paragraph;

Drafting Note: If a state approves forms, a state should add language to Subparagraph (a) reflecting such approvals.

(b) Upon request of the consumer or the consumer's designated representative, the producer shall disclose:

(i) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and

(ii) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and

(c) Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.

Drafting Note: If a state has adopted the NAIC *Annuity Disclosure Model Regulation* (#245), the state should insert an additional phrase in Subparagraph (c) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC *Annuity Disclosure Model Regulation* (#245).

(3) Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

(4) Documentation obligation. A producer shall at the time of recommendation or sale:

(a) Make a written record of any recommendation and the basis for the recommendation subject to this regulation;

(b) Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:

(i) A customer's refusal to provide the consumer profile information, if any; and

(ii) A customer's understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and

(c) Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's recommendation.

Drafting Note: If a state approves forms, a state should add language to Subparagraphs (b) and (c) of this paragraph reflecting such approvals.

(5) Application of the best interest obligation. Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

B. Transactions not based on a recommendation.

(1) Except as provided under Paragraph (2), a producer shall have no obligation to a consumer under Subsection A(1) related to any annuity transaction if:

(a) No recommendation is made;

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.

(2) An insurer's issuance of an annuity subject to Paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

C. Supervision system.

(1) Except as permitted under Subsection B, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information.

(2) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with this regulation, including, but not limited to, the following:

(a) The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals;

(b) The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of Section 7 of this regulation;

(c) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its producers;

(d) The insurer shall establish and maintain procedures for the review of each recommendation prior to issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(e) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with Subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity;

(f) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(g) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(h) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time; and

Drafting Note: The intent of Subparagraph (h) is to prohibit sales contests, sales quotas, bonuses and non-cash compensation based on the sale of a particular product within a limited period of time, but not to prohibit general incentives regarding the sales of a company's products with no emphasis on any particular product.

(i) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(3) (a) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with Subparagraph (b) of this paragraph.

(b) An insurer's supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(4) An insurer is not required to include in its system of supervision:

(a) A producer's recommendations to consumers of products other than the annuities offered by the insurer; or

(b) Consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

D. Prohibited Practices. Neither a producer nor an insurer shall dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer's request for confirmation of the consumer profile information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

E. Safe harbor.

(1) Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection shall limit the insurance commissioner's ability to investigate and enforce the provisions of this regulation.

Drafting Note: Non-compliance with comparable standards means that the recommendation or sale is subject to compliance with the requirements of this regulation.

(2) Nothing in Paragraph (1) shall limit the insurer's obligation to comply with Section 6C(1) of this regulation, although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(3) For paragraph (1) to apply, an insurer shall:

(a) Monitor the relevant conduct of the financial professional seeking to rely on Paragraph (1) or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal [or state] securities laws using information collected in the normal course of an insurer's business; and

(b) Provide to the entity responsible for supervising the financial professional seeking to rely on Paragraph (1), such as the financial professional's broker-dealer or investment adviser registered under federal [or state] securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

(4) For purposes of this subsection, "financial professional" means a producer that is regulated and acting as:

(a) A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;

(b) An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or

(c) A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

Drafting Note: The requirement that a producer be "regulated and acting" as a broker-dealer, a registered representative of a broker-dealer, an investment adviser, an investment adviser representative or a plan fiduciary means that a producer who is not explicitly acting in compliance with the relevant comparable standards, as specified in Paragraph (4) below, is not eligible for this safe harbor and is subject to compliance with the requirements of this regulation.

(5) For purposes of this subsection, "comparable standards" means:

(a) With respect to broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest and any amendments or successor regulations thereto;

(b) With respect to investment advisers registered under federal [or state] securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 [or applicable state securities law], including but not limited to, the Form ADV and interpretations; and

Drafting Note: State-registered investment advisers in this safe harbor are included in brackets so that each individual state that implements this model regulation may determine whether to include the state-regulated investment advisers. Given the varying treatment of annuities, particularly variable annuities, under state law, the varying structures of state securities and insurance departments, and the varying levels of cooperation between the two agencies, this is a decision best made in each individual state.

(c) With respect to plan fiduciaries or fiduciaries, means the duties, obligations, prohibitions and all other requirements attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

Section 7. Producer Training

A. A producer shall not solicit the sale of an annuity product unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with the insurer's standards for product training. A producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

B. (1) (a) A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(b) Producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits but may be longer.

(3) The training required under this subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities;

(b) Identification of the parties to an annuity;

(c) How product specific annuity contract features affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Appropriate standard of conduct, sales practices, replacement and disclosure requirements.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this state and comply with the rules and guidelines applicable to producer continuing education courses as set forth in [insert reference to state law or regulations governing producer continuing education course approval].

(6) A producer who has completed an annuity training course approved by the department of insurance prior to [insert effective date of amended regulation] shall, within six (6) months after [insert effective date of amended regulation], complete either:

(a) A new four (4) credit training course approved by the department of insurance after [insert effective date of amended regulation]; or

(b) An additional one-time one (1) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices, replacement and disclosure requirements under this amended regulation.

(7) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with [insert reference to state law or regulations governing producer continuing education course approval].

(8) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to state law or regulations governing producer continuing education course approval].

(9) The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

(10) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

(11) An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Section 8. Compliance Mitigation; Penalties; Enforcement

A. An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this regulation by the insurer, an entity contracted to perform the insurer's supervisory duties or by the producer;

(2) A general agency, independent agency or the producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of this regulation; and

(3) Appropriate penalties and sanctions.

B. Any applicable penalty under [insert statutory citation] for a violation of this regulation may be reduced or eliminated [, according to a schedule adopted by the commissioner,] if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Drafting Note: Subsection B above is intended to be consistent with the commissioner's discretionary authority to determine the appropriate penalty for a violation of this regulation. The language of Subsection B is not intended to require that a commissioner impose a penalty on an insurer for a single violation of this regulation if the commissioner has determined that such a penalty is not appropriate.

Drafting Note: A state that has authority to adopt a schedule of penalties may wish to include the words in brackets. In that case, "shall" should be substituted for "may" in the same sentence. States should consider inserting a reference to the NAIC *Unfair Trade Practices Act* (#880) or the state's statute that authorizes the commissioner to impose penalties and fines.

C. The authority to enforce compliance with this regulation is vested exclusively with the commissioner.

Section 9. Recordkeeping

A. Insurers, general agents, independent agencies and producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for [insert number] years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws. For some states this time period may be five (5) years.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in states that have a comprehensive recordkeeping law or regulation.

Section 10. Effective Date

The amendments to this regulation shall take effect [X] months after the date the regulation is adopted or on [insert date], whichever is later.

Chronological Summary of Action (All references are to the Proceedings of the NAIC).

2003 Proc. 3rd Quarter 17-18, 24-27, 32, 213 (adopted).
2006 Proc. 2nd Quarter 40, 90 (amended).
2010 Proc. 1st Quarter Vol. I 105-106, 117, 129-139, 146-159, 313 (amended).
2015 Proc. 1st Quarter, Vol. I 117-118, 131-134, 326-335, 431 (amended).
2020 Proc. Spring (amended).

APPENDIX A

INSURANCE AGENT (PRODUCER) DISCLOSURE FOR ANNUITIES
Do Not Sign Unless You Have Read and Understand the Information in this Form

Date: _____

INSURANCE AGENT (PRODUCER) INFORMATION ("Me", "I", "My")

First Name: _____ Last Name: _____

Business\Agency Name: _____ Website: _____

Business Mailing Address:_____

Business Telephone Number: _____

Email Address:_____

National Producer Number in [state]:_____

CUSTOMER INFORMATION ("You", "Your")

First Name: _____Last Name: _____

What Types of Products Can I Sell You?
I am licensed to sell annuities to You in accordance with state law. If I recommend that You buy an annuity, it means I believe that it effectively meets Your financial situation, insurance needs, and financial objectives. Other financial products, such as life insurance or stocks, bonds and mutual funds, also may meet Your needs.

I offer the following products:

- ☐ Fixed or Fixed Indexed Annuities
- ☐ Variable Annuities
- ☐ Life Insurance

I need a separate license to provide advice about or to sell non-insurance financial products. I have checked below any non-insurance financial products that I am licensed and authorized to provide advice about or to sell.

- ☐ Mutual Funds
- ☐ Stocks/Bonds
- ☐ Certificates of Deposits

Whose Annuities Can I Sell to You?

I am authorized to sell:

☐ Annuities from Only One (1) Insurer	☐ Annuities from Two or More Insurers
☐ Annuities from Two or More Insurers although I primarily sell annuities from: _____	

How I'm Paid for My Work:

It's important for You to understand how I'm paid for my work. Depending on the particular annuity You purchase, I may be paid a commission or a fee. Commissions are generally paid to Me by the insurance company while fees are generally paid to Me by the consumer. If You have questions about how I'm paid, please ask Me.

Depending on the particular annuity You buy, I will or may be paid cash compensation as follows:

- ☐ Commission, which is usually paid by the insurance company or other sources. If other sources, describe: _____.
- ☐ Fees (such as a fixed amount, an hourly rate, or a percentage of your payment), which are usually paid directly by the customer.
- ☐ Other (Describe): _____.

If You have questions about the above compensation I will be paid for this transaction, please ask me.

I may also receive other indirect compensation resulting from this transaction (sometimes called "non-cash" compensation), such as health or retirement benefits, office rent and support, or other incentives from the insurance company or other sources.

Drafting Note*: This disclosure may be adapted to fit the particular business model of the producer. As an example, if the producer only receives commission or only receives a fee from the consumer, the disclosure may be refined to fit that particular situation. This form is intended to provide an example of how to communicate producer compensation, but compliance with the regulation may also be achieved with more precise disclosure, including a written consulting, advising or financial planning agreement.*

Drafting Note: *The acknowledgement and signature should be in immediate proximity to the disclosure language.*

By signing below, You acknowledge that You have read and understand the information provided to You in this document.

_____
Customer Signature

_____
Date

_____
Agent (Producer) Signature

_____
Date

APPENDIX B

CONSUMER REFUSAL TO PROVIDE INFORMATION

Do Not Sign Unless You Have Read and Understand the Information in this Form

Why are You being given this form?

You're buying a financial product – an annuity.

To recommend a product that effectively meets Your needs, objectives and situation, the agent, broker, or company needs information about You, Your financial situation, insurance needs and financial objectives.

If You sign this form, it means You have not given the agent, broker, or company some or all the information needed to decide if the annuity effectively meets Your needs, objectives and situation. You may lose protections under the Insurance Code of [this state] if You sign this form or provide inaccurate information.

Statement of Purchaser:

☐ I **REFUSE** to provide this information at this time.

☐ I have chosen to provide LIMITED information at this time.

_____

Customer Signature

_____

Date

APPENDIX C

Consumer Decision to Purchase an Annuity NOT Based on a Recommendation

Do Not Sign This Form Unless You Have Read and Understand It.

Why are You being given this form? You are buying a financial product – an annuity.

To recommend a product that effectively meets your needs, objectives and situation, the agent, broker, or company has the responsibility to learn about You, your financial situation, insurance needs and financial objectives.

If You sign this form, it means You know that you're buying an annuity that was not recommended.

Statement of Purchaser:

I understand that I am buying an annuity, but the agent, broker or company did not recommend that I buy it. If I buy it **without a recommendation,** I understand I may lose protections under the Insurance Code of [this state].

_____
Customer Signature

_____
Date

_____
Agent/Producer Signature

_____
Date

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. § 482-1-137 (2006/2021).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.770 to 26.789 (2014/2022).		BULLETIN 2008-4 (2008); BULLETIN 2009-7 (2009); BULLETIN 22-07 (2022).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1243.01 to 1243.07 (2006/2021).		BULLETIN 2020-05 (2020).
Arkansas	ARK. ADMIN. CODE §§ 054.01.82-1 to 054.00.82-10 (2004/2021).		DIRECTIVE 2-2006 (2006); BULLETIN 11-2009 (2009); BULLETIN 5-2010 (2010); BULLETIN 7-2021 (2021); BULLETIN 12-2022 (2022).
California		CAL. INS. CODE §§ 10509.910 to 10509.918 (1990/2016).	
Colorado	3 COLO. CODE REGS. § 702-4:4-1-11 (2011/2022).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-432A-1 to 38a-432A-8 (2005/2022).		LICENSING BULLETIN L-18 (2012).
Delaware	18 DEL. CODE REGS. § 1214 (2006/2021).		

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia		D.C. MUN. REGS. tit. 26A, §§ 8400 to 8499 (2010/2011).	
Florida	FLA. STAT. § 627.4554 (2004/2023).		FLA. ADMIN. CODE ANN. R. 69B-162.011 (2009/2014) (forms required).
Georgia	GA. COMP. R. & REGS. 120-2-94-.01 to 120-2-94-.10 (2006/2015).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:10D-621 to 431:10D-626 (2008/2023).		MEMORANDUM 2011-2 (LC) (2011).
Idaho	IDAHO CODE ANN. §§ 41-1940 to 41-1940 (H.B. 79) (2021).		BULLETIN 21-05 (2021).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 3120.10 to 3120.90 (2007/2011).		
Indiana		760 IND. ADMIN. CODE 1-72-1 to 1-72-6 (2006/2015).	IND. CODE §§ 27-4-9-1 to 27-4-9-6 (2005/2007) (limited to seniors); § 27-1-15.6-19.5 (2011).
Iowa	IOWA ADMIN. CODE r. 191-15.72 to 191.15.78 (2006/2020).		IOWA ADMIN. CODE r. 191-15.8 (1963/2009) (life and annuity sales guidelines); 191-33.3 (1984/1999) (variable life); BULLETIN 2007-5 (2007); BULLETIN 2009-4 (2009).
Kansas	KAN. ADMIN. REGS.40-1-53 (2005/2023).		
Kentucky	806 KY. ADMIN. REGS. 12:120 (2007/2021).		
Louisiana		LA. ADMIN. CODE tit. 37, Pt. XIII §§ 11701 to 11719 (Reg. No. 89) (2006/2019).	

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine	917 ME. CODE R. § 02-031 (2007/2021).		ME. REV. STAT. ANN. tit. 24-A, § 2517 (1969/2005) (authority to adopt regulation).
Maryland	MD. CODE REGS. §§ 31.09.12.01 to 31.09.12.13 (2007/2022).		BULLETIN 2011-28 (2011); BULLETIN 2022-11 (2022).
Massachusetts	211 MASS. CODE REGS. 96.01 to 96.10 (2016/2022).		
Michigan	MICH. COMP. LAWS ANN. §§ 500.4151 to 500.4165 (2021).		
Minnesota	MINN. STAT. ANN. §§ 72A.20 to 72A.2036 (2012/2022).	MINN. STAT. ANN. §§ 60K.46 to 60K.56 (2012/2017).	MINN. STAT. ANN. § 61A.021 (1985) (tying prohibited).
Mississippi	19 MISS. ADMIN. CODE. R. Pt. 2, §§ 18.01 to 18.11 (2021).		BULLETIN 2014-7 (2014).
Missouri		MO. CODE REGS. ANN. tit. 20, § 400-5.900 (2017).	MO. REV. STAT. § 376.671 (2010); MO. CODE REGS. ANN. tit. 20, § 400-1.020 (1984/2002); § 700-1.146 (2005/2016).
Montana	MONT. CODE ANN. §§ 33-20-802 to 33-20-807 (2007/2021).		MONT. CODE ANN. § 33-20-141 (2018).
Nebraska	NEB. REV. STAT. §§ 44-8101 to 44-8109 (2006/2021).		BULLETIN CB-128 (2012).
Nevada		NEV. ADMIN. CODE §§ 688A.400 to 688A.475 (2005).	BULLETIN 2006-004 (2006).
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. 305.01 to 305.08 (2009/2014).	BULLETIN 14-036-AB (2014) (training requirement).

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey			N.J. ADMIN. CODE §§ 11:4-59A.1 to 11:4-59A.6 (2013) (previous version of model); N.J. STAT. ANN. § 17B:25-20 (1981/2005) (limits maturity dates and surrender charges for annuities sold to seniors); §§ 17B:25-34 to 17B:25-42 (2008); BULLETIN 2009-12 (2009).
New Mexico	N.M. ADMIN. CODE 13.9.20.1 to 13.9.20.12 (2022).		
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 224.0 to 224.9 (2011/2018).	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 225.0 to 225.3 (2013) (senior-specific certifications).
North Carolina	11 N.C. ADMIN. CODE 12.0462 (2022).	N. C. GEN. STAT. §§ 58-60-150 to 58-60-180 (2007/2009).	11 N.C. ADMIN. CODE 12.0420 (1976/1992) (submit suitability form).
North Dakota	N.D. CENT. CODE §§ 26.1-34.2-01 to 26.1-34.2-05 (2007/2022).		N.D. ADMIN. CODE §§ 45-02-02-14 (1984/2001) (recommendations to consumers over age 65); § 45-04-04-07 (1984).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-6-13 (2021).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:25-17-1 to 365:25-17-9 (2005/2007).		BULLETIN 1-12-2012 (2012) (training requirement).
Oregon	OR. REV. STAT. §§ 743.244 to 743.273 (2023).	OR. ADMIN. R. 836-080-0170 to 836-080-0193 (2011).	
Pennsylvania	40 PA. STAT. ANN. §§ 627-1 to 627-8 (2010/2022).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-25-1.1 to 20-25-1.11 (2011/2022).		BULLETIN 2011-2 (2011) (training requirement); BULLETIN 2021-1 (2021); BULLETIN 2021-2 (2021).

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. REGS. 69-29 (2022).		
South Dakota	S.D. CODIFIED LAWS. §§ 58-33A-13 to 58-33A-27 (2008/2022).		S.D. ADMIN. R. § 58-28-33 (2003); BULLETIN 2008-5 (2008).
Tennessee	TENN. COMP. R. & REGS. §§ 0780-01-86-.01 to 0780-1-86-.09 (2008/2015).		BULLETIN 5-22-2013 (2013).
Texas	TEX. INS. CODE ANN. §§ 1115.001 to 1115.102 (2007/2021).		
Utah	UTAH ADMIN. CODE R 590-230 (2004/2023).		
Vermont	VT. REG. I-2023-01 (2024) (effective 7/5/24).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-45-10 to 5-45-50 (2021).		ADMIN. LETTER 2017-1 (2017).
Washington	WASH. REV. CODE § 48.23.015 (2009/2023).	WASH. ADMIN. CODE § 284-17-265 (2012); § 284-23-390 (2012);	
West Virginia	W. VA. CODE R. §§ 114-11B-1 to 114-11B-8 (2008/2011).		
Wisconsin	WIS. STAT. § 628.347 (2004/2022).		INS. BULLETIN dated June 29, 2022 (2022).
Wyoming	WYO. ADMIN. CODE 044.0002.64 §§ 1 to 9 (2014/2023).		

PROJECT HISTORY - 2020

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)

1. Description of the Project, Issues Addressed, etc.

In 2017, the Life Insurance and Annuities (A) Committee established the Annuity Suitability (A) Working Group and charged the Working Group to review and revise, as necessary, the *Suitability in Annuity Transactions Model Regulation* (#275) and as part of that charge, consider how to promote greater uniformity across NAIC-member jurisdictions. The Committee adopted the charge and established the Working Group, in part, in response to the U.S. Department of Labor's (DOL) fiduciary rule, which was finalized in April 2016 but vacated in its entirety in March 2018. The DOL fiduciary rule would have expanded the scope of who is considered a fiduciary to federal Employee Retirement Income Security Act of 1974 (ERISA) retirement plans and individual retirement accounts (IRAs) to include a broader set of insurance agents, insurance brokers and insurers. Separately, the U.S. Securities and Exchange Commission (SEC) released a proposed rule package in May 2018, which included Regulation Best Interest (Reg BI). The SEC finalized Reg BI in June 2019. The final Reg BI establishes a best interest standard of conduct for broker-dealers beyond the existing suitability obligation. The new standard of conduct requires a broker-dealer when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer to act in the best interest of the retail customer at the time a recommendation is made without placing the financial or other interest of the broker-dealer or associated persons ahead of the interest of the retail customers.

While acknowledging the SEC's and the DOL's role in the regulatory landscape and believing that consumers are better protected when, to the extent possible, there is harmonization of the regulations enforced by the states, the SEC and the DOL, the Working Group continued its work to draft revisions to Model #275 to establish a framework for an enhanced standard of conduct that is more than the model's current suitability standard but not a fiduciary standard.

In 2018, the Working Group held two two-day interim meetings—one in June in Kansas City, MO, and one in October in Chicago—to discuss drafts of proposed revisions to Model #275. Additionally, the Working Group held several conference calls and additional in-person meetings at each national meeting.

After the SEC finalized its Reg BI in June 2019, as directed by the Life Insurance and Annuities (A) Committee at the 2019 Spring National Meeting, the Working Group met soon after in mid-June during an in-person interim meeting in Columbus, OH, to level set and work toward its goal of fleshing out the meaning of "best interest" and incorporating a best interest standard of conduct into the Model #275 revisions. During its June meeting, the Working Group discussed and agreed on a framework for the model revisions to include a best interest standard and a path forward for completing its work as soon as possible.

Based on this framework, the Working Group developed a draft of proposed model revisions including a best interest standard of care a producer or insurer can meet if the producer or insurer satisfies the four obligations under this standard of care: 1) the care obligation; 2) disclosure obligation; 3) material conflict of interest obligation; and 4) documentation obligation. The Working Group exposed the draft for public comment until Sept. 30, 2019.

The Working Group met Oct. 8, Oct. 15, Oct. 29 and Nov. 5, 2019, via conference call to discuss the comments received. The Working Group received comments from many stakeholders, including industry, consumers and producers. More than 100 interested parties and state insurance regulators participated in each of the conference calls. The Working Group adopted the proposed revisions to Model #275 on Nov. 5, 2019, via conference call. The Working Group agreed that it had completed its work as directed by the Life Insurance and Annuities (A) Committee during the 2019 Spring National Meeting and forwarded the draft to the Committee for its consideration. The Committee chair exposed the draft for a public comment period ending Nov. 26, 2019. At the 2019 Fall National Meeting, the Committee discussed the comments received and made some revisions to the Working Group's draft of proposed revisions to Model #275. During this meeting, the Committee provided preliminary approval to the proposed Model #275 revisions. The Committee also directed the Working Group to discuss the comments received on the proposed appendices during a meeting following the 2019 Fall National Meeting. The Working Group met Dec. 19, 2019, via conference call to discuss the Nov. 26, 2019, comments received on the proposed appendices. During this meeting, the Working Group revised the appendices and forwarded its work to the Committee for its consideration. The Committee met Dec. 30, 2019, via conference call to consider adoption of the proposed revisions to Model #275. The Committee adopted the proposed revisions to Model #275 by a vote of 11 to 1.

The proposed revisions establish a best interest standard of conduct for producers and insurers. This new standard of conduct is more than the model's current suitability standard, but it is not a fiduciary standard. Under this new standard of conduct, when making a recommendation of an annuity, a producer or insurer shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest

ahead of the consumer's financial interest. To satisfy this best interest obligation, a producer or an insurer must satisfy the four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation. The proposed revisions also revise the model's current insurer supervision requirements, including a new supervision requirement for the insurer to establish and maintain reasonable procedures to identify and eliminate certain sales incentives that are based on sales of specific annuities within a limited period of time. The proposed revisions also expand the model's current safe harbor provisions to apply the safe harbor to any financial professional in compliance with business rules, controls and procedures that satisfy a comparable standard, such as Reg BI, to the model's new standard of conduct. The proposed revisions define a financial professional to include a producer that is regulated and acting as: 1) a broker-dealer; 2) an investment adviser; or 3) a plan fiduciary. The proposed revisions also include new appendices to provide guidance to producers and insurers in satisfying the new disclosure and documentation obligations.

2. Name of Group Responsible for Drafting the Model and States Participating

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee drafted the proposed revisions to Model #275. The members of the Working Group were: Alabama, California, Delaware, Idaho, Iowa, Kansas, Nebraska, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, Tennessee and Wisconsin. Idaho chaired the Working Group in 2017 and 2018, and Ohio chaired the Working Group in 2019. The Life Insurance and Annuities (A) Committee also discussed and drafted proposed revisions to Model #275 after the Working Group completed its work. The members of the Committee were: Alabama, Arizona, Delaware, District of Columbia, Idaho, Iowa, Louisiana, Nebraska, Nevada, New York, North Dakota, Ohio, Puerto Rico, Tennessee and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Life Insurance and Annuities (A) Committee established the Annuity Suitability (A) Working Group in 2017 to carry out the charge below:

"Review and revise, as necessary, the *Suitability in Annuity Transactions Model Regulation* (#275) and consider how to promote greater uniformity across NAIC-member jurisdictions."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2017 and ending in December 2019, the Working Group reviewed and discussed all of the comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and producer representatives. Each draft of proposed revisions was posted to the Working Group's web page and the Committee's web page on the NAIC website. All comment letters received also were posted. The Working Group held open in-person interim meetings and met via conference call during the drafting process. The Working Group also met in person at each NAIC national meeting.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2017 and ending in December 2019, the Working Group reviewed and discussed all of the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and producer representatives. Each draft of proposed revisions was posted to the Working Group's web page and the Committee's web page on the NAIC website. All comment letters received also were posted. The Working Group held open in-person interim meetings and met via conference call during the drafting process. The Working Group also met in person at each NAIC national meeting.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

Several significant issues were raised throughout the drafting process. Those issues included: 1) expanding Model #275 to include investment-type life insurance products; 2) specifically applying the proposed revisions to in-force annuity products; 3) applying the proposed revisions to producers who may not have direct contact with the consumer, but participated in a material way to developing and making the recommendation purchase an annuity; and 4) including the drafting note stating that the proposed model revisions are a successor to the 2010 model revisions.

With respect to expanding Model #275 to include investment-type life insurance products, the Working Group discussed this issue during one of its first in-person interim meetings. The Working Group decided that given its charge to "review and revise, as necessary, the *Suitability in Annuity Transactions Model Regulation* (#275) and consider how to promote greater uniformity across NAIC-member jurisdictions," expanding Model #275 to include investment-type life insurance products was beyond the scope of its charge. The Working Group concluded that the Life Insurance and Annuities (A) Committee was the appropriate forum for raising and considering this issue.

Another significant issue discussed was whether the model revisions should specifically apply to in-force annuity contracts. The Working Group discussed this issue extensively during multiple meetings. It decided ultimately not to include language in the proposed revisions specifically applying to in-force annuity contracts. However, during these discussions, it was suggested that in certain situations, in making a recommendation, a producer or insurer would have to and would be expected to consider a consumer's existing insurance products, including annuities, to determine whether the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives as part of satisfying the best interest standard of conduct.

The Working Group also extensively discussed whether the model revisions should apply to producers not having direct contact with a consumer, but exercised material control or influence in the making of the recommendation. The Working Group decided to add language applying the model revisions to such producers under certain circumstances. Specifically, in Section 6A(5), the model revisions provide that any requirement applicable to a producer under Section 6—Duties of Insurers and Producers applies to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale regardless of whether the producer has had any direct contact with the consumer.

Another issue the Working Group discussed was whether the revised model establishing the new best interest standard of conduct would be considered for purposes of Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act) a successor to the 2010 model revisions, which established the suitability standard of conduct. The proposed revisions include a drafting note in Section 1—Purpose expressly stating the proposed revisions are a successor to the 2010 model revisions. The Working Group deferred the issue to the NAIC Legal Division for additional research. The NAIC Legal Division did not expressly provide an opinion, but initial research found that with or without the Section 1 drafting note, the revised model most likely would be considered a successor to the 2010 model. The Working Group determined that this was a policy issue for the Committee, the Executive (EX) Committee and Plenary to decide. The model revisions, as adopted by the Committee, retain the proposed drafting note.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2015

SUITABILTY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)

1. Description of the Project, Issues Addressed, etc.

The *Suitability in Annuity Transactions Model Regulation* (#275) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Deleting references to variable and fixed and leaving the broader reference to "annuities" in Section 6H, which states that sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation.

- Adding to Section 7. Producer Training the clarification that training include how **product-specific** annuity contract features affect consumers.

2. Name of Group Responsible for Drafting the Model and States Participating

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Ted Nickel, Chair	Wisconsin	Roger A. Sevigny/Keith Nyhan	New Hampshire
Robert Chester	Connecticut	Joseph Torti III/Elizabeth Dwyer	Rhode Island
Jim Mumford	Iowa	Michael Humphreys	Tennessee
Jason Lapham	Kansas	Tomasz Serbinowski	Utah
Bruce R. Ramge	Nebraska		

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

There were concerns that using the term "CDAs" when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

PROJECT HISTORY - 2010

SUITABILTY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) make three core changes to the existing model: 1) clarify that the insurer is responsible for compliance with the model's requirements even if the insurer contracts out to a third party to perform those requirements; 2) require the review of all recommended annuity transactions in a manner the carrier considers appropriate to ensure compliance with this requirement to better protect consumers from unsuitable sales and abusive sales and marketing practices; and 3) establish general training and specific-product training for insurance producers to ensure the producer knows what he or she is selling.

2. Name of Group Responsible for Drafting the Model and States Participating

The Suitability of Annuity Sales (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Wisconsin, Chair	Missouri
Alabama	New Hampshire
Alaska	New Jersey
California	New York
Colorado	Ohio
Connecticut	Oregon
Florida	Tennessee
Iowa	Texas
Kansas	Utah
Minnesota	Vermont

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2008 by the following charge: review and consider changes to the *Suitability in Annuity Transactions Model Regulation* (#275) to improve the regulation of annuity sales and to provide insurers uniform guidance in developing agent training, supervision and monitoring standards in order to better protect annuity consumers from unsuitable sales and abusive sales and marketing practices. The Executive (EX) Committee approved the model law request for revising the *Suitability of Annuity Transactions Model Regulation* (#275) at the 2008 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC Web site. The Working Group adopted a draft of proposed revisions on Dec. 1, 2009, which was then forwarded to the Committee for its consideration at the 2009 Winter National Meeting. At that meeting, the Committee decided to reopen the draft for additional comments. After reviewing and considering these additional comments, the Committee unanimously adopted a revised draft on Dec. 21, 2009.

All drafts were distributed to over 200 interested parties and posted on the NAIC Web site. Numerous interested parties participated, including industry representatives, such as the American Council of Life Insurers (ACLI), the National Association for Fixed Annuities (NAFA), and the Insured Retirement Institute (IRI); life insurance companies, such as MetLife, Prudential, MassMutual and Nationwide; insurance producer representatives, such as the National Association for Insurance and Financial Advisors (NAIFA); consumer representatives, such the Center for Economic Justice (CEJ) and the Western Minnesota Legal Services; and others, such as the National Association of Independent Life Brokerage Agencies (NAILBA) and the Insurance Marketplace Standards Association (IMSA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

After the Committee established the Working Group in March 2008, the Working Group met at each NAIC quarterly meeting in 2008 and at the NAIC 2009 Spring, Summer and Fall National Meetings. The Working Group also held five conference calls. Comments were requested and received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC Web site. The comments were also posted on the NAIC Web site.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

There were a number of significant issues or items of controversy raised during the drafting process. These issues or items of controversy generally concerned the extent to which the revisions, given the different distribution channels insurers use to sell annuity products, should delineate the specific supervisory responsibilities and ultimate responsibility of insurers for ensuring suitable annuity sales even if they contract with a third party for the performance of their responsibilities under the model. In addition, an issue was raised concerning the necessity of revising the model regulation to address these issues rather than through the development of interpretative guidelines or a model bulletin. Some interested parties argued that because a large number of states have adopted the model, with many having done so in recent years, the model should not be revised and urged the Working Group to develop interpretative guidelines or a model bulletin that states could uniformly adopt. Some Working Group members argued that interpretative guidelines and model bulletins have no force of law and, as such, the model should be revised. After extensive discussions of this issue during several conference calls and several meetings, the Working Group voted to revise the model and focus on developing such revisions. Another issue arose concerning the type and scope of training that should be required of insurance producers. Most interested parties conceded that insurance producers should know what they are selling and that some form of training would be appropriate to ensure insurance producers selling annuity products know what they are selling. However, the manner in which such training should be provided was somewhat controversial. After discussion of this issue during several conference calls and at several meetings, the Working Group decided to include a section in the revised model requiring producer training that tracks Iowa's training requirements for indexed annuities and other states' training requirements for long-term care insurance partnership policies.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2006

SENIOR PROTECTION IN ANNUITY TRANSACTIONS
MODEL REGULATION (#275)

1. Description of the project, issues addressed, etc.

This model regulation was amended to expand its suitability protections to consumers of all ages, not just those over the age of 65.

2. Name of group responsible for draft the model:

Life Insurance and Annuities (A) Committee

States Participating:

North Dakota, Chair	Kansas
Kentucky, Vice Chair	Nebraska
Alabama	New Mexico
Arkansas	New York
California	Ohio
Florida	Pennsylvania
Iowa	

3. Project authorized by what charge and date first given to the group:

The following charge was given in 2006:

Review and consider changes to the Senior Protection in Annuity Transactions Model Regulation to address the suitability issue with regard to all annuity transactions.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the Committee. Numerous interested parties participated, including industry representatives, such as the American Council of Life Insurers (ACLI), The Financial Planning Association (FPA); and the National Association of Independent Life Brokerage Agencies (NAILBA); and funded consumer representatives, such as the Center For Economic Justice, University of Georgia and The University of Texas at Austin.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There was one draft of the proposed revisions. The draft was circulated for comment to interested parties. In addition, the draft was posted on the NAIC website. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the Committee.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

No significant issues arose during the drafting process.

7. Any other important information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2003

SENIOR PROTECTION IN ANNUITY TRANSACTIONS
MODEL REGULATION (#275)

1. Description of the Project, Issues Addressed, etc.

In 2000, the NAIC adopted a white paper recommending the establishment of suitability standards for life insurance and annuities. Shortly thereafter a working group was appointed by the Life Insurance and Annuities (A) Committee to draft standards. The purpose of the model act and regulation developed by that working group was to regulate the activities of insurers and producers that make recommendations to consumers to purchase certain life insurance and annuity products to ensure that insurers and producers will make suitable recommendations based on relevant information obtained from the persons who purchase life insurance and annuity products.

2. Group Responsible for Drafting the Model and States Participating

The model act and regulation that resulted from the charge were drafted by the Suitability Working Group, which was chaired by Iowa, and included representatives from Louisiana (vice-chair), Illinois, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, and Vermont. The draft targeted to sales of annuities to seniors was developed by the A Committee, chaired by Utah, with the following states as members: Iowa, Alabama, California, District of Columbia, Florida, Kentucky, Louisiana, New Mexico, North Dakota, Ohio, Oklahoma and South Carolina.

3. Project Authorized by what Charge and Date First Given to the Group

The Life Insurance and Annuities (A) Committee was given a charge to draft a model in 2001. The charge was to draft of a model law and/or regulation regarding suitability of sales of life insurance and annuities. The Suitability Working Group that had drafted the white paper was asked to continue in service and draft the model.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

A model act and regulation were adopted by the working group and forwarded to the A Committee. That Committee did not support adoption of the model as it existed and further amendments were made at the A Committee. Because of the lack of support for a wide-reaching suitability standard, since none had existed before in most states, the Committee recommended a narrow model that addressed the area of most concern to regulators: the sale of annuities to seniors. The A Committee produced a new model in early 2003 and held open meetings and conference calls to solicit comments. The American Council of Life Insurers (ACLI), individual life insurance companies, consumer groups, the Financial Planning Association, the National Association of Insurance and Financial Advisors, The National Association of Securities Dealers (NASD), and others participated. The process resulted in this new model that was adopted at a conference call on July 21, 2003. The Executive Committee took up the model at a Sept. 3, 2003 conference call in response to a comment letter from the ACLI suggesting further amendments. The Executive Committee voted to add technical changes suggested by the ACLI to the draft.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The drafting process was open and the working group received comments from interested parties representing life insurance companies, consumer groups and producer groups, as well as from securities regulators. When the A Committee took on the drafting project, a hearing was held, comments solicited and an open meeting in Salt Lake City and several conference calls were held to discuss all concerns that were raised. Interested parties also submitted numerous drafting suggestions.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There were many controversial items raised during the extensive drafting effort. The working group discussed whether to use the Unfair Trade Practices Act as authority for development of a regulation. Interested parties urged the working group to develop language specific to suitability of sales. This discussion also extended to whether to require a pattern of conduct, as in the Unfair Trade Practices Act, or whether a single violation was sufficient to invoke penalties. After a brief discussion on

whether the Act might create a private cause of action, the working group adopted the position that had been taken during development of the Unfair Trade Practices Act and included specific language stating that this Act should not be construed to create a private cause of action. The working group noted that some states might already have the authority to adopt the regulation.

One of the most controversial issues was balancing the responsibilities of the insurers and the producers. The working group was convinced that the proper balance was to require responsibility for both. The working group draft required the insurer to have standards for suitable recommendations in place and a system designed to make sure that producers know and follow those standards. The producer had a responsibility to follow the standards set by the insurer. One significant addition to the draft made by the A Committee was to add standards for mitigation of penalties if the producer and insurer work to right any wrongs done to a consumer.

Determining what standards to use was also the topic of extensive discussion. Insurers requested more specific guidance on how their standards should look so that they were reasonably assured that they were adequate. Regulators discussed using membership in an organization such as the Insurance Marketplace Standards Association as a standard, but rejected that approach. They also considered using the NASD standards. The draft adopted by the working group contained some of those concepts to assist insurers that already had extensive suitability standards for their variable life producers, so that they would not have to maintain two parallel structures. The approach taken by the A Committee follows the NASD standards much more closely.

Extensive discussion took place on whether the model should cover all recommendations or just recommendations that result in a sale. Ultimately the drafters settled on a focus on recommendations that result in sales. They expressed concern that all recommendations be suitable but recognized the record-keeping burden that would be imposed by extending the model to cover all recommendations.

Once the model was narrowed to apply only to sales of annuities to seniors, many of the issues that previously had been controversial no longer applied, such as many of the exemptions included in the earlier draft. However one new issue was whether the rules should apply to all transactions involving an annuity, or just a transaction where an annuity was being purchased. The language settled on refers to a purchase or exchange of an annuity.

The life insurance industry raised concerns about the various distribution systems when variable products were included. They expressed concern that some of the standards would not work as well when an independent broker/dealer was involved. Modifications to the draft were made to address the different distribution systems.

7. Any other important information (e.g., amending an accreditation standard).

None.

MODEL REGULATION ON THE USE OF SENIOR SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

Table of Contents

Section 1. Purpose

The purpose of this regulation is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

Section 2. Scope

This regulation shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by an insurance producer.

Section 3. Authority

A. This regulation is issued under the authority of [insert reference to enabling legislation].

Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.

B. Nothing in this regulation shall limit the commissioner's authority to enforce existing provisions of law.

Drafting Note: States should use the appropriate designation for the chief insurance regulatory official as a substitute for the word "commissioner" above.

Section 4. Definition

For purposes of this regulation, "insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance, including annuities.

Section 5. Prohibited Uses of Senior-Specific Certifications and Professional Designations

A. (1) It is an unfair and deceptive act or practice in the business of insurance within the meaning of [insert the reference to State unfair trade practices act] for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

(2) The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(a) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(b) Use of a nonexistent or self-conferred certification or professional designation;

(c) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the insurance producer using the certification or designation does not have; and

(d) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

(i) Is primarily engaged in the business of instruction in sales or marketing;

(ii) Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;

(iii) Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

(iv) Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

B. There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for purposes of subsection A(2)(d) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the organization or the certification or designation in question has been accredited by:

(1) The American National Standards Institute (ANSI);

(2) The National Commission for Certifying Agencies; or

(3) Any organization that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

C. In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

(1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "advisor," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

D. (1) For purposes of this regulation, a job title within an organization that is licensed or registered by a State or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

(a) Indicates seniority or standing within the organization; or

(b) Specifies an individual's area of specialization within the organization.

(2) For purposes of this subsection, financial services regulatory agency includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

Section 6. Effective Date

This regulation shall become effective [insert effective date of the regulation].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2008 Proc. 3rd Quarter 3-17 to 3-21, 6-9 to 6-11, 6-12 to 6-14, 6-17 to 6-19 (adopted).

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 830-X-3-.28 (2008) (portions of model).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.820 to 26.825 (2009).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			REGULATORY BULLETIN 2008-07 (11/24/08).
Arkansas	054.00.096 ARK. CODE R. §§ 1 to 6 (2009).		
California			CAL. INS. CODE § 787.1 (2008/2011).
Colorado	3 COLO. CODE REGS. § 702-1:1-2-18 (2009).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-432b-1 to 38a-432b-4 (2010).		CONN. GEN. STAT. § 36b-4 (2009).
Delaware	6 DEL. ADMIN. CODE. § 800 (2009/2015).		
District of Columbia	D.C. MUN. REGS. tit. 26A, §§ 5800.1 to 5899 (2010).		

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69W-600.0133 (2009/2014).		
Georgia			GA. COMP. R. & REGS. 590-4-5-.16(3) (2011).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. ANN. § 431:10D-642 (2011).		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 14, § 130.855 (2009).		
Indiana	760 IND. ADMIN. CODE 1-79-1 to 1-79-4 (2012).		
Iowa	IOWA ADMIN. CODE r. 191-10.19 (2008).		
Kansas	KAN. ADMIN. REGS. § 40-9-23 (2010).		
Kentucky	806 KY. ADMIN. REGS. 9:020 (2011); 808 KY. ADMIN. REGS. 10:042 (2009).		
Louisiana			LA. REV. STAT. ANN. § 51:738 (2016).
Maine	02-032 ME. CODE R. ch. 512, §§ 1to 2 (2008).		
Maryland	MD. CODE REGS. 02.02.01.09 (2009/2011) (portions of model).		MD. CODE ANN. INS., INS. § 27-223 (2010); MD. CODE ANN., CORP. & ASSNS. § 11-305 (2009).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. ADMIN. CODE R 451.4.28 (2019).		
Minnesota	MINN. STAT. § 72A.204 (2009).		

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 700-1.140(6) (1991/2008).		
Montana	MONT. ADMIN. R. 6.10.601 to 6.10.607 (2008).		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NEV. ADMIN. CODE §§ 686A.501 to 686.A.503 (2010).		
New Hampshire	N.H. CODE ADMIN. R. INS. 311.01 to 311.04 (2010/2017).		
New Jersey	N.J. STAT. ANN. § 49:3-52.2 (2010).		
New Mexico	N.M. CODE R. §§ 12.11.17.1 to 12.11.17.12 (2010).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 225.0 to 225.3 (Regulation No. 199) (2011/2013).		
North Carolina	N.C. GEN. STAT. § 58-63-75 (2009); 11 N.C. ADMIN. CODE 12.0461 (2010).		
North Dakota			BULLETIN 2008-2 (2008).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-5-11 (2009).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:25-21-1 to 365:25-21-6 (2009/2019).		
Oregon	OR. ADMIN. R. 836-080-0160 (2009).		Memorandum 9-15-2009 (2009).
Pennsylvania	10 PA. CODE § 305.020 (2018).		Notice 5-14-2011 (2011).

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. §§ 20-25-13.1 to 20-25-13.6 (2009).		
South Carolina	S.C. CODE ANN. REGS. 69-40.1 (2010).		
South Dakota	S.D. ADMIN. R. 20:08:03:07.01 (2010).		
Tennessee	TENN. COMP. R. & REGS. 0780-01-94-.01 to 0780-01-94-.05 (2016).		
Texas	TEX. INS. CODE ANN. § 1117 (2009).		
Utah	UTAH ADMIN. CODE r. R590-252-1 to R590-252-8 (2009).		
Vermont	VT. CODE R. §§ 4-4-6:1 to 4-4-6:6 (2011).		VT. STAT. ANN. tit. 8, § 24 (2010/2017).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-43-10 to 5-43-30 (2009).		
Washington	WASH. ADMIN. CODE 460-25A-010 to 460-25A-060 (2008).		
West Virginia	W. VA. CODE R. §§ 114-89-1 to 114-89-2 (2010).		
Wisconsin	WIS. ADMIN. CODE INS. DFI-SEC. §§ 10.01 to 10.02 (2008/2009); § 6.90 (2009/2010).		
Wyoming	WYO. CODE R. 044.0002.33 § 3 (2018).		

PROJECT HISTORY - 2008

MODEL REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES (#278)

1. Description of the project, issues addressed, etc.

Recently, states have become aware of an ever-growing issue and possible fraudulent marketing and sales activity related to the use of senior-specific certifications and professional designations in the sale of life insurance and annuities to seniors. Individuals often boast designations and credentials using terms such as "certified", "accredited", "retirement planner", "senior advisor" or "senior consultant" to convince people they have special expertise to help seniors choose investment strategies. This may not be true in some cases. This model regulation establishes standards for the use of senior-specific certifications and professional designations by insurance producers in the sale of life insurance and annuities to all consumers regardless of age.

2. Name of group responsible for draft the model and states participating:

Life Insurance and Annuities (A) Committee

States Participating during the drafting process:

New York, Chair
Alabama
California
Connecticut
District of Columbia
Florida
Iowa
Minnesota
Missouri
Nebraska
Tennessee
Utah
Wisconsin

3. Project authorized by what charge and date first given to the group:

The following charge was given in 2008:

Consider the development of a new model regulation on the use of senior-specific certifications and professional designations in connection with an offer, sale or purchase of life insurance or an annuity to seniors or the provision of advice to seniors in connection with an offer, sale or purchase of life insurance or annuity; and in developing the model regulation, the Committee may consult with the market regulation committee, as it considers appropriate.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Committee reviewed and discussed each draft and the comments submitted on each draft. Each draft was distributed to over 150 interested parties and posted on the NAIC Web site. Interested parties that commented on the drafts included industry groups such as the American Council of Life Insurers (ACLI) and the National Association of Insurance and Financial Advisors (NAIFA); the American College; the North American Securities Administrators Association (NASAA); and consumer groups, such as the Center for Economic Justice (CEJ) and AARP.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

The Committee reviewed and discussed an initial draft of the proposed model during the 2008 Summer National Meeting. The Committee discussed subsequent drafts during conference calls on June 25, 2008 and July 15, 2008. Prior to each conference call, a draft of the proposed model was circulated to interested parties for comment and posted on the NAIC Web site. All written comments received were discussed by the Committee. Interested parties were given the opportunity to comment during each conference call as well.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

One issue that arose during the drafting process concerned the scope of the proposed model—whether it should apply to all consumers or limited to seniors. The Committee decided that it was appropriate to protect consumers regardless of age. A similar issue arose as to whether the proposed model should be more broadly drafted to apply to all certifications and professional designations and not limited to senior-specific certifications and professional designations. After discussion, the Committee decided that the current problems in the market involved senior-specific certifications and professional designations. As such, the model should be narrowly drafted to apply to these types of certifications and professional designations.

Another issue arose concerning a provision in the proposed model that would carve out certain academic degrees and job titles from falling within its scope. Questions were also raised about whether academic degrees needed to be included. After discussion, the Committee decided to retain the provision with two changes. First, the Committee decided to delete the references to academic degrees. Second, the Committee decided to add language qualifying this carve out such that it would not apply to job titles that are used in a manner that would confuse or mislead a reasonable consumer.

Finally, an issue arose as to whether the proposed model should apply to insurers. After discussion, the Committee agreed to remove insurers from the scope of the proposed model. The Committee decided that insurance regulators have other regulatory tools to prevent insurers from engaging in the marketing practices targeted in the proposed model. As such, their inclusion in the proposed model was not necessary.

7. Any other important information (e.g., amending an accreditation standard).

None.

INVESTMENTS OF INSURERS MODEL ACT
(Defined Limits Version)

ARTICLE I. GENERAL PROVISIONS

ARTICLE II. LIFE AND HEALTH INSURERS

ARTICLE III. PROPERTY AND CASUALTY, FINANCIAL GUARANTY AND MORTGAGE GUARANTY INSURERS

Statement of Principles

The development of regulation of the investments of insurers requires an analysis of the complexities, uncertainties, competitive forces and frequent changes in the investment markets and in the insurance business, the diversity among insurers, and the need for a balance among risk, reward and liquidity of an insurer's investments. It also requires an analysis of how to safeguard the financial condition of domestic insurers and at the same time to permit domestic insurers to be competitive with insurer's domiciled in other states and with other financial industries that operate under different regulatory regimes.

Each state is urged to determine through independent study which methods are best suited to its needs and whether its existing regulatory structure may be improved by using provisions of model laws recommended by the National Association of Insurance Commissioners (NAIC) or existing regulatory structures in other states or industries.

This model law is not considered by the NAIC to exhaust regulatory methods to address the regulation of investments of insurers. Nor is this model law recommended by the NAIC to be used as a standard for the examination of insurers unless substantially similar provisions are found in the statutes and regulations of the state of domicile of the insurer.

ARTICLE I. GENERAL PROVISIONS

Section 1. Purpose and Scope

A. Purpose

The purpose of this Act is to protect the interests of insureds by promoting insurer solvency and financial strength. This will be accomplished through the application of investment standards that facilitate a reasonable balance of the following objectives:

(1) To preserve principal;

(2) To assure reasonable diversification as to type of investment, issuer and credit quality; and

(3) To allow insurers to allocate investments in a manner consistent with principles of prudent investment management to achieve an adequate return so that obligations to insureds are adequately met and financial strength is sufficient to cover reasonably foreseeable contingencies.

B. Scope

This Act shall apply only to investments and investment practices of domestic insurers and United States branches of alien insurers entered through this state. This Act shall not apply to separate accounts of an insurer except to the extent that the provisions of [see Drafting Note 2] so provide.

Drafting Note: This Act does not define the types of insurers subject to its provisions, leaving this to other sections of the code since state laws treat insurers writing various lines of insurance differently. For example, if an entity is authorized to operate as a health maintenance organization, the state may provide additional investment authority commensurate to operating as a health maintenance organization.

Drafting Note: Insert a cross-reference to the section of the code governing separate accounts that states when the provisions of this Act are applicable to investments in separate accounts, either aggregated with an insurer's general account investments or treated as if the assets in each separate account were all of an insurer's admitted assets. Except to the extent specifically provided in that section, this Act has no application to the investments of separate accounts. If the code does not so provide, then Section 1B must be amended to provide that this Act does not apply to separate accounts.

Section 2. Definitions

For purposes of this Act:

A. "Acceptable collateral" means:

(1) As to securities lending transactions, and for the purpose of calculating counterparty exposure amount, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation, and as to lending foreign securities, sovereign debt rated 1 by the SVO;

(2) As to reverse repurchase transactions, cash, cash equivalents and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation; and

(3) As to repurchase transactions, cash and cash equivalents.

B. "Acceptable private mortgage insurance" means insurance written by a private insurer protecting a mortgage lender against loss occasioned by a mortgage loan default and issued by a licensed mortgage insurance company, with an SVO 1 designation or a rating issued by a nationally recognized statistical rating organization equivalent to an SVO 1 designation, that covers losses to an eighty percent (80%) loan-

to-value ratio.

C. "Accident and health insurance" means protection which provides payment of benefits for covered sickness or accidental injury, excluding credit insurance, disability insurance, accidental death and dismemberment insurance and long-term care insurance.

D. "Accident and health insurer" means a licensed life or health insurer or health service corporation whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively.

E. "Admitted assets" means assets [see Drafting Note 3] permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner, but excluding assets of separate accounts, the investments of which are not subject to the provisions of this Act.

Drafting Note: If the code contains a definition of admitted assets, insert "determined in accordance with the requirements of [insert section defining admitted assets]."

Drafting Note: Whenever the term "commissioner" appears, the title of the chief insurance regulatory official shall be inserted.

F. "Affiliate" means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

G. "Asset-backed security" means a security or other instrument, excluding a mutual fund, evidencing an interest in, or the right to receive payments from, or payable from distributions on, an asset, a pool of assets or specifically divisible cash flows which are legally transferred to a trust or another special purpose bankruptcy-remote business entity, on the following conditions:

(1) The trust or other business entity is established solely for the purpose of acquiring specific types of assets or rights to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

(2) The assets of the trust or other business entity consist solely of interest bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights. However, the existence of credit enhancements, such as letters of credit or guarantees, or support features such as swap agreements, shall not cause a security or other instrument to be ineligible as an asset-backed security.

H. "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for-profit or not-for-profit.

I. "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

J. "Capital and surplus" means the sum of the capital and surplus of the insurer required to be shown on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

K. "Cash equivalents" means short-term, highly rated and highly liquid investments or securities readily convertible to known amounts of cash without penalty and so near maturity that they present insignificant risk of change in value. Cash equivalents include money market mutual funds. For purposes of this definition:

(1) "Short-term" means investments with a remaining term to maturity of ninety (90) days or less; and

(2) "Highly rated" means an investment rated "P-1" by Moody's Investors Service, Inc., or "A-1" by Standard and Poor's division of The McGraw Hill Companies, Inc. or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

L. "Code" means [insert reference to adopting state's insurance code].

M. "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

N. "Commercial mortgage loan" means a loan secured by a mortgage, other than a residential mortgage loan.

O. "Construction loan" means a loan of less than three (3) years in term, made for financing the cost of construction of a building or other improvement to real estate, that is secured by the real estate.

P. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Q. "Counterparty exposure amount" means:

(1) The net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse ("over-the-counter derivative instrument"). The amount of credit risk equals:

(a) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(b) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(2) If over-the-counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or if not within the United States, within a foreign jurisdiction listed in the *Purposes and Procedures of the NAIC Investment Analysis Office* as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(a) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(b) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(3) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

R. "Covered" means that an insurer owns or can immediately acquire, through the exercise of options, warrants or conversion rights already owned, the underlying interest in order to fulfill or secure its obligations under a call option, cap or floor it has written, or has set aside under a custodial or escrow agreement cash or cash equivalents with a market value equal to the amount required to fulfill its

obligations under a put option it has written, in an income generation transaction.

S. "Credit tenant loan" means a mortgage loan which is made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real estate pledged as collateral in the form of a first lien.

T. (1) "Derivative instrument" means an agreement, option, instrument or a series or combination thereof:

(a) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(b) That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(2) Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures and any other agreements, options or instruments substantially similar thereto or any series or combination thereof and any agreements, options or instruments permitted under regulations adopted under Section 8. Derivative instruments shall not include an investment authorized by Sections 11 through 17, 19 and 24 through 30.

U. "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

V. "Direct" or "directly," when used in connection with an obligation, means that the designated obligor is primarily liable on the instrument representing the obligation.

W. "Dollar roll transaction" means two (2) simultaneous transactions with different settlement dates no more than ninety-six (96) days apart, so that in the transaction with the earlier settlement date, an insurer sells to a business entity, and in the other transaction the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(1) Asset-backed securities issued, assumed or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation or their respective successors; and

(2) Other asset-backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. § 77r-1), as amended.

X. "Domestic jurisdiction" means the United States, Canada, any state, any province of Canada or any political subdivision of any of the foregoing.

Y. "Equity interest" means any of the following that are not rated credit instruments:

(1) Common stock;

(2) Preferred stock;

(3) Trust certificate;

(4) Equity investment in an investment company other than a money market mutual fund or a listed bond mutual fund;

(5) Investment in a common trust fund of a bank regulated by a federal or state agency;

(6) An ownership interest in minerals, oil or gas, the rights to which have been separated from the underlying fee interest in the real estate where the minerals, oil or gas are located;

(7) Instruments which are mandatorily, or at the option of the issuer, convertible to equity;

(8) Limited partnership interests and those general partnership interests authorized under Section 5D;

(9) Member interests in limited liability companies;

(10) Warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired; or

(11) Instruments that would be rated credit instruments except for the provisions of Subsection 2RRR (2) of this section.

Z. "Equivalent securities" means:

(1) In a securities lending transaction, securities that are identical to the loaned securities in all features including the amount of the loaned securities, except as to certificate number if held in physical form, but if any different security shall be exchanged for a loaned security by recapitalization, merger, consolidation or other corporate action, the different security shall be deemed to be the loaned security;

(2) In a repurchase transaction, securities that are identical to the sold securities in all features including the amount of the sold securities, except as to the certificate number if held in physical form; or

(3) In a reverse repurchase transaction, securities that are identical to the purchased securities in all features including the amount of the purchased securities, except as to the certificate number if held in physical form.

AA. "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which that a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

BB. "Foreign currency" means a currency other than that of a domestic jurisdiction.

CC. (1) "Foreign investment" means an investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under this Act, other than under Sections 17 and 30. An investment shall not be deemed to be foreign if the issuing person, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(a) The issuing person is a shell business entity; and

(b) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(2) For purposes of this definition:

(a) "Shell business entity" means a business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction;

(b) "Qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction; and

(c) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

DD. "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

EE. "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

FF. "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

GG. "Government money market mutual fund" means a money market mutual fund that at all times:

(1) Invests only in obligations issued, guaranteed or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(2) Qualifies for investment without a reserve under the *Purposes and Procedures of the NAIC Investment Analysis Office* or any successor publication.

HH. "Government sponsored enterprise" means a:

(1) Governmental agency; or

(2) Corporation, limited liability company, association, partnership, joint stock company, joint venture, trust or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose.

II. "Guaranteed or insured," when used in connection with an obligation acquired under this Act, means that the guarantor or insurer has agreed to:

(1) Perform or insure the obligation of the obligor or purchase the obligation; or

(2) Be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity or sufficient liquidity to enable the obligor to pay the obligation in full.

JJ. "Hedging transaction" means a derivative transaction which is entered into and maintained to reduce:

(1) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(2) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

KK. "High grade investment" means a rated credit instruments rated 1 or 2 by the SVO.

LL. "Income" means, as to a security, interest, accrual of discount, dividends or other distributions, such as rights, tax or assessment credits, warrants and distributions in kind.

MM. "Income generation transaction" means a derivative transaction involving the writing of covered call options, covered put options, covered caps or covered floors that is intended to generate income or enhance return.

NN. "Initial margin" means the amount of cash, securities or other consideration initially required to be deposited to establish a futures position.

OO. "Insurance future" means a future relating to an index or pool that is based on insurance-related items.

PP. "Insurance futures option" means an option on an insurance future.

QQ. "Investment company" means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended, and a person described in Section 3(c) of that Act.

RR. "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

SS. "Investment practices" means transactions of the types described in Sections 16, 18, 29 or 31.

TT. "Investment subsidiary" means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investment in any asset so that its investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or avoid any other provisions of this Act applicable to the insurer. As used in this subsection, the total investment of the insurer shall include:

(1) Direct investment by the insurer in an asset; and

(2) The insurer's proportionate share of an investment in an asset by an investment subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership interest in the subsidiary.

UU. "Investment strategy" means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investing and value investing.

VV. "Letter of credit" means a clean, irrevocable and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the *Purposes and Procedures of the NAIC Investment Analysis Office* or any successor publication. To constitute acceptable collateral for the purposes of Sections 16 and 29, a letter of credit must have an expiration date beyond the term of the subject transaction.

WW. "Limited liability company" means a business organization, excluding partnerships and ordinary business corporations, organized or operating under the laws of the United States or any state thereof that limits the personal liability of investors to the equity investment of the investor in the business entity.

XX. "Listed bond mutual fund" means a mutual fund that at all times qualifies for inclusion on the "bond fund list" within the *Purposes and Procedures of the NAIC Investment Analysis Office* or any successor publication.

YY. "Lower grade investment" means a rated credit instrument rated 4, 5 or 6 by the SVO.

ZZ. "Market value" means:

(1) As to cash and letters of credit, the amounts thereof; and

(2) As to a security as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income thereon to the extent not included in the price as of that date.

AAA. "Medium grade investment" means a rated credit instrument rated 3 by the SVO.

BBB. "Money market mutual fund" means a mutual fund that meets the conditions of 17 Code of Federal Regulations Par. 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended or renumbered.

CCC. "Mortgage loan" means an obligation secured by a mortgage, deed of trust, trust deed or other consensual lien on real estate.

DDD. "Multilateral development bank" means an international development organization of which the United States is a member.

EEE. "Mutual fund" means an investment company or, in the case of an investment company that is organized as a series company, an investment company series, that, in either case, is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended.

FFF. "NAIC" means the National Association of Insurance Commissioners.

GGG. "Obligation" means a bond, note, debenture, trust certificate including an equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing net leases and other evidence of indebtedness for the payment of money (or participations, certificates or other evidences of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

HHH. "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

III. "Person" means an individual, a business entity, a multilateral development bank or a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

JJJ. "Potential exposure" means the amount determined in accordance with the *NAIC Annual Statement Instructions*.

KKK. "Preferred stock" means preferred, preference or guaranteed stock of a business entity authorized to issue the stock, that has a preference in liquidation over the common stock of the business entity.

LLL. "Qualified bank" means:

(1) A national bank, state bank or trust company that at all times is no less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System; or

(2) A bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country's government or an agency thereof and that at all times is no less than adequately capitalized as determined by the standards adopted by international banking authorities.

MMM. "Qualified business entity" means a business entity that is:

(1) An issuer of obligations or preferred stock that are rated 1 or 2 by the SVO or an issuer of obligations, preferred stock or derivative instruments that are rated the equivalent of 1 or 2 by the SVO or by a nationally recognized statistical rating organization recognized by the SVO; or

(2) A primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

NNN. "Qualified clearinghouse" means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

OOO. "Qualified exchange" means:

(1) A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78 *et seq.*), as amended;

(2) A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission or any successor thereof;

(3) Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

(4) A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended; or

(5) A qualified foreign exchange.

PPP. "Qualified foreign exchange" means a foreign exchange, board of trade or contract market located outside the United States, its territories or possessions:

(1) That has received regulatory comparability relief under Commodity Futures Trading Commission (CFTC) Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30);

(2) That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade or contract market is located; or

(3) Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's Office of General Counsel, provided that an exchange, board of trade or contract market that qualifies as a "qualified foreign exchange" only under this subsection shall only be a "qualified foreign exchange" as to foreign stock index futures contracts that are the subject of no-action relief.

QQQ. (1) "Rated credit instrument" means a contractual right to receive cash or another rated credit instrument from another entity which instrument:

(a) Is rated or required to be rated by the SVO;

(b) In the case of an instrument with a maturity of 397 days or less, is issued, guaranteed or insured by an entity that is rated by, or another obligation of such entity is rated by, the SVO or by a nationally recognized statistical rating organization recognized by the SVO;

(c) In the case of an instrument with a maturity of 90 days or less is issued by a qualified bank;

(d) Is a share of a listed bond mutual fund; or

(e) Is a share of a money market mutual fund.

(2) However, "rated credit instrument" does not mean:

(a) An instrument that is mandatorily, or at the option of the issuer, convertible to an equity interest; or

(b) A security that has a par value and whose terms provide that the issuer's net obligation to repay all or part of the security's par value is determined by reference to the performance of an equity, a commodity, a foreign currency or an index of equities, commodities, foreign currencies or combinations thereof.

RRR. "Real estate" means:

(1) (a) Real property;

(b) Interests in real property, such as leaseholds, minerals and oil and gas that have not been separated from the underlying fee interest;

(c) Improvements and fixtures located on or in real property; and

(d) The seller's equity in a contract providing for a deed of real estate.

(2) As to a mortgage on a leasehold estate, real estate shall include the leasehold estate only if it has an unexpired term (including renewal options exercisable at the option of the lessee) extending beyond the scheduled maturity date of the obligation that is secured by a mortgage on the leasehold estate by a period equal to at least twenty percent (20%) of the original term of the obligation or ten (10) years, whichever is greater.

SSS. "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this Act. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

TTT. "Repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

UUU. "Required liabilities" means total liabilities required to be reported on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

VVV. "Residential mortgage loan" means a loan primarily secured by a mortgage on real estate improved with a one-to-four family residence.

WWW. "Reverse repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

XXX. "Secured location" means the contiguous real estate owned by one person.

YYY. "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

ZZZ. "Series company" means an investment company that is organized as a series company, as defined in Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended.

AAAA. "Sinking fund stock" means preferred stock that:

(1) Is subject to a mandatory sinking fund or similar arrangement that will provide for the redemption (or open market purchase) of the entire issue over a period not longer than forty (40) years from the date of acquisition; and

(2) Provides for mandatory sinking fund installments (or open market purchases) commencing not more than ten and one half (10.5) years from the date of issue, with the sinking fund installments providing for the purchase or redemption, on a cumulative basis commencing ten (10) years from the date of issue, of at least two and one half percent (2.5%) per year of the original number of

shares of that issue of preferred stock.

BBBB. "Special rated credit instrument" means a rated credit instrument that is:

(1) An instrument that is structured so that, if it is held until retired by or on behalf of the issuer, its rate of return, based on its purchase cost and any cash flow stream possible under the structure of the transaction, may become negative due to reasons other than the credit risk associated with the issuer of the instrument; however, a rated credit instrument shall not be a special rated credit instrument under this subsection if it is:

(a) A share in a listed bond mutual fund;

(b) An instrument, other than an asset-backed security, with payments of par value fixed as to amount and timing, or callable but in any event payable only at par or greater, and interest or dividend cash flows that are based on either a fixed or variable rate determined by reference to a specified rate or index;

(c) An instrument, other than an asset-backed security, that has a par value and is purchased at a price no greater than one hundred ten percent (110%) of par;

(d) An instrument, including an asset-backed security, whose rate of return would become negative only as a result of a prepayment due to casualty, condemnation or economic obsolescence of collateral or change of law;

(e) An asset-backed security that relies on collateral that meets the requirements of Subparagraph (b) of this paragraph, the par value of which collateral:

(i) Is not permitted to be paid sooner than one half of the remaining term to maturity from the date of acquisition;

(ii) Is permitted to be paid prior to maturity only at a premium sufficient to provide a yield to maturity for the investment, considering the amount prepaid and reinvestment rates at the time of early repayment, at least equal to the yield to maturity of the initial investment; or

(iii) Is permitted to be paid prior to maturity at a premium at least equal to the yield of a treasury issue of comparable remaining life; or

(f) An asset-backed security that relies on cash flows from assets that are not prepayable at any time at par, but is not otherwise governed by Subparagraph (e) of this paragraph, if the asset-backed security has a par value reflecting principal payments to be received if held until retired by or on behalf of the issuer and is purchased at a price no greater than one hundred five percent (105%) of such par amount.

(2) An asset-backed security that:

(a) Relies on cash flows from assets that are prepayable at par at any time;

(b) Does not make payments of par that are fixed as to amount and timing; and

(c) Has a negative rate of return at the time of acquisition if a prepayment threshold assumption is used with such prepayment threshold assumption defined as either:

(i) Two (2) times the prepayment expectation reported by a recognized, publicly available source as being the median of expectations contributed by broker dealers or other entities, except insurers, engaged in the business of selling or evaluating such securities or assets. The prepayment expectation used in this calculation shall be, at the insurer's election, the prepayment expectation for pass-through securities of the Federal National Mortgage Association, the

Federal Home Loan Mortgage Corporation, the Government National Mortgage Association, or for other assets of the same type as the assets that underlie the asset-backed security, in either case with a gross weighted average coupon comparable to the gross weighted average coupon of the assets that underlie the asset-backed security; or

(ii) Another prepayment threshold assumption specified by the commissioner by regulation promulgated under Section 8.

(3) For purposes of Subparagraph 2 of this subsection, if the asset-backed security is purchased in combination with one or more other asset-backed securities that are supported by identical underlying collateral, the insurer may calculate the rate of return for these specific combined asset-backed securities in combination. The insurer must maintain documentation demonstrating that such securities were acquired and are continuing to be held in combination.

CCCC. "State" means a state, territory or possession of the United States of America, the District of Columbia or the Commonwealth of Puerto Rico.

DDDD. "Substantially similar securities" means securities that meet all criteria for substantially similar specified in the NAIC *Accounting Practices and Procedures Manual*, as amended, and in an amount that constitutes good delivery form as determined from time to time by the Public Securities Administration.

EEEE. "SVO" means the Securities Valuation Office of the NAIC or any successor office established by the NAIC.

FFFF. "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

GGGG. "Underlying interest" means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities or derivative instruments.

HHHH. "Unrestricted surplus" means the amount by which total admitted assets exceed 125 percent of the insurer's required liabilities.

IIII. "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity.

Section 3. General Investment Qualifications

A. Insurers may acquire, hold or invest in investments or engage in investment practices as set forth in this Act. Investments not conforming to this Act shall not be admitted assets.

Drafting Note: It may be necessary to modify the language in Section 3A to address investments in affiliated entities permitted under other portions of the code.

B. Subject to Subsection C of this section, an insurer shall not acquire or hold an investment as an admitted asset unless at the time of acquisition it is:

(1) Eligible for the payment or accrual of interest or discount (whether in cash or other securities), eligible to receive dividends or other distributions or is otherwise income producing; or

(2) Acquired under Sections 15C, 16, 18, 20, 28C, 29, 31 or 32 or under the authority of sections of the code other than this Act.

C. An insurer may acquire or hold as admitted assets investments that do not otherwise qualify as provided in this Act if the insurer has not acquired them for the purpose of circumventing any limitations contained in this Act, if the insurer acquires the investments in the following circumstances and the insurer complies with the provisions of Sections 5 and 7 as to the investments:

(1) As payment on account of existing indebtedness or in connection with the refinancing, restructuring or workout of existing indebtedness, if taken to protect the insurer's interest in that investment;

(2) As realization on collateral for an obligation;

(3) In connection with an otherwise qualified investment or investment practice, as interest on or a dividend or other distribution related to the investment or investment practice or in connection with the refinancing of the investment, in each case for no additional or only nominal consideration;

(4) Under a lawful and *bona fide* agreement of recapitalization or voluntary or involuntary reorganization in connection with an investment held by the insurer; or

(5) Under a bulk reinsurance, merger or consolidation transaction approved by the commissioner if the assets constitute admissible investments for the ceding, merged or consolidated companies.

D. An investment or portion of an investment acquired by an insurer under Subsection C of this section shall become a nonadmitted asset three (3) years (or five (5) years in the case of mortgage loans and real estate) from the date of its acquisition, unless within that period the investment has become a qualified investment under a section of this Act other than Subsection C of this section, but an investment acquired under an agreement of bulk reinsurance, merger or consolidation may be qualified for a longer period if so provided in the plan for reinsurance, merger or consolidation as approved by the commissioner. Upon application by the insurer and a showing that the nonadmission of an asset held under Subsection C of this section would materially injure the interests of the insurer, the commissioner may extend the period for admissibility for an additional reasonable period of time.

E. Except as provided in Subsections F and H of this section, an investment shall qualify under this Act if, on the date the insurer committed to acquire the investment or on the date of its acquisition, it would have qualified under this Act. For the purposes of determining limitations contained in this Act, an insurer shall give appropriate recognition to any commitments to acquire investments.

F. (1) An investment held as an admitted asset by an insurer on the effective date of this Act which qualified under [insert reference to state's prior code provisions on insurer investments] shall remain qualified as an admitted asset under this Act.

(2) Each specific transaction constituting an investment practice of the type described in this Act that was lawfully entered into by an insurer and was in effect on the effective date of this Act shall continue to be permitted under this Act until its expiration or termination under its terms.

G. Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the commissioner. For purposes of computing any limitation based upon admitted assets, the insurer shall deduct from the amount of its admitted assets the amount of the liability recorded on its statutory balance sheet for:

(1) The return of acceptable collateral received in a repurchase transaction or a securities lending transaction;

(2) Cash received in a dollar roll transaction; and

(3) The amount reported as borrowed money in the most recently filed financial statement to the extent not included in Paragraphs (1) and (2) of this subsection.

H. An investment qualified, in whole or in part, for acquisition or holding as an admitted asset may be qualified or requalified at the time of acquisition or a later date, in whole or in part, under any other section, if the relevant conditions contained in the other section are satisfied at the time of qualification or requalification.

I. An insurer shall maintain documentation demonstrating that investments were acquired in accordance with this Act, and specifying the section of this Act under which they were acquired.

J. An insurer shall not enter into an agreement to purchase securities in advance of their issuance for resale to the public as part of a distribution of the securities by the issuer or otherwise guarantee the distribution, except that an insurer may acquire privately placed securities with registration rights.

K. Notwithstanding the provisions of this Act, the commissioner, for good cause, may order under the state's administrative procedures or equivalent, an insurer to nonadmit, limit, dispose of, withdraw from or discontinue an investment or investment practice. The authority of the commissioner under this subsection is in addition to any other authority of the commissioner.

L. Insurance futures and insurance futures options are not considered investments or investment practices for purposes of this Act.

Section 4. Authorization of Investments by the Board of Directors

A. An insurer's board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity and diversification of investments and other specifications including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs and its capital and surplus. The board shall review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written plan concerning an investment strategy or investment practice.

B. Investments acquired and held under this Act shall be acquired and held under the supervision and direction of the board of directors of the insurer. The board of directors shall evidence by formal resolution, at least annually, that it has determined whether all investments have been made in accordance with delegations, standards, limitations and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

C. On no less than a quarterly basis, and more often if deemed appropriate, an insurer's board of directors or committee of the board of directors shall:

(1) Receive and review a summary report on the insurer's investment portfolio, its investment activities and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

(2) Review and revise, as appropriate, the written plan.

D. In discharging its duties under this section, the board of directors shall require that records of any authorizations or approvals, other documentation as the board may require and reports of any action taken under authority delegated under the plan referred to in Subsection A of this section shall be made available on a regular basis to the board of directors.

E. In discharging their duties under this section, the directors of an insurer shall perform their duties in good faith and with that degree of care that ordinarily prudent individuals in like positions would use under similar circumstances.

F. If an insurer does not have a board of directors, all references to the board of directors in this Act shall be deemed to be references to the governing body of the insurer having authority equivalent to that of a board of directors.

Section 5. Prohibited Investments

An insurer shall not, directly or indirectly:

A. Invest in an obligation or security or make a guarantee for the benefit of or in favor of an officer or director of the insurer, except as provided in Section 6;

B. Invest in an obligation or security, make a guarantee for the benefit of or in favor of, or make other investments in a business entity of which ten percent (10%) or more of the voting securities or equity interests are owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer, except as authorized in the [insert reference to holding company law] or provided in Section 6;

C. Engage on its own behalf or through one or more affiliates in a transaction or series of transactions designed to evade the prohibitions of this Act;

D. (1) Invest in a partnership as a general partner, except that an insurer may make an investment as a general partner:

(a) If all other partners in the partnership are subsidiaries of the insurer;

(b) For the purpose of:

(i) Meeting cash calls committed to prior to the effective date of this Act;

(ii) Completing those specific projects or activities of the partnership in which the insurer was a general partner as of the effective date of this Act that had been undertaken as of that date; or

(iii) Making capital improvements to property owned by the partnership on the effective date of this Act if the insurer was a general partner as of that date; or

(c) In accordance with Section 3C;

(2) This subsection shall not prohibit a subsidiary or other affiliate of the insurer from becoming a general partner; or

E. Invest in or lend its funds upon the security of shares of its own stock, except that an insurer may acquire shares of its own stock for the following purposes, but the shares shall not be admitted assets of the insurer:

(1) Conversion of a stock insurer into a mutual or reciprocal insurer or a mutual or reciprocal insurer into a stock insurer;

(2) Issuance to the insurer's officers, employees or agents in connection with a plan approved by the commissioner for converting a publicly held insurer into a privately held insurer under [insert reference to the section of the code providing for approval of a conversion plan] or in connection with other stock option and employee benefit plans; or

(3) In accordance with any other plan approved by the commissioner.

Section 6. Loans to Officers and Directors

A. (1) Except as provided in Section 6B, an insurer shall not, without the prior written approval of the commissioner, directly or indirectly:

(a) Make a loan to or other investment in an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest;

(b) Make a guarantee for the benefit of or in favor of an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest; or

(c) Enter into an agreement for the purchase or sale of property from or to an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest.

(2) For purposes of this section, an officer or director shall not be deemed to have a financial interest by reason of an interest that is held directly or indirectly through the ownership of equity interests representing less than two percent (2%) of all outstanding equity interests issued by a person that is a party to the transaction, or solely by reason of that individual's position as a director or officer of a person that is a party to the transaction.

(3) This subsection does not permit an investment that is prohibited by Section 5.

(4) This subsection does not apply to a transaction between an insurer and any of its subsidiaries or affiliates that is entered into in compliance with the [insert reference to holding company law], other than a transaction between an insurer and its officer or director.

B. An insurer may make, without the prior written approval of the commissioner:

(1) Policy loans in accordance with the terms of the policy or contract and Section 19;

(2) Advances to officers or directors for expenses reasonably expected to be incurred in the ordinary course of the insurer's business or guarantees associated with credit or charge cards issued or credit extended for the purpose of financing these expenses;

(3) Loans secured by the principal residence of an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans comply with the requirements of Section 15 or 28 and the terms and conditions otherwise are the same as those generally available from unaffiliated third parties;

(4) Secured loans to an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans:

(a) Do not have a term exceeding two (2) years;

(b) Are required to finance mortgage loans outstanding at the same time on the prior and new residences of the officer;

(c) Do not exceed an amount equal to the equity of the officer in the prior residence; and

(d) Are required to be fully repaid upon the earlier of the end of the two (2) year period or the sale of the prior residence; and

(5) Loans and advances to officers or directors made in compliance with state or federal law specifically related to the loans and advances by a regulated non-insurance subsidiary or affiliate of the insurer in the ordinary course of business and on terms no more favorable than available to other customers of the entity.

Section 7. Valuation of Investments

For the purposes of this Act, the value or amount of an investment acquired or held, or an investment practice engaged in, under this Act, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the NAIC, including the *Purposes and Procedures of the NAIC Investment Analysis Office*, the *Valuation of Securities* manual, the *Accounting Practices and Procedures* manual, the *Annual Statement Instructions* or any successor valuation procedures officially adopted by the NAIC.

Section 8. Regulations

The commissioner may, in accordance with [insert reference to administrative procedures act or other statutes concerning promulgation of regulations], promulgate regulations implementing the provisions of this Act.

ARTICLE II. LIFE AND HEALTH INSURERS

Section 9. Applicability

This Article shall apply to the investments and investment practices of life and health insurers, subject to the provisions of Section 1B.

Section 10. General Three Percent Diversification, Medium and Lower Grade Investments and Canadian Investments

A. General Three Percent Diversification

(1) Except as otherwise specified in this Act, an insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under this Act if, as a result of and after giving effect to the investment, the insurer would hold more than three percent (3%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured or guaranteed by a single person, or five percent (5%) of its admitted assets in investments in the voting securities of a depository institution or any company that controls the institution.

(2) This three percent (3%) limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of Paragraph (1) of this subsection, however an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity, then held by the insurer would exceed three percent (3%) of its admitted assets.

B. Medium and Lower Grade Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 11, 14, 17 or counterparty exposure under Section 18D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments then held by the insurer would exceed twenty percent (20%) of its admitted assets;

(b) The aggregate amount of lower grade investments then held by the insurer would exceed ten percent (10%) of its admitted assets;

(c) The aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed three percent (3%) of its admitted assets;

(d) The aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed one percent (1%) of its admitted assets; or

(e) The aggregate amount of medium and lower grade investments then held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life, would exceed one percent (1%) of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 11, 14, 17 or counterparty exposure under Section 18D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one percent (1%) of its admitted assets; or

(b) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one half of one percent (.5%) of its admitted assets.

(3) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection, the insurer shall not thereby be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

C. Canadian Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, a Canadian investment authorized by this Act, if as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed forty percent (40%) of its admitted assets, or if the aggregate amount of Canadian investments not acquired under Section 11B then held by the insurer would exceed twenty-five percent (25%) of its admitted assets.

(2) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of Paragraph (1) of this subsection shall be increased by the greater of:

(a) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(b) One hundred fifteen percent (115%) of the amount of its reserves and other obligations under contracts on lives or risks resident or located in Canada.

Section 11. Rated Credit Instruments

Subject to the limitations of Subsection F of this section, an insurer may acquire rated credit instruments:

A. Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(1) The United States; or

(2) A government sponsored enterprise of the United States, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

B. (1) Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(a) Canada; or

(b) A government sponsored enterprise of Canada, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada;

(2) However, an insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection would exceed forty percent (40%) of its admitted assets.

C. (1) Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments, excluding asset-backed securities:

(a) Issued by a government money market mutual fund or a listed bond mutual fund;

(b) Issued, assumed, guaranteed or insured by a government sponsored enterprise of the United States other than those eligible under Subsection A of this section;

(c) Issued, assumed, guaranteed or insured by a state, if the instruments are general obligations of the state; or

(d) Issued by a multilateral development bank;

(2) However, an insurer shall not acquire an instrument of any one fund, any one enterprise or entity or any one state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise or entity or state under this subsection would exceed ten percent (10%) of its admitted assets.

D. Subject to the limitations of Section 10, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(1) The aggregate amount of preferred stocks then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of preferred stocks then held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed ten percent (10%) of its admitted assets.

E. Subject to the limitations of Section 10, in addition to those investments eligible under Subsections A, B, C and D of this section, an insurer may acquire rated credit instruments that are not foreign investments.

F. An insurer shall not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed five percent (5%) of its admitted assets.

Drafting Note: In states which have not adopted Secondary Mortgage Market Enhancement Act of 1984, as amended (SMMEA) override legislation, obligations of Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, and other mortgage-backed or mortgage related securities as defined in Section 106 of Title I of SMMEA (15 U.S.C. § 77r-1) may be invested in to the same extent as allowed under Section 11A, whether or not they are rated credit instruments authorized in Section 11A. Appropriate changes to Section 11 or other Sections of this Act may be necessary.

Section 12. Insurer Investment Pools

A. An insurer may acquire investments in investment pools that:

(1) Invest only in:

(a) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(ii) A remaining maturity of three (3) years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(b) Government money market mutual funds; or

(c) Securities lending, repurchase and reverse repurchase transactions that meet all the requirements of Section 16, except the quantitative limitations of Section 16D; or

(2) Invest only in investments which an insurer may acquire under this Act, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this Act.

B. For an investment in an investment pool to be qualified under this Act, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and repurchase transactions that meet the requirements of Section 16 except the quantitative limitations of Section 16D; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from or invested in any one business entity under this section to exceed ten percent (10%) of the total assets of the investment pool.

C. The limitations of Section 10A shall not apply to an insurer's investment in an investment pool, however an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(1) In any one investment pool would exceed ten percent (10%) of its admitted assets;

(2) In all investment pools investing in investments permitted under Subsection A(2) of this section would exceed twenty-five percent (25%) of its admitted assets; or

(3) In all investment pools would exceed thirty-five percent (35%) of its admitted assets.

D. For an investment in an investment pool to be qualified under this Act, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(a) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(b) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and

(c) Other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:

(a) State and recognize the claims and rights of each participant;

(b) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(c) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

E. The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under Subsection A(1) of this section, the insurer and its subsidiaries, affiliates or any pension or profit sharing plan of the insurer, its subsidiaries and affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(a) Each participant owns an undivided interest in the underlying assets of the investment pool; and

(b) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy or receivership, its trustee, receiver or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five (5) business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(a) In cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(b) In kind, a pro rata share of each underlying asset; or

(c) In a combination of cash and in kind distributions, a pro rata share in each underlying asset; and

(6) The pool manager shall make the records of the investment pool available for inspection by the commissioner.

Section 13. Equity Interests

A. Subject to the limitations of Section 10, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.

B. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed twenty percent (20%) of its admitted assets, or the amount of equity interests then held by the insurer that are not listed on a qualified exchange would exceed five percent (5%) of its admitted assets. An accident and health insurer shall not be subject to this section but shall be subject to the same aggregate limitation on equity interests as a property and casualty insurer under Section 26 and also to the provisions of Section 22 of this Act.

C. An insurer shall not acquire under this section any investments that the insurer may acquire under Section 15.

D. An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within six (6) months of the short sale.

Section 14. Tangible Personal Property Under Lease

A. (1) Subject to the limitations of Section 10, an insurer may acquire tangible personal property or equity interests therein located or used wholly or in part within a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates or other similar instruments.

(2) Investments acquired under Paragraph (1) of this subsection shall be eligible only if:

(a) The property is subject to a lease or other agreement with a person whose rated credit instruments in the amount of the purchase price of the personal property the insurer could then acquire under Section 11; and

(b) The lease or other agreement provides the insurer the right to receive rental, purchase or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be adequate to return the cost of the insurer's investment in the property, plus a return deemed adequate by the insurer.

B. The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

C. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:

(1) Two percent (2%) of its admitted assets ; or

(2) One half of one percent (.5%) of its admitted assets as to any single item of tangible personal property.

D. For purposes of determining compliance with the limitations of Section 10, investments acquired by an insurer under this section shall be aggregated with those acquired under Section 11, and each lessee of the property under a lease referred to in this section shall be deemed the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided in Subsection B of this section.

E. Nothing in this section is applicable to tangible personal property lease arrangements between an insurer and its subsidiaries and affiliates under a cost sharing arrangement or agreement permitted under [insert reference to holding company law].

Section 15. Mortgage Loans and Real Estate

A. Mortgage Loans

(l) Subject to the limitations of Section 10, an insurer may acquire, either directly, indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments, obligations secured by mortgages on real estate situated within a domestic jurisdiction, but a mortgage loan which is secured by other than a first lien shall not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority, shall not, at the time of acquisition of the obligation, exceed:

(a) Ninety percent (90%) of the fair market value of the real estate, if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(b) Eighty percent (80%) of the fair market value of the real estate, if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of thirty (30) years or less and periodic payments made no less frequently than annually. Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the eighty percent (80%) limitation may be increased to ninety-seven percent (97%) if acceptable private mortgage insurance has been obtained; or

(c) Seventy-five percent (75%) of the fair market value of the real estate for mortgage loans that do not meet the requirements of Subparagraphs (a) or (b) of this paragraph.

(2) For purposes of Paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

(3) A mortgage loan that is held by an insurer under Section 3F or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the *NAIC Accounting Practices and Procedures Manual* or successor publication shall continue to qualify as a mortgage loan under this Act.

(4) Subject to the limitations of Section 10, credit lease transactions that do not qualify for investment under Section 11 with the following characteristics shall be exempt from the provisions of Paragraph (1) of this subsection:

(a) The loan amortizes over the initial fixed lease term at least in an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate ;

(b) The lease payments cover or exceed the total debt service over the life of the loan;

(c) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO as a full faith and credit obligation to make the lease payments;

(d) The insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(e) The expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking and heating, ventilation and air conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and

(f) There is a perfected assignment of the rents due pursuant to the lease to, or for the benefit of, the insurer.

B. Income Producing Real Estate

(1) An insurer may acquire, manage and dispose of real estate situated in a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income producing or intended for improvement or development for investment purposes under an existing program (in which case the real estate shall be deemed to be income producing).

(2) The real estate may be subject to mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsections D(2) and D(3) of this section.

C. Real Estate for the Accommodation of Business

An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer's (which may include its affiliates) business operations, including home office, branch office and field office operations.

(1) Real estate acquired under this subsection may include excess space for rent to others, if the excess space, valued at its fair market value, would otherwise be a permitted investment under Subsection B of this section and is so qualified by the insurer;

(2) The real estate acquired under this subsection may be subject to one or more mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsection D(4) of this section; and

(3) For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds. An insurer may acquire real estate used for these purposes under Subsection B of this section.

D. Quantitative Limitations

(1) An insurer shall not acquire an investment under Subsection A of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under Subsection A of this section would exceed:

(a) One percent (1%) of its admitted assets in mortgage loans covering any one secured location;

(b) One quarter of one percent (.25%) of its admitted assets in construction loans covering any one secured location; or

(c) Two percent (2%) of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under Subsection B of this section if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under Subsection B of this section plus the guarantees then outstanding would exceed:

(a) One percent (1%) of its admitted assets in one parcel or group of contiguous parcels of real estate, except that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds, such as hospitals, medical clinics, medical professional buildings or other health facilities used for the purpose of providing health services; or

(b) Fifteen percent (15%) of its admitted assets in the aggregate, but not more than five percent (5%) of its admitted assets as to properties that are to be improved or developed.

(3) An insurer shall not acquire an investment under Subsections A or B of this section if, as a result of and after giving effect to the investment and any guarantees made by the insurer in connection with the investment, the aggregate amount of all investments then held by the insurer under Subsections A and B of this section plus the guarantees then outstanding would exceed forty-five percent (45%) of its admitted assets. However, an insurer may exceed this limitation by no more than thirty percent (30%) of its admitted assets if:

(a) This increased amount is invested only in residential mortgage loans;

(b) The insurer has no more than ten percent (10%) of its admitted assets invested in mortgage loans other than residential mortgage loans;

(c) The loan-to-value ratio of each residential mortgage loan does not exceed sixty percent (60%) at the time the mortgage loan is qualified under this increased authority, and the fair market value is supported by an appraisal no more than two (2) years old, prepared by an independent appraiser;

(d) A single mortgage loan qualified under this increased authority shall not exceed one half of one percent (0.5%) of its admitted assets;

(e) The insurer files with the commissioner, and receives approval from the commissioner for, a plan that is designed to result in a portfolio of residential mortgage loans that is sufficiently geographically diversified; and

(f) The insurer agrees to file annually with the commissioner records that demonstrate that its portfolio of residential mortgage loans is geographically diversified in accordance with the plan.

(4) The limitations of Section 10 shall not apply to an insurer's acquisition of real estate under Subsection C of this section. An insurer shall not acquire real estate under Subsection C of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of real estate then held by the insurer under Subsection C of this section would exceed ten percent (10%) of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under Subsection C of this section.

Section 16. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions

An insurer may enter into securities lending, repurchase, reverse repurchase and dollar roll transactions with business entities, subject to the following requirements:

A. The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan in Section 4A that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

B. The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

(1) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(2) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

C. Cash received in a transaction under this section shall be invested in accordance with this Act and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the commissioner:

(1) Possession of the acceptable collateral;

(2) A perfected security interest in the acceptable collateral; or

(3) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

D. The limitations of Sections 10 and 17 shall not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer's future obligation to resell securities, in the case of a reverse repurchase transaction, or to repurchase securities, in the case of a repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned, sold to or purchased from any one business entity counterparty under this section would exceed five percent (5%) of its admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned, sold to or purchased from all business entities under this section would exceed forty percent (40%) of its admitted assets.

E. In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102 percent of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the market value of the loaned securities.

F. In a repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five percent (95%) of the market value of the transferred securities.

G. In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

H. In a reverse repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102 percent of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100 percent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the purchase price. Securities acquired by an insurer in a reverse repurchase transaction shall not be sold in a repurchase transaction, loaned in a securities lending transaction or otherwise pledged.

Drafting Note: Subsections E, F, and H of this section contain requirements that at the time of drafting this model act were contained in the *Purposes and Procedures of the Investmeent Analysis Office*. However, concomitant with the drafting of this model act, a separate task force was considering a revised publication which did not contain these requirements inasmuch as the SVO considered these requirements as accounting-type rules which were deemed not suitable to such a publication. Moreover, another working group was developing a draft of a revised accounting manual but had not considered proposing separate accounting guidance regarding these requirements. Instead, the accounting manual implicitly referred to the requirements stipulated in this model act. Pending the results of consideration of these requirements by the three groups, in concert, these requirements have been included in this model act. If after due consideration, these requirements are included in the revised accounting manual as representative of statutory accounting principles or, in the alternative, are inserted in the revised *Purposes and Procedures of the Investment Analysis Office*, then States may opt not to codify these requirements within their insurer investment code.

Section 17. Foreign Investments and Foreign Currency Exposure

A. Subject to the limitations of Section 10, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer is permitted to acquire under this Act, other than of the type permitted under Section 12, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investments then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of foreign investments then held by the insurer under this subsection in a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or three percent (3%) of its admitted assets as to any other foreign jurisdiction.

B. Subject to the limitations of Section 10, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under Subsection A of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(1) The aggregate amount of investments then held by the insurer under this subsection denominated in foreign currencies does not exceed ten percent (10%) of its admitted assets; and

(2) The aggregate amount of investments then held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or three percent (3%) of its admitted assets as to any other foreign jurisdiction.

(3) However, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under Section 18 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

C. In addition to investments permitted under Subsections A and B of this section, an insurer that is authorized to do business in a foreign jurisdiction, and that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction, subject to the limitations of Section 10. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 10 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

(1) The amount the insurer is required by the law of the foreign jurisdiction to invest in the foreign jurisdiction; or

(2) One hundred fifteen percent (115%) of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

D. In addition to investments permitted under Subsections A and B of this section, an insurer that is not authorized to do business in a foreign jurisdiction, but which has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction subject to the limitations of Section 10. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 10 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105 percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

E. Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this Act, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions and government sponsored enterprises of these persons, except for those exempted under Subsections C and D of this section, shall be subject to the limitations of Section 10.

Section 18. Derivative Transactions

An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions :

A. General Conditions

(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the commissioner.

(2) An insurer shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

B. Limitations on Hedging Transactions

An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps and floors written in hedging transactions does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of its admitted assets.

C. Limitations on Income Generation Transactions

An insurer may only enter into the following types of income generation transactions if as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this Act, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(4) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

D. Counterparty Exposure

An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of Section 10.

E. Additional Transactions

Pursuant to regulations promulgated under Section 8, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of Subsection B of this section or for other risk management purposes under regulations promulgated by the commissioner, but replication transactions shall not be permitted for other than risk management purposes.

Section 19. Policy Loans

A life insurer may lend to a policyholder on the security of the cash surrender value of the policyholder's policy a sum not exceeding the legal reserve that the insurer is required to maintain on the policy.

Section 20. Additional Investment Authority

A. Solely for the purpose of acquiring investments that exceed the quantitative limitations of Sections 10 through 17, an insurer may acquire under this subsection an investment, or engage in investment practices described in Section 16, but an insurer shall not acquire an investment, or engage in investment practices described in Section 16, under this subsection if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of investments then held by an insurer under this subsection would exceed three percent (3%) of its admitted assets; or

(2) The aggregate amount of investments as to one limitation in Sections 10 through 17 then held by the insurer under this subsection would exceed one percent (1%) of its admitted assets.

B. (1) In addition to the authority provided under Subsection A of this section, an insurer may acquire under this subsection an investment of any kind, or engage in investment practices described in Section 16, that are not specifically prohibited by this Act, without regard to the categories, conditions, standards or other limitations of Sections 10 through 17 if, as a result of and after giving effect to the transaction, the aggregate amount of investments then held under this subsection would not exceed the lesser of:

(a) Ten percent (10%) of its admitted assets; or

(b) Seventy-five percent (75%) of its capital and surplus.

(2) However, an insurer shall not acquire any investment or engage in any investment practice under this subsection if, as a result of and after giving effect to the transaction, the aggregate amount of all investments in any one person then held by the insurer under this subsection would exceed three percent (3%) of its admitted assets.

C. In addition to the investments acquired under Subsections A and B of this section, an insurer may acquire under this subsection an investment of any kind, or engage in investment practices described in Section 16, that are not specifically prohibited by this Act without regard to any limitations of Sections 10 through 17 if:

(1) The commissioner grants prior approval;

(2) The insurer demonstrates that its investments are being made in a prudent manner and that the additional amounts will be invested in a prudent manner; and

(3) As a result of and after giving effect to the transaction the aggregate amount of investments then held by the insurer under this subsection does not exceed the greater of:

(a) Twenty-five percent (25%) of its capital and surplus; or

(b) One hundred percent (100%) of capital and surplus less ten percent (10%) of its admitted assets.

D. An investment prohibited under Section 5, not permitted under Section 18 or additional derivative instruments acquired under Section 18 shall not be acquired under this section.

ARTICLE III. PROPERTY AND CASUALTY, FINANCIAL GUARANTY AND MORTGAGE GUARANTY INSURERS

Section 21. Applicability

This Article shall apply to the investments and investment practices of property and casualty, financial guaranty and mortgage guaranty insurers, subject to the provisions of Section 1B.

Section 22. Reserve Requirements

A. Reserve Requirements

(1) Subject to all other limitations and requirements of this Act, a property and casualty, financial guaranty, mortgage guaranty or accident and health insurer shall maintain an amount at least equal to one hundred percent (100%) of adjusted loss reserves and loss adjustment expense reserves, one hundred percent (100%) of adjusted unearned premium reserves and one hundred percent (100%) of statutorily required policy and contract reserves in:

(a) Cash and cash equivalents;

(b) High and medium grade investments that qualify under Sections 24 or 25;

(c) Equity interests that qualify under Section 26 and that are traded on a qualified exchange;

(d) Investments of the type set forth in Section 30 if the investments are rated in the highest generic rating category by a nationally recognized statistical rating organization recognized by the SVO for rating foreign jurisdictions and if any foreign currency exposure is effectively hedged through the maturity date of the investments;

(e) Qualifying investments of the type set forth in Subparagraphs (b), (c) or (d) of this paragraph that are acquired under Section 32;

(f) Interest and dividends receivable on qualifying investments of the type set forth in Subparagraphs (a) through (e) of this subsection; or

(g) Reinsurance recoverable on paid losses.

(2) Reserve Requirement Amount

(a) For purposes of determining the amount of assets to be maintained under this subsection, the calculation of adjusted loss reserves and loss adjustment expense reserves, adjusted unearned premium reserves and statutorily required policy and contract reserves shall be based on the amounts reported as of the most recent annual or quarterly statement date.

(b) Adjusted loss reserves and loss adjustment expense reserves shall be equal to the sum of the amounts derived from the following calculations:

(i) The result of each amount reported by the insurer as losses and loss adjustment expenses unpaid for each accident year for each individual line of business; multiplied by

(ii) The discount factor that is applicable to the line of business and accident year published by the Internal Revenue Service under Internal Revenue Code Section 846 (26 U.S.C. § 846), as amended, for the calendar year that corresponds to the most recent annual statement of the insurer; minus

(iii) Accrued retrospective premiums discounted by an average discount factor. The discount factor shall be calculated by dividing the losses and loss adjustment expenses unpaid after discounting (the product of Items (i) and (ii) in this subparagraph) by loss and loss adjustment expense reserves before discounting Item (i) of this subparagraph.

(iv) For purposes of these calculations, the losses and loss adjustment expenses unpaid shall be determined net of anticipated salvage and subrogation, and gross of any discount for the time value of money or tabular discount.

(c) Adjusted unearned premium reserves shall be equal to the result of the following calculation:

(i) The amount reported by the insurer as unearned premium reserves; minus

(ii) The admitted asset amounts reported by the insurer as:

(I) Premiums in and agents' balances in the course of collection, accident and health premiums due and unpaid and uncollected premiums for accident and health premiums;

(II) Premiums, agents' balances and installments booked but deferred and not yet due; and

(III) Bills receivable, taken for premium.

Drafting Note: The amounts to be subtracted are the amounts allowed to be reported as admitted assets on lines 9.1, 9.2 and 11 of page 2 of the Property and Casualty Annual Statement, line 15 of page 2 of the Life and Accident and Health Annual Statement, or line 9 of the Hospital Medical and Dental Service or Indemnity Corporations Annual Statement in accordance with the applicable *Annual Statement Instructions* and the applicable *Accounting Practices and Procedures Manual* of the NAIC and like amounts reported in quarterly statements.

(d) Statutorily required policy and contract reserves also shall include, in the case of a financial guaranty insurer, the amounts required by [cite sections of the code that require contingency reserves and any other reserves that are not covered by the terms "loss reserves," "loss adjustment expense reserves" and "unearned premium reserves" for financial guaranty insurers] and, in the case of a mortgage guaranty insurer, the amounts required by [cite sections of the code that require contingency reserves and any other reserves that are not covered by the terms "loss reserves," "loss adjustment expense reserves" and "unearned premium reserves" for mortgage guaranty insurers] and, in the case of an accident and health insurer, the amounts required by [cite sections of the code that require additional or contingency reserves and any other reserves that are not covered by the terms "loss reserves," "loss adjustment expense reserves" and "unearned premium reserves" for accident and health insurers].

B. Monitoring and Reporting

A property and casualty, financial guaranty, mortgage guaranty or accident and health insurer shall supplement its annual statement with a reconciliation and summary of its assets and reserve requirements as required in Subsection A of this section. A reconciliation and summary showing that an insurer's assets as required in Subsection A of this section are greater than or equal to its undiscounted reserves referred to in Subsection A of this section shall be sufficient to satisfy this requirement. Upon prior notification, the commissioner may require an insurer to submit such a reconciliation and summary with any quarterly statement filed during the calendar year.

Drafting Note: The supplement to the annual statement is not intended to be a new exhibit to the NAIC Annual Statement blank. This filing is a state specific filing required by those states adopting this Model Act. Upon adoption by a significant number of states, a change to the NAIC Annual Statement blank to incorporate this exhibit may be considered.

C. Notification Requirements and Mandatory Safeguards

If a property and casualty, financial guaranty, mortgage guaranty or accident and health insurer's assets and reserves do not comply with Subsection A of this section, the insurer shall notify the commissioner immediately of the amount by which the reserve requirements exceed the annual statement value of the qualifying assets, explain why the deficiency exists and within thirty (30) days of the date of the notice propose a plan of action to remedy the deficiency.

D. Authority of the Commissioner

(1) If the commissioner determines that an insurer is not in compliance with Subsection A of this section, the commissioner shall require the insurer to eliminate the condition causing the noncompliance within a specified time from the date the notice of the commissioner's requirement is mailed or delivered to the insurer.

(2) If an insurer fails to comply with the commissioner's requirement under Paragraph (1) of this subsection, the insurer is deemed to be in hazardous financial condition, and the commissioner shall take one or more of the actions authorized by law as to insurers in hazardous financial condition.

Section 23. General Five Percent Diversification, Medium and Lower Grade Investments and Canadian Investments

A. General Five Percent Diversification

(1) Except as otherwise specified in this Act, an insurer shall not acquire directly or indirectly through an investment subsidiary an investment under this Act if, as a result of and after giving effect to the investment, the insurer would hold more than five percent (5%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured or guaranteed by a single person.

(2) This five percent (5%) limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of paragraph (1) of this subsection, however an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity, then held by the insurer would exceed five percent (5%) of its admitted assets.

B. Medium and Lower Grade Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 24, 27, 30 or counterparty exposure under Section 31D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of all medium and lower grade investments then held by the insurer would exceed twenty percent (20%) of its admitted assets;

(b) The aggregate amount of lower grade investments then held by the insurer would exceed ten percent (10%) of its admitted assets;

(c) The aggregate amount of investments rated 5 or 6 by the SVOthen held by the insurer would exceed five percent (5%) of its admitted assets;

(d) The aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed one percent (1%) of its admitted assets; or

(e) The aggregate amount of medium and lower grade investments then held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life, would exceed one percent (1%) of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 24, 27, 30 or counterparty exposure under Section 31D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one percent (1%) of its admitted assets; or

(b) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one half of one percent (.5%) of its admitted assets.

(3) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection, the insurer shall not thereby be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

C. Canadian Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, any Canadian investments authorized by this Act, if as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed forty percent (40%) of its admitted assets, or if the aggregate amount of Canadian investments not acquired under Section 24B then held by the insurer would exceed twenty-five percent (25%) of its admitted assets.

(2) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of Paragraph (1) of this subsection shall be increased by the greater of:

(a) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(b) One hundred twenty-five percent (125%) of the amount of its reserves and other obligations under contracts on risks resident or located in Canada.

Section 24. Rated Credit Instruments

Subject to the limitations of Subsection F of this section, an insurer may acquire rated credit instruments:

A. Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(1) The United States; or

(2) A government sponsored enterprise of the United States, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

B. (1) Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(a) Canada; or

(b) A government sponsored enterprise of Canada, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada;

(2) However, an insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection would exceed forty percent (40%) of its admitted assets.

C. (1) Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments, excluding asset-backed securities:

(a) Issued by a government money market mutual fund or a listed bond mutual fund;

(b) Issued, assumed, guaranteed or insured by a government sponsored enterprise of the United States other than those eligible under Subsection A of this section;

(c) Issued, assumed, guaranteed or insured by a state, if the instruments are general obligations of the state; or

(d) Issued by a multilateral development bank.

(2) However, an insurer shall not acquire an instrument of any one fund, any one enterprise or entity, or any one state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise or entity or state under this subsection would exceed ten percent (10%) of its admitted assets.

D. Subject to the limitations of Section 23, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(1) The aggregate amount of preferred stocks then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of preferred stocks then held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed ten percent (10%) of its admitted assets.

E. Subject to the limitations of Section 23 in addition to those investments eligible under Subsections A, B, C and D of this section, an insurer may acquire rated credit instruments that are not foreign investments.

F. An insurer shall not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed five percent (5%) of its admitted assets.

Drafting Note: In states which have not adopted Secondary Mortgage Market Enhancement Act of 1984, as amended (SMMEA) override legislation, obligations of Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, and other mortgage-backed or mortgage related securities as defined in Section 106 of Title I of SMMEA (15 U.S.C. § 77r-1) may be invested in to the same extent as allowed under Section 24A, whether or not they are rated credit instruments authorized in Section 24A. Appropriate changes to Section 24 or other Sections of this Act may be necessary.

Section 25. Insurer Investment Pools

A. An insurer may acquire investments in investment pools that:

(1) Invest only in:

(a) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(ii) A remaining maturity of three (3) years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(b) Government money market mutual funds; or

(c) Securities lending, repurchase and reverse repurchase transactions that meet all the requirements of Section 29, except the quantitative limitations of Section 29D; or

(2) Invest only in investments which an insurer may acquire under this Act, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this Act.

B. For an investment in an investment pool to be qualified under this Act, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and repurchase transactions that meet the requirements of Section 29 except the quantitative limitations of Section 29D; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from or invested in any one business entity under this section to exceed ten percent (10%) of the total assets of the investment pool.

C. The limitations of Section 23A shall not apply to an insurer's investment in an investment pool, however an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(1) In any one investment pool would exceed ten percent (10%) of its admitted assets;

(2) In all investment pools investing in investments permitted under Subsection A(2) of this section would exceed twenty-five percent (25%) of its admitted assets; or

(3) In all investment pools would exceed forty percent (40%) of its admitted assets.

D. For an investment in an investment pool to be qualified under this Act, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. §§ 80a-1 *et seq.*), as amended or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(a) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(b) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and

(c) Other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:

(a) State and recognize the claims and rights of each participant;

(b) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(c) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

E. The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under Subsection A(1) of this section, the insurer and its subsidiaries, affiliates or any pension or profit sharing plan of the insurer, its subsidiaries and affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(a) Each participant owns an undivided interest in the underlying assets of the investment pool; and

(b) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy or receivership, its trustee, receiver or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five (5) business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(a) In cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(b) In kind, a pro rata share of each underlying asset; or

(c) In a combination of cash and in kind distributions, a pro rata share in each underlying asset; and

(6) The pool manager shall make the records of the investment pool available for inspection by the commissioner.

Section 26. Equity Interests

A. Subject to the limitations of Section 23, an insurer may acquire equity interests in business entities organized under the laws any domestic jurisdiction.

B. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed the greater of twenty-five percent (25%) of its admitted assets or one hundred percent (100%) of its surplus as regards policyholders.

C. An insurer shall not acquire under this section any investments that the insurer may acquire under Section 28.

D. An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within six (6) months of the short sale.

Section 27. Tangible Personal Property Under Lease

A. (1) Subject to the limitations of Section 23, an insurer may acquire tangible personal property or equity interests therein located or used wholly or in part within a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates or other similar instruments.

(2) Investments acquired under Paragraph (1) of this subsection shall be eligible only if:

(a) The property is subject to a lease or other agreement with a person whose rated credit instruments in the amount of the purchase price of the personal property the insurer could then acquire under Section 24; and

(b) The lease or other agreement provides the insurer the right to receive rental, purchase or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be adequate to return the cost of the insurer's investment in the property, plus a return deemed adequate by the insurer.

B. The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

C. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:

(1) Two percent (2%) of its admitted assets; or

(2) One half of one percent (.5%) of its admitted assets as to any single item of tangible personal property.

D. For purposes of determining compliance with the limitations of Section 23, investments acquired by an insurer under this section shall be aggregated with those acquired under Section 24, and each lessee of the property under a lease referred to in this section shall be deemed the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided in Subsection B of this section.

E. Nothing in this section is applicable to tangible personal property lease arrangements between an insurer and its subsidiaries and affiliates under a cost sharing arrangement or agreement permitted under [insert reference to holding company law].

Section 28. Mortgage Loans and Real Estate

A. Mortgage Loans

(l) Subject to the limitations of Section 23, an insurer may acquire, either directly, indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments, obligations secured by mortgages on real estate situated within a domestic jurisdiction, but a mortgage loan which is secured by other than a first lien shall not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority, shall not, at the time of acquisition of the obligation, exceed:

(a) Ninety percent (90%) of the fair market value of the real estate, if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(b) Eighty percent (80%) of the fair market value of the real estate, if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of thirty (30) years or less and periodic payments made no less frequently than annually. Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance which would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the eighty percent (80%) limitation may be increased to ninety-seven percent (97%) if acceptable private mortgage insurance has been obtained; or

(c) Seventy-five percent (75%) of the fair market value of the real estate for mortgage loans that do not meet the requirements of Subparagraphs (a) or (b) of this paragraph.

(2) For purposes of Paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

(3) A mortgage loan that is held by an insurer under Section 3F or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the *NAIC Accounting Practices and Procedures Manual* or successor publication shall continue to qualify as a mortgage loan under this Act.

(4) Subject to the limitations of Section 23, credit lease transactions that do not qualify for investment under Section 24 with the following characteristics shall be exempt from the provisions of Paragraph (1) of this subsection:

(a) The loan amortizes over the initial fixed lease term at least in an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate;

(b) The lease payments cover or exceed the total debt service over the life of the loan;

(c) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO has a full faith and credit obligation to make the lease payments;

(d) The insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(e) The expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking and heating, ventilation and air conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and

(f) There is a perfected assignment of the rents due pursuant to the lease to, or for the benefit of, the insurer.

B. Income Producing Real Estate

(1) An insurer may acquire, manage and dispose of real estate situated in a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income producing or intended for improvement or development for investment purposes under an existing program (in which case the real estate shall be deemed to be income producing).

(2) The real estate may be subject to mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsections D(2) and D(3) of this section.

C. Real Estate for the Accommodation of Business

An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer's (which may include its affiliates) business operations, including home office, branch office and field office operations.

(1) Real estate acquired under this subsection may include excess space for rent to others, if the excess space, valued at its fair market value, would otherwise be a permitted investment under Subsection B of this section and is so qualified by the insurer;

(2) The real estate acquired under this subsection may be subject to one or more mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsection D(4) of this section; and

(3) For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively. An insurer may acquire real estate used for these purposes under Subsection B of this section.

D. Quantitative Limitations

(1) An insurer shall not acquire an investment under Subsection A of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under Subsection A of this section would exceed:

(a) One percent (1%) of its admitted assets in mortgage loans covering any one secured location;

(b) One quarter of one percent (.25%) of its admitted assets in construction loans covering any one secured location; or

(c) One percent (1%) of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under Subsection B of this section if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under Subsection B of this section plus the guarantees then outstanding would exceed:

(a) One percent (1%) of its admitted assets in any one parcel or group of contiguous parcels of real estate, except that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively, such as hospitals, medical clinics, medical professional buildings or other health facilities used for the purpose of providing health services; or

(b) The lesser of ten percent (10%) of its admitted assets or forty percent (40%) of its surplus as regards policyholders in the aggregate, except for an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively, this limitation shall be increased to fifteen percent (15%) of its admitted assets in the aggregate.

(3) An insurer shall not acquire an investment under Subsection A or B of this section if, as a result of and after giving effect to the investment and any guarantees it has made in connection with the investment, the aggregate amount of all investments then held by the insurer under Subsections A and B of this section plus the guarantees then outstanding would exceed twenty-five percent (25%) of its admitted assets.

(4) The limitations of Section 23 shall not apply to an insurer's acquisition of real estate under Subsection C of this section. An insurer shall not acquire real estate under Subsection C of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of all real estate then held by the insurer under Subsection C of this section would exceed ten percent (10%) of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under Subsection C of this section.

Section 29. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions

An insurer may enter into securities lending, repurchase, reverse repurchase and dollar roll transactions with business entities, subject to the following requirements:

A. The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan in Section 4A that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

B. The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

(1) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(2) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

C. Cash received in a transaction under this section shall be invested in accordance with this Act and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the commissioner:

(1) Possession of the acceptable collateral;

(2) A perfected security interest in the acceptable collateral; or

(3) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

D. The limitations of Sections 23 and 30 shall not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer's future obligation to resell securities, in the case of a reverse repurchase transaction, or to repurchase securities, in the case of a repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned, sold to or purchased from any one business entity counterparty under this section would exceed five percent (5%) of its admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned, sold to or purchased from all business entities under this section would exceed forty percent (40%) of its admitted assets but the limitation of this subsection shall not apply to reverse repurchase transactions for so long as the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and subject to a plan approved by the commissioner.

E. In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102 percent of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the market value of the loaned securities.

F. In a repurchase transaction, (other than a dollar roll transaction), the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five percent (95%) of the market value of the transferred securities.

G. In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

H. In a reverse repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102 percent of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100 percent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the purchase price. Securities acquired by an insurer in a reverse repurchase transaction shall not be sold in a repurchase transaction, loaned in a securities lending transaction or otherwise pledged.

Drafting Note: Subsections E, F, and H of this section contain requirements that at the time of drafting this model act were contained in the *Purposes and Procedures of the Investment Analysis Office*. However, concomitant with the drafting of this model act, a separate task force was considering a revised publication which did not contain these requirements inasmuch as the SVO considered these requirements as accounting-type rules which were deemed not suitable to such a publication. Moreover, another third working group was developing a draft of a revised accounting manual but had not considered proposing separate accounting guidance regarding these requirements. Instead, the accounting manual implicitly referred to the requirements stipulated in this model act. Pending the results of consideration of these requirements by the three groups, in concert, these requirements have been included in this model act. If after due consideration, these requirements are included in the revised accounting manual as representative of statutory accounting principles or, in the alternative, are inserted in the revised *Purposes and Procedures of the Investment Analysis Office*, then States may opt not to codify these requirements within their insurer investment code.

Section 30. Foreign Investments and Foreign Currency Exposure

A. Subject to the limitations of Section 23, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer is permitted to acquire under this Act, other than of the type permitted under Section 25, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investments then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of foreign investments then held by the insurer under this subsection in a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or five percent (5%) of its admitted assets as to any other foreign jurisdiction.

B. Subject to the limitations of Section 23, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under Subsection A of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(1) The aggregate amount of investments then held by the insurer under this subsection denominated in foreign currencies does not exceed fifteen percent (15%) of its admitted assets; and

(2) The aggregate amount of investments then held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed ten percent (10%) of its admitted as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or five percent (5%) of its admitted assets as to any other foreign jurisdiction.

(3) However, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under Section 31 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

C. In addition to investments permitted under Subsections A and B of this section, an insurer that is authorized to do business in a foreign jurisdiction, and that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction, subject to the limitations of Section 23. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 23 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

(1) The amount the insurer is required by law to invest in the foreign jurisdiction; or

(2) One hundred twenty-five percent (125%) of the amount of its reserves, net of reinsurance, and other obligations under the contracts.

D. In addition to investments permitted under Subsections A and B of this section, an insurer that is not authorized to do business in a foreign jurisdiction but which has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in a foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction subject to the limitations set forth in Section 23. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 23 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105 percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts on risks resident or located in the foreign jurisdiction.

E. Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this Act, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions and government sponsored enterprises of these persons, except for those exempted

under Subsections C and D of this section, shall be subject to the limitations of Section 23.

Section 31. Derivative Transactions

An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions :

A. General Conditions

(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the commissioner.

(2) An insurer shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of transactions through cash flow testing or other appropriate analyses.

B. Limitations on Hedging Transactions

An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction :

(1) The aggregate statement value of options, caps, floors and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps and floors written in hedging transactions does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of its admitted assets.

C. Limitations on Income Generation Transactions

An insurer may only enter into the following types of income generation transactions if as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold; or

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this Act, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold.

D. Counterparty Exposure

An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of Section 23.

E. Additional Transactions

Pursuant to regulations promulgated under Section 8, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of Subsection B of this section or for other risk management purposes under regulations promulgated by the commissioner, but replication transactions shall not be permitted for other than risk management purposes.

Section 32. Additional Investment Authority

A. An insurer may acquire under this section investments, or engage in investment practices, of any kind that are not specifically prohibited by this Act, or engage in investment practices, without regard to any limitation in Sections 23 through 30, but an insurer shall not acquire an investment or engage in an investment practice under this section if, as a result of and after giving effect to the transaction, the aggregate amount of the investments then held by the insurer under this section would exceed the greater of:

(1) Its unrestricted surplus; or

(2) The lesser of:

(a) Ten percent (10%) of its admitted assets; or

(b) Fifty percent (50%) of its surplus as regards policyholders.

B. An insurer shall not acquire any investment or engage in any investment practice under Subsection A(2) of this section if, as a result of and after giving effect to the transaction the aggregate amount of all investments in any one person then held by the insurer under that subsection would exceed five percent (5%) of its admitted assets.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 11, 33, 50-86, 264 (adopted).
2001 Proc. 1st Quarter 373-374 (amendments adopted later are printed here).
2001 Proc. 2nd Quarter 11, 14, 319, 339 (amended).
2017 3rd Quarter (technical edits)

INVESTMENTS OF INSURERS MODEL ACT

(Defined Limits Version)

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INVESTMENTS OF INSURERS MODEL ACT
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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-41-1 to 27-41-41 (1977/2013) (life).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.201 to 21.399 (2001/2005).		ALASKA STAT. §§ 21.21.010 to 21.21.420 (1966/2001) (authority to adopt regulations consistent with defined limits version).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-531 to 20-562 (1954/2000).
Arkansas			ARK. CODE ANN. §§ 23-63-801 to 23-63-842 (1959/2015).
California			CAL. INS. CODE §§ 1170 to 1212 (1935/2009).
Colorado			COLO. REV. STAT. §§ 10-3-213 to 10-3-243 (1969/2015).
Connecticut			CONN. GEN. STAT. §§ 38a-102 to 38a-102*i* (1991/2010); BULLETIN FS-14c-00 (2000).
Delaware			DEL. CODE ANN. tit. 18, §§ 1301 to 1334 (1953/2014).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. CODE §§ 31-1371.01 to 31-1375.01 (2002).		
Florida			FLA. STAT. §§ 625.301 to 625.340 (1959/1993).
Georgia			GA. CODE ANN. §§ 33-11-80 to 33-11-89 (1999); §§ 33-11-50 to 33-11-67 (1999/2008).
Guam			GUAM CODE ANN. tit. 22, § 15317 (1951/2015).
Hawaii			HAW. REV. STAT. §§ 431:6-101 to 431:6-501 (1987/2009); §§ 431:6-401 to 431:6-404 (1987); §§ 431:6-601 to 431:6-602 (1987/2008).
Idaho			IDAHO CODE ANN. §§ 41-701 to 41-736 (1961/2014).
Illinois	215 ILL. COMP. STAT. 5/126.1 to 5/126.32 (1997).		
Indiana			IND. CODE §§ 27-1-12-2 to 27-1-12-3.5 (1935/2020) (Life); §§ 27-1-13-3 to 27-1-13-3.5 (1935/2020) (P/C).
Iowa			IOWA CODE §§ 511.8 (1963/2023) (life); § 515.35 (1947/2015) (P/C); IOWA ADMIN. CODE r. 191-5.32 (1963/2021).
Kansas			KAN. STAT. ANN. §§ 40-2a01 to 40-2a28 (1972/2015) (P/C); §§ 40-2b01 to 40-2b30 (1972/2019) (life).
Kentucky	KY. REV. STAT. ANN. §§ 304.7-010 to 304.7-473 (2000/2010).		

INVESTMENTS OF INSURERS MODEL ACT
(Defined Limits Version)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Louisiana			LA. REV. STAT. ANN. §§ 22:601.1 to 22:601.21 (2021).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1101 to 1137 (1969/2023) (P/C); §§ 1151 to 1161 (1987/2021) (life).
Maryland			MD. CODE ANN., INS. §§ 5-501 to 5-512 (1922/2015) (life); §§ 5-601 to 5-609 (1943/2006) (P/C).
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 63 to 68 (1817/2006).
Michigan			MICH. COMP. LAWS §§ 500.901 to 500.947 (1956/2014).
Minnesota			MINN. STAT. § 60A.11 (1967/2019) (P/C); §§ 61A.28 to 61A.315 (1969/2001); §§ 60L.01 to 60L.15 (1998/2009).
Mississippi			MISS. CODE ANN. §§ 83-19-51 to 83-19-55 (1892/2010).
Missouri			MO. REV. STAT. §§ 375.325 to 375.355 (1939/2007); §§ 375.532 to 375.534 (1991/2005) (All insurers); §§ 376.291 to 376.311 (1939/2007) (life) §§ 376.311, 379.083 (1997/2002); § 375.345 (2002); MO. CODE REGS. ANN. tit. 20, § 200-12.020 (2009/2015).
Montana	MONT. CODE ANN. §§ 33-12-101 to 33-12-312 (1999/2001) (portions of model).		
Nebraska			NEB. REV. STAT. §§ 44-5101 to 44-5154 (1991/2022).

INVESTMENTS OF INSURERS MODEL ACT
(Defined Limits Version)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NEV. REV. STAT. §§ 682A.005 to 682A.572 (1971/2015).		
New Hampshire			N.H. REV. STAT. ANN. §§ 402:27 to 402:30-a (1917/1991) (all insurers); §§ 411-A:1 to 411-A:37 (1978/2009) (life).
New Jersey	N.J. STAT. ANN. §§ 17:24-28 to 17:24-36 (1999) (Section 25).		N.J. STAT. ANN. §§ 17:24-1 to 17:24-16 (1902/2023) (P/C);§§ 17B:20-1 to 17B:20-8 (1971/2005) (life).
New Mexico			N.M. STAT. ANN. §§ 59A-9-1 to 59A-9-27 (1984/1988).
New York			N.Y. INS. LAW §§ 1401 to 1415 (1984/2013).
North Carolina			N.C. GEN. STAT. §§ 58-7-165 to 58-7-205 (1991/2011).
North Dakota			N.D. CENT. CODE §§ 26.1-05-18 to 26.1-05-28 (1983/2001).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3907.14 to 3907.21(1953/2014); §§ 3925.19 to 3925.21 (1953/2014) (life); §§ 3925.05 to 3925.11 (1953) (P/C).
Oklahoma			OKLA. STAT. tit. 36, §§ 1601 to 1629 (1957/2012).
Oregon			OR. REV. STAT. §§ 733.510 to 733.780 (1959/2013).
Pennsylvania			40 PA. STAT. ANN. §§ 504.1 to 506.1 (1986/2010) (Life); 40 PA. STAT. ANN. §§ 721 to 729 (P/C) (1921/1992).
Puerto Rico			P.R. LAWS ANN. tit. 26, § 648-662 (2003).

INVESTMENTS OF INSURERS MODEL ACT
(Defined Limits Version)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island			R.I. GEN. LAWS §§ 27-11-1 to 27-11-3 (1947/1956); §§ 27-11.1-1 to 27-11.1-8 (1984/2002).
South Carolina	S.C. CODE ANN. §§ 38-12-10 to 38-12-510 (2002).		
South Dakota			S.D. CODIFIED LAWS §§ 58-27-1 to 58-27-111 (1966/2005); S.D. ADMIN. R. 20:06:26:01 (2005/2014).
Tennessee			TENN. CODE ANN. §§ 56-3-301 to 56-3-307 (1907/1998) (life); §§ 56-3-401 to 56-3-409 (1979/1984) (P/C).
Texas			TEX. INS. CODE ANN. §§ 424.001 to 424.218 (2005/2013); TEX. INS. CODE ANN. §§ 425.001 to 425.009 (2007); TEX. INS. CODE ANN. §§ 425.101 to 425.232 (2007).
Utah			UTAH CODE ANN. §§ 31A-18-101 to 31A-18-110 (1985/2011).
Vermont			VT. STAT. ANN. tit. 8, §§ 3461 to 3472 (1967/2003).
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 551 to 583 (1968).
Virginia			VA. CODE ANN. §§ 38.2-1400 to 38.2-1447 (1986/2014).
Washington			WASH. REV. CODE ANN. §§ 48.13.005 to 48.13.360 (1947/2011).
West Virginia	W. VA. CODE §§ 33-8-1 to 33-8-32 (1957/2004).		
Wisconsin			WIS. STAT. §§ 620.01 to 620.25 (1971/1992).
Wyoming			WYO. STAT. ANN. §§ 26-7-101 to 26-7-116 (1967/2001).

DERIVATIVE INSTRUMENTS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted and promulgated by the Commissioner of Insurance pursuant to [insert citation to state law equivalent to Section 8 of the Investments of Insurers Model Act].

Section 2. Purpose

The purpose of this regulation is to set standards for the prudent use of derivative instruments in accordance with [insert citation to state law equivalent to Section 9 and 18 of the Investments of Insurers Model Act].

Section 3. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether for-profit or not-for-profit.

B. "Counterparty exposure amount" means:

(1) The net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse ("over-the-counter derivative instrument"). The amount of credit risk equals:

(a) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurance company; or

(b) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurance company.

(2) If over-the-counter derivative instruments are entered into pursuant to a written master agreement which provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or if not within the United States, within a foreign jurisdiction listed in the *Purposes and Procedures of the Securities Valuation Office* as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(a) The market value of the over-the-counter derivative instruments entered into pursuant to the agreement, the liquidation of which would result in a final cash payment to the insurance company; and

(b) The market value of the over-the-counter derivative instruments entered into pursuant to the agreement, the liquidation of which would result in a final cash payment by the insurance company to the business entity.

(3) For open transactions, market value shall be determined at the end of the most recent quarter of the insurance company's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurance company or placed in escrow by one or both parties.

C. (1) "Derivative instrument" means an agreement, option, instrument or a series or combination thereof:

(a) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(b) That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(2) Derivative instruments include options, warrants, caps, floors, collars, swaps, forwards, futures and any other agreements, options or instruments substantially similar thereto or any series or combination thereof. Derivative instruments shall additionally include any agreements, options or instruments permitted under regulations adopted pursuant to [insert citation to state law equivalent to Section 8 of the Investments of Insurers Model Act]. Derivative instruments shall not include an investment authorized by [insert state law equivalent to Sections 11 through 17, 19 and 24 through 30 of the Investments of Insurers Model Act].

D. "Qualified clearinghouse" means a clearinghouse for, and subject to the rules of a qualified exchange or a qualified foreign exchange, which clearinghouse provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

E. "Qualified exchange" means:

(1) A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78 *et seq.*), as amended;

(2) A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission or any successor thereof;

(3) Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

(4) A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended; or

(5) A qualified foreign exchange.

F. "Qualified foreign exchange" means a foreign exchange, board of trade or contract market located outside the United States, its territories or possessions:

(1) That has received regulatory comparability relief pursuant to Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30);

(2) That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief pursuant to Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations, 17 C.F.R. Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade or contract market is located; or

(3) Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's Office of General Counsel, but an exchange, board of trade or contract market that qualifies as a "qualified foreign exchange" only under this paragraph shall only be a "qualified foreign exchange" as to foreign stock index futures contracts that are the subject of such no-action relief under this paragraph.

Section 4. Guidelines and Internal Control Procedures

A. Before engaging in a derivative transaction, an insurance company shall establish written guidelines, approved by the Commissioner, that shall be used for effecting and maintaining derivative transactions. The guidelines shall:

(1) Specify insurance company objectives for engaging in derivative transactions and derivative strategies and all applicable risk constraints, including credit risk limits;

(2) Establish counterparty exposure limits and credit quality standards

(3) Identify permissible derivative transactions and the relationship of those transactions to insurance company operations; for example, a precise identification of the risks being hedged by a derivative transaction; and

(4) Require compliance with internal control procedures.

B. An insurance company shall have a written methodology for determining whether a derivative instrument used for hedging has been effective.

C. An insurance company shall have written policies and procedures describing the credit risk management process and a credit risk management system for over-the-counter derivative transactions that measures credit risk exposure using the counterparty exposure amount.

D. An insurance company's board of directors shall, in accordance with [insert citation to state law equivalent of Section 4 of the Investments of Insurers Model Act]:

(1) Approve the written guidelines, methodology and policies and procedures required by Subsection A, B and C respectively, of this section and the systems required by Subsections B and C of this section; and

(2) Determine whether the insurance company has adequate professional personnel, technical expertise and systems to implement investment practices involving derivatives.

(3) Review whether derivatives transactions have been made in accordance with the approved guidelines and consistent with stated objectives.

(4) Take action to correct any deficiencies in internal controls relative to derivative transactions.

Section 5. Commissioner Approval

Written documentation explaining the insurance company's internal guidelines and controls governing derivative transactions shall be submitted for approval to the Commissioner. The Commissioner shall have the authority to disapprove the guidelines and controls proposed by the company if the insurance company cannot demonstrate the proposed internal guidelines and controls would be adequate to manage the risks associated with the derivative transactions the insurance company intends to engage in.

Section 6. Documentation Requirements

An insurance company shall maintain documentation and records relating to each derivative transaction, such as:

A. The purpose or purposes of the transaction;

B. The assets or liabilities to which the transaction relates;

C. The specific derivative instrument used in the transaction;

D. For over-the-counter derivative instrument transactions, the name of the counterparty and the market value; and

E. For exchange traded derivative instruments, the name of the exchange and the name of the firm that handled the trade and the market value.

Section 7. Trading Requirements

Each derivative instrument shall be:

A. Traded on a qualified exchange;

B. Entered into with, or guaranteed by, a business entity;

C. Issued or written with the issuer of the underlying interest on which the derivative instrument is based; or

D. Entered into with a qualified foreign exchange.

Section 8. Effective Date

This regulation shall become effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 33, 264 (adopted).
2009 Proc. 2nd Quarter, Vol. II 116, 119-129 (amended).

DERIVATIVE INSTRUMENTS MODEL REGULATION

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If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

DERIVATIVE INSTRUMENTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA ADMIN. CODE tit. 3, § 21.271 (2001/2011); § 21.365 (2001/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-560 (2012).
Arkansas			ARK. CODE ANN. § 23-63-841 (2005/2009).
California			CAL. CODE REGS. tit. 10, §§ 2690.90 to 2690.94 (2007); BULLETIN 95-5A (1995).
Colorado	3 COLO. CODE REGS. § 702-3:3-2-8 (2014).		
Connecticut			BULLETIN FS-14c-00 (2000).
Delaware	18 DEL. ADMIN. CODE §§ 404-1.0 to 404-15.0 (2014) (portions of model).		
District of Columbia			D.C. Code § 31-1372.10 (2002).

DERIVATIVE INSTRUMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. § 33-11-56 (1999).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE. tit. 50, §§ 806.10 to 806.60 (1998/2001).		BULLETIN 92-2 (1992).
Indiana	IND. CODE § 27-1-12-2.2 (2012); § 27-1-13-3 (1986/2012) (portions of model).		
Iowa	IOWA ADMIN. CODE r. 191-49.1 to 191-49.5 (2002) (portions of model).		IOWA ADMIN. CODE r. 191-93.6 (2006/2009).
Kansas			KAN. STAT. ANN. § 40-2b25 (1985/2001).
Kentucky	806 KY. ADMIN. REGS 7:110 (2013).		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. tit. 24-A, § 1153 (1987/2000).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. COMP. LAWS ANN. § 500.943 (1987/2002) (portions of model).		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		

DERIVATIVE INSTRUMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri			MO. ANN. STAT. § 375.345 (1985/2007).
Montana			MONT. CODE ANN. § 33-12-210 (1999).
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. ANN. § 682A.568 (2015).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 178.0 to 178.8 (Regulation 168) (2001) (portions of model).		
North Carolina	N.C. GEN. STAT. ANN. § 58-7-205 (2001).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-3-12 (2014) (portions of model).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania			40 PA. STAT. ANN. 504.2 (1986/2010).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. §§ 38-12-300; 38-12-510 (2002).

DERIVATIVE INSTRUMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. § 56-3-303 (1983/1999).
Texas	TEX. INS. CODE ANN. §§ 425.125 to 425.129 (2005) (portions of model).		
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, § 3463 (1999/2003).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-1428 (2001/2011).
Washington	WASH. ADMIN. CODE §§ 284-13-900 to 284-13-960 (2014).		
West Virginia			W. VA. CODE ANN. §§ 33-8-2; 33-8-18; 33-8-21 (2004).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY REPORT - 2009

DERIVATIVES INSTRUMENT MODEL REGULATION (#282)

1. Description of the project, issues addressed, etc.

The review of Model 282 was conducted at the request of senior NAIC staff to determine its continued relevance to the NAIC regulatory framework for investments. Senior NAIC staff placed the request for review on the agenda of the Valuation of Securities (E) Task Force in the winter of 2005. The Valuation of Securities (E) Task Force formed the Derivatives Market Study (E) Working Group and charged it with studying the derivatives market to determine whether the NAIC should consider changes in regulation and whether it should discard or revise and retain the Model Regulation. The Working Group concluded that:

- Credit derivatives are a large and growing portion of fixed income markets. Credit derivatives can be a suitable part of insurer investment strategies. Greater participation by insurers in this market is impeded by market infrastructure issues. Insurer participation in derivatives is likely to increase in proportion to improvements in infrastructure.

- The principal risk in credit derivative investment is credit risk. However, other risks arise primarily because credit derivative markets are at an earlier stage of development.

- Risks or issues specific to credit derivatives include:

    - Documentation – Trade documentation processing has not kept up with trade volume. Backlogs could exacerbate market disruptions. The Federal Reserve and trade associations appear to be addressing this issue.

    - Settlement – The outstanding volume of credit derivatives is often several times larger than the outstanding underlying securities available to settle default events. A more robust settlement framework is under development.

    - Legal – Case and statutory law pertaining to enforceability of credit derivative contracts are not as well established as for bonds and loans.

    - Complexity – Cash flow and risk characteristics of credit derivatives are complex. This poses training challenges for investment and risk management professionals and for examiners and regulators.

    - Counterparty concentration risk – One of fourteen large money center banks is a counterparty to most credit derivative contracts. Their net exposure to underlying entities is unknown and could become a performance issue upon occurrence of major credit events.

These considerations led the Working Group to recommend a complete revision in the NAIC approach to derivative investments. The revisions to the Model Regulation must be understood as part of this broader effort to modernize the NAIC regulatory framework for derivatives. The Working Group made the following recommendations and referrals:

- The Capital Adequacy (E) Task Force should consider allowing credit for derivative hedges that reduce an insurer's risk.

- Certain types of derivative transactions are not captured on NAIC Schedule DB, including derivative transactions by subsidiaries, risk transferred to an insurer via insurance contracts, default swaps written as surety bonds and others.

- NAIC derivative schedules require a complete revision to reduce the number of schedules, elicit information that is relevant and meaningful to regulators and to reflect current derivative practices.

- Derivatives, including credit default swaps, represent a significant portion of financial instruments available for insurers. Public policy and practical financial solvency monitoring procedures require uniform and robust state regulator oversight of this activity. Model Regulation 282 should be revised and retained as a national standard despite the seemingly limited number of states that have embraced the Model Regulation.

- Model Regulation 282 should be revised to require a derivative use plan that has been reviewed and approved by the Commissioner before the company is authorized to engage in derivatives transactions.

2. Name of group responsible for draft the model:

The Derivatives Market Study (E) Working Group of the Valuation of Securities (E) Task Force:

States Participating:
New York, Chair
California, Vice Chair
Connecticut
Delaware
Illinois
Minnesota
Virginia

3. Project authorized by what charge and date first given to the group:

The following charge was given to the Derivatives Market Study (E) Working Group in 2006:

The charge of the Derivatives Market Study (E) Working Group of the Valuation of Securities (E) Task Force is to provide an updated understanding of the derivatives marketplace in order to permit an assessment whether developments in the derivatives marketplace since the early 1990s requires changes in regulation. The findings of the Working Group will be disseminated, among others, to senior NAIC staff to permit a determination whether NAIC Model Regulation 282 should be discarded or revised and retained and if so, in what form.

The Working Group will consider current regulatory guidance for derivatives, hear testimony of participants and experts in the derivatives markets about the derivative market today, consider the activities of insurance companies in the derivatives market and conduct whatever other activities seem appropriate to it in the fulfillment of this charge.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The amendments to the model act were drafted by the members of the Working Group in public hearings.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

The Working Group held a series of public meetings during which it took testimony from derivatives experts, federal regulators and industry. Speakers included J. P. Morgan Securities, the International Swaps and Derivatives Association (ISDA), TIAA-CREF, and the Office of Comptroller of the Currency (OCC). In a series of public hearings, the Working Group reviewed the existing NAIC framework for derivatives in which it discussed seeming shortcomings in the NAIC regulatory framework given the testimony it had heard about current derivative practices. It was in this time period that the Working Group identified the issues discussed in paragraph 1 above. It was only at the conclusion of this process that the Working Group turned to a consideration whether the Model Regulation should be revised and retained or discarded. New York led the effort to revise the Model Regulation making proposal for revisions in a series of public hearings and providing ample time for review comment by interested persons. It was during this time frame that the NAIC changed the process governing the amendment of model regulation, so the Working Group concluded its review and made its final recommendations to the Valuation of Securities (E) Task Force. The Task Force suspended work on the Model Regulation while it complied with the new NAIC model law procedure. At the conclusion of that process, the proposed revisions to the Model Regulation were again released for comment and a hearing heard during the NAIC 2009 Spring National Meeting to hear such comments. The Task Force adopted the revisions at the Spring National Meeting.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

There were two primary changes made to Model Regulation 282. The first was the addition of the requirement of a written derivative use plan that contained a statement of planned derivative activity, the relationship of planned activity to company operations, the policies and procedures that would govern the derivative activity and the command-and-control process that would be employed to manage the risks of derivative transactions. The second change was a requirement that the derivative use plan be reviewed and approved by the Commissioner before the insurer could engage in derivatives transactions.

The proposed prior approval standard was not universally accepted by the members. Some members were concerned that state insurance departments lack the resources to properly evaluate derivative use plans. Other states preferred a file and use standard because they felt it insulated them from legal claims of responsibility for the results of insurer results under derivative use plans. In response to these concerns, the SVO staff conducted legal research and a survey of the states. The legal research supported the view that insurance departments, already responsible for regulation, would be better served by evidence of proactive assessment of the appropriateness of an insurer's planned use of derivatives. The survey demonstrated that while the respondents were almost evenly split on which standard should be reflected in the Model Regulation, there was unanimous agreement that the prior approval standard was most consistent with professional responsibility and reflected best practices. The Valuation of Securities (E) Task Force concluded that the better regulatory response was to require the prior approval standard and that states lacking resources to properly review derivative use plan should rely on the expertise of the Securities Valuation Office for such assessment or prohibit the use of derivatives for companies in that state.

A second issue was in part policy and in part procedural. The policy issue centered on the amended model regulation process: was it a condition to national standard status for the members to be nearly unanimous in their commitment to adopt a model law or regulation? Only four states (CA, CT, IL and NY) could be identified as having adopted the Model Regulation. However, nineteen states had adopted the derivatives portion of the Investment of Insurers Model Regulation (Defined Limits Version). The Valuation of Securities (E) Task Force concluded that the Model Regulation should be retained as a national standard irrespective of the relative level of interest by the states, given the nature of derivative transactions and their potential impact on financial solvency of insurers.

7. Any other important information (e.g., amending an accreditation standard).

None.

INVESTMENTS OF INSURERS MODEL ACT
(Defined Standards Version)

Table of Contents

Statement of Principles

The development of regulation of the investments of insurers requires an analysis of the complexities, uncertainties, and competitive forces and frequent changes in the investment markets and in the insurance business, the diversity among insurers, and the need for a balance among risk, reward and liquidity of an insurer's investments. It also requires an analysis of how to safeguard the financial condition of domestic insurers and at the same time to permit domestic insurers to be competitive with insurers domiciled in other states and with other financial industries that operate under different regulatory regimes.

Each state is urged to determine through independent study which methods are best suited to its needs, and whether its existing regulatory structure may be improved by using provisions from either or both of the model laws recommended by the National Association of Insurance Commissioners (NAIC) or from existing regulatory structures in other states or industries. Two alternative model laws are recommended by the NAIC. These are:

A. Investments of Insurers Model Act (Defined Limits Version);

B. Investments of Insurers Model Act (Defined Standards Version).

These model laws are not considered by the NAIC to exhaust regulatory methods to address the regulation of investments of insurers. Nor are these model laws recommended by the NAIC to be used as standards for the examination of insurers unless substantially similar provisions are found in the statutes and regulations of the state of domicile of the insurer.

Drafting Note: States considering provisions in this model should also read the statement of principles and annotations prepared by the drafters to supplement and explain significant concepts in investment statutes.

Section 1. Purpose and Scope

A. The purpose of this Act is to protect and to further the interests of insureds, creditors and the general public by providing, with minimum interference with management initiative and judgment, prudent standards for the development and administration of insurer investment programs.

B. This Act and the regulations adopted to interpret and implement it apply to domestic insurers and U. S. branches of alien insurers entered through this state, except for insurers organized pursuant to [cite statutes applicable to exempted insurers].

Drafting Note: This Act does not define the types of insurers subject to its provisions, leaving this to other sections of the code since state laws treat insurers writing various lines of insurance differently. For example, if an entity is authorized to operate as a health maintenance organization, the state may provide different investment authority commensurate to operating as a health maintenance organization.

C. Separate accounts established in accordance with [cite statutes allowing the creation and maintenance of separate accounts] shall be evaluated separately pursuant to that section.

Section 2. Definitions

For purposes of this Act:

A. "Derivative instrument" means an item appropriately reported in schedule DB (derivative instruments) or schedule DC (insurance futures and insurance futures options) of an insurer's statutory financial statement (or successor schedules), pursuant to applicable annual statement instructions or statutory accounting guidelines.

B. "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

C. "Income generation" means a derivative transaction involving the writing of covered options, caps or floors that is intended to generate income or enhance return.

D. "Lower grade investment" means a rated credit instrument or debt-like preferred stock rated 4, 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners (NAIC) or any successor office.

E. "Medium grade investment" means a rated credit instrument or debt-like preferred stock rated 3 by the Securities Valuation Office of the NAIC or any successor office.

F. "Minimum asset requirement" is the sum of an insurer's liabilities and its minimum financial security benchmark.

G. "Minimum financial security benchmark" is the amount an insurer is required to have under Section 3.

H. "Replication" means a derivative transaction involving one or more derivative instruments being used to modify the cash flow characteristics of one or more investments held by an insurer in a manner so that the aggregate cash flows of the derivative instruments and investments reproduce the cash flows of another investment having a higher risk-based capital charge than the risk-based capital charge of the original investments or investments.

I. "SVO listed mutual fund" means a money market mutual fund or short-term bond fund that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, and that has been determined by the NAIC's Securities Valuation Office to be eligible for special reserve and reporting treatment (other than as common stock).

Section 3. Minimum Financial Security Benchmark

A. Minimum Financial Security Benchmark.

(1) Unless otherwise established in accordance with Paragraphs (2) and (3) of this subsection, the amount of the minimum financial security benchmark for an insurer shall be the greater of:

(a) The authorized control level risk-based capital applicable to the insurer as set forth by [insert reference to the risk-based capital law] less the asset valuation reserve and voluntary investment reserves as defined under [insert reference to the risk-based capital law]; or

(b) The minimum capital or minimum surplus required by statute or regulation for maintenance of an insurer's certificate of authority.

(2) The commissioner may, in accordance with the factors in Subsection B(2) of this section, establish by order a minimum financial security benchmark to apply to a specific insurer provided it is not less than the amount determined by Paragraph (1) of this subsection.

(3) Except as provided in [cite applicable state laws consistent with drafting note following Section 1B], the commissioner may establish by regulation a minimum financial security benchmark that is a multiple of authorized control level risk-based capital to apply to any class of insurers provided the amount established by the regulation is not less than the amount determined in Paragraph (1) of this subsection.

B. The commissioner shall determine the amount of surplus that shall constitute an insurer's minimum financial security benchmark, as an amount that will provide reasonable security against contingencies affecting the insurer's financial position that are not fully covered by reserves or by reinsurance.

Drafting Note: Insert the title of the chief insurance regulatory officer whenever the term "commissioner" appears.

(1) Types of contingencies. The commissioner shall consider the risks of:

(a) Increases in the frequency or severity of losses beyond the levels contemplated by the rates charged;

(b) Increases in expenses beyond those contemplated by the rates charged;

(c) Decreases in the value of or the return on invested assets below those planned on;

(d) Changes in economic conditions that would make liquidity more important than contemplated and would force untimely sale of assets or prevent timely investments;

(e) Currency devaluation to which the insurer may be subject; and

(f) Any other contingencies the commissioner can identify that may affect the insurer's operations.

(2) Controlling factors. In making the determination under this subsection, the commissioner shall take into account the following factors:

(a) The most reliable information available as to the magnitude of the various risks under Paragraph (1) of this subsection;

(b) The extent to which the risks in Paragraph (1) of this subsection are independent of each other or are related, and whether any dependency is direct or inverse;

(c) The insurer's recent history of profits or losses;

(d) The extent to which the insurer has provided protection against the contingencies in other ways than the establishment of surplus; including redundancy of premiums, adjustability of contracts under their terms, investment valuation reserves whether voluntary or mandatory, appropriate reinsurance, the use of conservative actuarial assumptions to provide a margin of security, reserve adjustments in recognition of previous rate inadequacies, contingency or catastrophe reserves, diversification of assets and underwriting risks;

(e) Independent judgments of the soundness of the insurer's operations, as evidenced by the ratings of reliable professional financial reporting services; and

(f) Any other relevant factors.

Section 4. Authorized Investments

A. Subject to the provisions of this Act, an insurer may loan or invest its funds, and may buy, sell, hold title to, possess, occupy, pledge, convey, manage, protect, insure and deal with its investments, property and other assets to the same extent as any other person or corporation under the laws of this state and of the United States.

B. With respect to all of the insurer's investments, the board of directors of an insurer shall exercise the judgment and care, under the circumstances then prevailing, that persons of reasonable prudence, discretion and intelligence exercise in the management of a like enterprise, not in regard to speculating but in regard to the permanent disposition of their funds, considering the probable income as well as the probable safety of their capital. Investments shall be of sufficient value, liquidity and diversity to assure the insurer's ability to meet its outstanding obligations based on reasonable assumptions as to new business production for current lines of business. As part of its exercise of judgment and care, the board of directors shall take into account the prudence evaluation criteria of Section 5 of this Act.

C. The insurer shall establish and implement internal controls and procedures to assure compliance with investment policies and procedures to assure that:

(1) The insurer's investment staff and any consultants used are reputable and capable;

(2) A periodic evaluation and monitoring process occurs for assessing the effectiveness of investment policy and strategies;

(3) Management's performance is assessed in meeting the stated objectives within the investment policy; and

(4) Appropriate analyses are undertaken of the degree to which asset cash flows are adequate to meet liability cash flows under different economic environments. These analyses shall be conducted at least annually and make specific reference to economic conditions.

Section 5. Prudence Evaluation Criteria

The following factors shall be evaluated by the insurer and considered along with its business in determining whether an investment portfolio or investment policy is prudent; the commissioner shall consider the following factors prior to making a determination that an insurer's investment portfolio or investment policy is not prudent:

A. General economic conditions;

B. The possible effect of inflation or deflation;

C. The expected tax consequences of investment decisions or strategies;

D. The fairness and reasonableness of the terms of an investment considering its probable risk and reward characteristics and relationship to the investment portfolio as a whole;

E. The extent of the diversification of the insurer's investments among:

(1) Individual investments;

(2) Classes of investments;

(3) Industry concentrations;

(4) Dates of maturity; and

(5) Geographic areas;

F. The quality and liquidity of investments in affiliates;

G. The investment exposure to the following risks, quantified in a manner consistent with the insurer's acceptable risk level identified in Section 6H:

(1) Liquidity;

(2) Credit and default;

(3) Systemic (market);

(4) Interest rate;

(5) Call, prepayment and extension;

(6) Currency; and

(7) Foreign sovereign;

H. The amount of the insurer's assets, capital and surplus, premium writings, insurance in force, and other appropriate characteristics;

I. The amount and adequacy of the insurer's reported liabilities;

J. The relationship of the expected cash flows of the insurer's assets and liabilities, and the risk of adverse changes in the insurer's assets and liabilities;

K. The adequacy of the insurer's capital and surplus to secure the risks and liabilities of the insurer; and

L. Any other factors relevant to whether an investment is prudent.

Section 6. Insurer Investment Policy

In acquiring, investing, exchanging, holding, selling and managing investments, an insurer shall establish and follow a written investment policy that shall be reviewed and approved by the insurer's board of directors at least annually. The content and format of an insurer's investment policy are at the insurer's discretion, but shall include written guidelines appropriate to the insurer's business as to the following:

A. The general investment policy of the insurer containing policies, procedures and controls covering all aspects of the investing function;

B. Quantified goals and objectives regarding the composition of classes of investments, including maximum internal limits;

C. Periodic evaluation of the investment portfolio as to its risk and reward characteristics. This subsection shall not preclude an insurer from the use of "modern portfolio theory" to manage its investments;

Drafting Note: States may wish to consider whether it is necessary to include a definition of "modern portfolio theory" as used in Section 6C.

D. Professional standards for the individuals making day-to-day investment decisions to assure that investments are managed in an ethical and capable manner;

E. The types of investments to be made and those to be avoided, based on their risk and reward characteristics and the insurer's level of experience with the investments;

F. The relationship of classes of investments to the insurer's insurance products and liabilities;

G. The manner in which the insurer intends to implement Section 5; and

H. The level of risk (based on quantitative measures) appropriate for the insurer given the level of capitalization and expertise available to the insurer.

Section 7. Authorized Classes of Investments

The following classes of investments may be counted for the purposes specified in Section 11, whether they are made directly or as a participant in a partnership, joint venture or limited liability company:

A. Cash in the direct possession of the insurer or on deposit with a financial institution regulated by any federal or state agency of the United States;

B. Bonds, debt-like preferred stock and other evidences of indebtedness of governmental units in the United States or Canada, or the instrumentalities of the governmental units, or private business entities domiciled in the United States or Canada, including asset-backed securities and SVO listed mutual funds;

C. Loans secured by mortgages, trust deeds, or other security interests in real property located in the United States or Canada or secured by insurance against default issued by a government insurance corporation of the United States or Canada or by an insurer authorized to do business in this state;

D. Common stock or equity-like preferred stock or equity interests in any United States or Canadian business entity, or shares of mutual funds registered with the Securities and Exchange Commission of the United States under the Investment Company Act of 1940, other than SVO listed mutual funds;

E. Real property necessary for the convenient transaction of the insurer's business;

F. Real property, together with the fixtures, furniture, furnishings and equipment pertaining thereto in the United States or Canada, which produces or after suitable improvement can reasonably be expected to produce substantial income;

G. Loans, securities, or other investments of the types described in Subsections A to F of this section in countries other than the United States and Canada;

H. Bonds or other evidences of indebtedness of international development organizations of which the United States is a member;

I. Loans upon the security of the insurer's own policies in amounts that are adequately secured by the policies and that in no case exceed the surrender values of the policies;

J. Tangible personal property under contract of sale or lease under which contractual payments may reasonably be expected to return the principal of and provide earnings on the investment within its anticipated useful life;

K. Other investments the commissioner authorizes by regulation; and

L. Investments not otherwise permitted by this section, and not specifically prohibited by statute, to the extent of not more than five percent (5%) of the first $500,000,000 of the insurer's admitted assets plus ten percent (10%) of the insurer's admitted assets exceeding $500,000,000.

Drafting Note: This Act is silent with respect to an insurer's participation in partnerships as a general partner. States may consider limitations on an insurer's authority to act as a general partner due to the legal complexities attendant on this role. The language in Subsection D of this section in no way authorizes the insurer to act as a general partner.

Section 8. Limitations Generally Applicable

A. Class Limitations. For the purposes of Section 11, the following limitations on classes of investments apply:

(1) Investments authorized by Section 7B, and investments authorized by Section 7G that are of the types described in Section 7B;

(a) The aggregate amount of medium and lower grade investments, twenty percent (20%) of its admitted assets;

(b) The aggregate amount of lower grade investments, ten percent (10%) of its admitted assets;

(c) The aggregate amount of investments rated 5 or 6 by the SVO, five percent (5%) of its admitted assets;

(d) The aggregate amount of investments rated 6 by the SVO, one percent (1%) of its admitted assets; or

(e) The aggregate amount of medium and lower grade investments that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life, one percent (1%) of its admitted assets.

(2) Investments authorized by Section 7C, forty-five percent (45%) of admitted assets in the case of life insurers and twenty-five percent (25%) of admitted assets in the case of non-life insurers;

(3) Investments authorized by Section 7D, other than subsidiaries of the types authorized under [cite applicable provisions of holding company law] twenty percent (20%) of admitted assets in the case of life insurers and twenty-five percent (25%) of admitted assets in the case of non-life insurers;

(4) Investments authorized by Section 7E, ten percent (10%) of admitted assets;

(5) Investments authorized by Section 7F, twenty percent (20%) of admitted assets in the case of life insurers, and ten percent (10%) of admitted assets in the case of non-life insurers;

(6) Investments authorized by Section 7G, twenty percent (20%) of admitted assets;

(7) Investments authorized by Section 7H, two percent (2%) of admitted assets; and

(8) Investments authorized by Section 7J, two percent (2%) of admitted assets.

B. Individual limitations. For purposes of determining compliance with Section 11, securities of a single issuer and its affiliates, other than the government of the United States and subsidiaries authorized under [cite applicable provisions of holding company law], shall not exceed three percent (3%) of admitted assets in the case of life insurers, and five percent (5%) in the case of non-life insurers. Investments in the voting securities of a depository institution, or any company that controls a depository institution, shall not exceed five percent (5%) of the insurer's admitted assets.

C. Investment subsidiaries. For purpose of determining compliance with the limitations of this section, the admitted portion of assets of subsidiaries under [cite applicable provisions of holding company law] shall be deemed to be owned directly by the insurer and any other investors in proportion to the market value or if there is no market, the reasonable value, of their interest in the subsidiaries.

D. Effect of quantity limitations. To the extent that investments exceed the limitations specified in Subsections A and B, the excess may be assigned to the investment class authorized in Section 7L, until that limit is exhausted.

E. Special rule for mutual funds, pooled investment vehicles and other investment companies. If the commissioner considers it desirable in order to get a proper evaluation of the investment portfolio of an insurer, the commissioner may require that investments in mutual funds, pooled investment vehicles or other investment companies be treated for purposes of this Act as if the investor owned directly its proportional share of the assets owned by the mutual fund, pooled investment vehicle or investment company.

F. Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the commissioner.

Drafting Note: States may consider additional language intended to prevent the "grossing-up" of admitted assets and consequent evasion of this Act's investment limitations by requiring that the amount of admitted assets be reduced by the amount of the liability recorded on an insurer's statutory balance sheet for; the return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction, cash received in a dollar roll transaction, and other amounts reported as borrowed money in the most recently filed financial statement.

Drafting Note: Some states encourage domestic investment as a matter of public policy through premium tax or other incentives. States with such a public policy might consider expanded individual issuer limitations for state general obligations, if a preference for public-sector investment is desired.

Section 9. Protection Against Currency Fluctuations

An insurer doing business that requires it to make payment in different currencies shall have investments in securities in each of these currencies in an amount that independently of all other investments meets the requirements of this Act as applied separately to the insurer's obligations in each currency. The commissioner may by order exempt an insurer, or by regulation a class of insurers, from this requirement if the obligations in other currencies are small enough that no significant problem for financial solidity would be created by substantial fluctuations in relative currency values.

Section 10. Prohibited Investments

A. (1) An insurer shall not invest in investments that are prohibited for an insurer by statutes or regulations of this state.

(2) The use of a derivative instrument for replication, or for any purposes other than hedging or income generation, is prohibited.

B. A reasonable time, not in excess of 5 years, shall be allowed for disposal of a prohibited investment in hardship cases if the investment is demonstrated by the insurer to have been legal when made, or the result of a mistake made in good faith, or if the commissioner deems that the sale of the asset would be contrary to the interests of insureds, creditors, or the general public.

Drafting Note: Derivative instruments shall not be used for replication, or for any purposes other than hedging or income generation, until such time as the National Association of Insurance Commissioners adopts methods of disclosure, reserving for risk-based capital and asset valuation reserve, and assessing risks associated with these investments. At that time, the prohibition against the use of derivative instruments for replication shall sunset.

Drafting Note: This Act does not address an insurer's investments in or loans to officers or directors or their immediate families. States should consider the need for specific guidance for these types of investments and loans if they are not addressed in another part of the insurance code.

Section 11. Effect of Investment Restrictions

A. Invested assets may be counted toward satisfaction of the minimum asset requirement only so far as they are invested in compliance with this Act and applicable regulations promulgated and orders issued by the commissioner pursuant to this Act. Assets other than invested assets may be counted toward satisfaction of the minimum asset requirement at admitted annual statement value.

B. An investment held as an admitted asset by an insurer on the effective date of this Act which qualified under [insert reference to state′s prior code provisions on insurer investments] shall remain qualified as an admitted asset under this Act.

C. Assets acquired in the bona fide enforcement of creditors' rights or in bona fide workouts or settlements of disputed claims may be counted for the purposes of Subsection A for five (5) years after acquisition if real property and three (3) years if not real property, even if they could not otherwise be counted under this Act. The commissioner may allow reasonable extensions of these periods if replacement of the assets within the periods would not be possible without substantial loss.

D. If an insurer does not own, or is unable to apply toward compliance with this Act, an amount of assets equal to its minimum asset requirement, the commissioner may deem it to be financially hazardous under [insert reference to statute providing the lawful grounds for liquidation and rehabilitation].

Section 12. Reports and Replies

A. The commissioner may require any of the following from a person subject to regulation under this Act:

(1) Statements, reports, answers to questionnaires and other information, and evidence thereof, in whatever reasonable form the commissioner designates, and at such reasonable intervals as the commissioner chooses.

(2) Full explanation of the programming of any data storage or communication system in use.

(3) That information from any books, records, electronic data processing systems, computers or any other information storage system be made available to the commissioner at a reasonable time and in a reasonable manner.

B. The commissioner may prescribe forms for the reports under Subsection A and specify who shall execute or certify the reports. The forms for the reports required under Subsection A shall be consistent, so far as practicable, with those prescribed by other jurisdictions.

C. The commissioner may prescribe reasonable minimum standards and techniques of accounting and data handling to ensure that timely and reliable information will exist and will be available to the commissioner.

D. Any officer, manager or general agent of an insurer subject to this Act, any person controlling or having a contract under which the person has a right to control the insurer, whether exclusively or otherwise, or a person with executive authority over or in charge of any segment of the insurer's affairs, shall reply promptly in writing or in other reasonably designated form, to a written inquiry from the commissioner requesting a reply.

E. The commissioner may require that any communication made to the commissioner under this section be verified.

F. A communication to the commissioner, or to an expert or consultant retained by the commissioner, required by the provisions of this Act shall not subject the person making it to an action for damages for the communication in the absence of actual malice.

G. Notwithstanding the provisions of Subsection F, the commissioner may bring suit against any person providing information required under this Act that is not truthful and accurate.

Drafting Note: If a state's insurance code and regulations contain provisions substantially similar to this section, the state may consider deleting this section or replacing this section with language contained in other portions of its code.

Section 13. Retention of Experts

The commissioner may retain at the insurer's expense attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist in reviewing the insurer's investments. Persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

Section 14. Commissioner's Orders

A. If the commissioner determines that an insurer's investment practices do not meet the provisions of this Act, the commissioner may, after notification to the insurer of the commissioner's findings, order the insurer to make changes necessary to comply with the provisions of this Act.

B. If the commissioner determines that by reason of the financial condition, current investment practice, or current investment plan of an insurer, the interests of insureds, creditors or the general public are or may be endangered, the commissioner may impose reasonable additional restrictions upon the admissibility or valuation of investments or may impose restrictions on the investment practices of an insurer, including prohibition or divestment.

C. The commissioner may count toward satisfaction of the minimum asset requirement any assets in which an insurer is required to invest under the laws of a country other than the United States as a condition for doing business in that country if the commissioner finds that counting them does not endanger the interests of insureds, creditors or the general public.

D. If the commissioner is satisfied by evidence of the solidity of an insurer and the competence of management and its investment advisors, the commissioner, after a hearing, may by order adjust the class limitations in Section 8, for that insurer, to the extent that the commissioner is satisfied that the interests of insureds, creditors and the public of this state are sufficiently protected in other ways. Adjustments granted with respect to Section 8, in aggregate, are limited to an amount equal to ten percent (10%) of the insurer's liabilities.

Section 15. Administrative Hearings

A. An insurer aggrieved by an order or any other act or failure to act of the commissioner regarding compliance with this Act or regulations promulgated under this Act may request a hearing by following the procedures of [insert citation to statutes on requesting hearings before the commissioner].

B. The commissioner shall hold hearings under this section privately unless the insurer requests a public hearing, in which case the hearing shall be public.

Drafting Note: This section is written to permit insurers to request or participate in hearings whether the cause of aggrievement is direct or indirect. This section contemplates that a state's hearing officer or other authorized public official may apply administrative law to make appropriate determinations of a complainant's standing. If a state's administrative statutes or regulations with respect to hearings bar any standing to parties other than those directly aggrieved by an act or omission of the commissioner, then the word "directly" should be inserted in Section 15A after "insurer" and before "aggrieved."

Drafting Note: If a state does not confine hearing requests and participation to only those parties that are directly aggrieved by an act or omission of the commissioner, then consideration must be given to the procedures that will be employed to publicize the subject of pending hearings and adjudge the standing of each party at interest that is not directly, but only indirectly, aggrieved. To allow participation of indirectly aggrieved parties in closed proceedings without adequate publication and screening procedures is likely to bias proceedings in that only parties in favor with those directly at interest would have an opportunity to seek standing and redress. This model law is silent with respect to specific publication and screening requirements.

Section 16. Confidentiality of Information

The investment policy, or information related to the investment policy provided to the commissioner for review under this Act shall be considered confidential and shall not be a public record or subject to subpoena, except as [insert citations to statutes on filing financial statements with the commissioner, statutes on examinations, and statutes on rehabilitation and liquidation] may permit disclosure.

Section 17. Conflict of Laws and Other Standards

A. This Act shall prevail over any other statute except [cite state holding company law] purporting to authorize an insurer to make a particular investment if the other statute was enacted before [fill in effective date], and shall prevail over any statute enacted thereafter unless the latter negates the application of this section or of particular provisions in this Act by specifically designating them by number.

B. An insurer shall value its assets in accordance with the valuation standards of the NAIC to the extent those standards are consistent with the statutes of this state or regulations or orders of the commissioner.

Drafting Note: If a state's insurance code and regulations contain provisions substantially similar to this section, the state may consider deleting this section or replacing this section with language contained in other portions of its code.

Section 18. Regulations

A. The commissioner may, in accordance with [insert citation to administrative procedures act or other statutes concerning promulgation of regulations], promulgate regulations interpreting and implementing the provisions of this Act.

B. The commissioner may, in accordance with [insert citation to administrative procedures, act, or other statutes concerning promulgation of regulations], promulgate special investment restrictions as follows:

(1) The commissioner may by regulation prescribe for defined classes of insurers special procedural requirements including special reports, prior approval or subsequent disapproval of investments.

(2) The commissioner may by regulation prescribe substantive restrictions on investments of defined classes of insurers, including:

(a) Specification of classes of assets that may not be counted toward satisfaction of the minimum asset requirement even though they may be counted for unrestricted insurers;

(b) Specification of maximum amounts of assets that may be invested in a single investment, or an issue, a class or a group of classes of investments, expressed as percentages of total assets, capital, surplus, legal reserves or other variables;

(c) Prescription of qualitative tests for investments and conditions under which investments may be made, including requirements of specified ratings from investment advisory services, listing on specified stock exchanges, collateral, marketability, currency matching and the financial and legal status of the issuer and its earnings capacity.

C. If the commissioner is satisfied by evidence of the solidity of an insurer and the competence of management and its investment advisors, the commissioner, after a hearing, may by order grant an exemption to that insurer from any restriction under Subsection B of this section to the extent that the commissioner is satisfied that the interests of insureds, creditors and the general public of this state are protected in other ways.

Section 19. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1997 Proc. 3rd Quarter 25-26, 268, 274-286 (adopted).
2001 Proc. 1st Quarter 372-373 (amendments adopted later are printed here).
2001 Proc. 2nd Quarter 11, 14, 319, 339 (amended).

ANNOTATIONS

INVESTMENTS OF INSURERS MODEL ACT
(Defined Standards Version)

Section 3

Annotation 1: This Act references certain capital standards, provides a framework in which these standards relate to the investment laws, and establishes consequences for failure to meet capital standards. To the extent an insurer's investment program is imprudent, the insurer is unsound.

The minimum financial security benchmark and the minimum asset requirement together form the cornerstone for this Act's approach. This approach represents an effort to solve the basic dilemma in regulating insurer investments: (1) that the investment staffs of most insurers are better equipped than the insurance department or the legislature to make decisions about the appropriate investment programs for themselves, and (2) that this is not true of all insurers. Managements of insurers are not equally wise, skilled or responsible. While many will agree that the expertise of an individual insurer with respect to setting its investment policy usually equals or exceeds that of regulators and legislators, many will also agree that allowing complete discretion on the part of an insurer would be an unsound means of protecting the public interest.

Setting a reasonable minimum financial security benchmark, and thus, a minimum asset requirement, for which a more stringent investment regulatory framework is used, allows a high level of company discretion for investments above the minimum asset requirement while still providing adequate regulatory protections for policyholders and claimants from adverse insurer financial results.

This section sets a minimum asset requirement under which invested assets counted toward satisfaction of the requirement must be invested according to the limitations and restrictions of this Act. Assets in excess of the minimum asset requirement would not be subject to these limitations and restrictions, except in qualified circumstances, and may be invested in accordance with the insurer's own written investment policy.

The key to this regulatory approach to investments, then, is the setting of the minimum financial security benchmark. States should consider the nature of the business, (e.g., property and casualty, life, health, financial guaranty, etc.) in looking at the factors for setting the minimum financial security benchmark. The various levels contained in the NAIC's risk-based capital models may be an appropriate standard for states to consider in setting the minimum financial security benchmark. In addition, from an enforcement and solvency regulation standpoint, it is important that the minimum financial security benchmark, and thus, the minimum asset requirement, be tied to the state's liquidation and rehabilitation laws. This means that an insurer failing to meet the minimum asset requirement would be considered in hazardous or potentially hazardous financial condition, allowing the commissioner to take appropriate regulatory action.

It is essential to describe three concepts for capital requirement in order to convey an understanding of this Act's approach.

1. The "minimum capital" (for stock corporations) and "minimum surplus" (for mutuals) are intended to provide solidity at the time a new corporation is launched, and for a reasonable time into the future, during the formative period. The amount needed depends on what the new insurer intends to do, and is fixed on the basis of the information given to the commissioner at the time of incorporation. This concept is included in this Act as Section 3A (1)(b).

   After formation, the financial needs of a company will change as it develops and expands its operations. A minimum capital or surplus fixed permanently at the time of incorporation is too static to satisfy developing needs. If the minimum capital or surplus were to accommodate all possible or imaginable developments, it would be so large that it would prevent all new incorporations.

2. The "minimum financial security benchmark" is designed to measure the minimum capital requirements of a going concern; it expands as the financial needs of the corporation expand, but it may also contract with them. It is the amount of surplus necessary to provide reasonable security against contingencies affecting the insurer's financial position that are not fully covered by reserves or by reinsurance. It is the lowest permissible figure, below which the insurer's operation could have to be considered so hazardous as to permit, but not require, delinquency proceedings. This concept is included as Section 3A (1)(a).
   The authorized control level risk-based capital may be seen by some states as being too small a margin of safety.

Some states may consider it advisable for an insurer at that point to have already initiated changes to its investment practices, or even to have been placed in liquidation or rehabilitation. Section 3A (3) offers a means to establish a higher standard for specific classes of insurers. Section 3A (2) permits the commissioner to establish a higher standard for a specific insurer by issuance of an order.

3. The "proper surplus" for a particular company's operation is a level for the determination of an insurer's board of directors, in consultation with management. Their viewpoint on the subject is constrained by the minimums imposed by other concepts of capital requirement. Desirable ratings from the principal rating agencies, for example, can be expected to require surplus in excess of the minimum financial security benchmark. "Proper surplus" does not require statutory definition.

Section 4

Annotation 2: This section is not intended to require strict matching of asset and liability cash flows nor to suggest that the insurer's investment staff or its investment consultants cannot undertake the required analysis of cash flows.

Annotation 3: For some insurers, such as farm mutuals, county mutuals, fraternals, etc., recognition of each of the factors might be confined to a written acknowledgment that one or two investment classes are the only classes appropriate for that company under a multitude of conditions. For a multistate or multinational company, a periodically revised, sophisticated appraisal of the economy and its effect on the company's operations, products and investments would be appropriate. The necessary degree of technical sophistication will legitimately vary based upon the type and size of the insurer.

Section 6

Annotation 4: The insurer's board of directors has the central responsibility for formulating and assuring implementation of the investment policy. The purpose of this section is to encourage the board of directors to define long-range objectives appropriate to the insurer, set a written investment policy consistent with these objectives, and make sure that management is following the plan. A good written investment policy promotes a clear understanding of objectives by both management and board, thereby preventing rash actions during inevitable periods of volatility. Most importantly, an investment policy can help an insurer to avoid running afoul of the law, or to jeopardize its policyholders' interests through poor investment choices. Regulatory review can assure that the investment plan document exists, and appears competent in its preparation.

Despite these potentially salutary effects, review of the investment plan is ill suited as the primary basis for regulatory enforcement. Indeed, this Act has no automatic filing requirement for an insurer's investment policy; rather, the commissioner may request it under Section 12 or may require automatic filing by a regulation promulgated under Section 18. As written, this Act does not contemplate formal approval of an insurer's investment policy by the commissioner.

The reason for this approach is that a plan, by its very nature, is strictly prospective. Regulatory enforcement must also consider actions and their results. An assessment of the prospective advisability of any insurer's written investment plan is subject to highly technical and academic argumentation. When an insurer's investment policy results in adverse financial trends, decisive action is needed, not ponderous symposia of investment theory before a court of law.

Section 7

Annotation 5: States could adopt an entirely different plan of investment categories based on an independently commissioned study, retain their existing investment categories, or seek guidance from the defined limits version of this Act. A state's history and indigenous industries may serve as useful considerations. For example, if oil exploration and refining have long been an important part of a given state's economy, and persons possessing the requisite knowledge and interest are thus more commonly found among residents of that state than throughout the nation at large, a special category for that investment may be worthy of consideration. Alternatively, a state may decide that its dependence on a particular industry is so substantial that it may wish to encourage its financial institutions to diversify, and accordingly, establish no preferential category.

Section 8

Annotation 6: States could adopt limitations based on an independently commissioned study, retain their existing limitations, or seek guidance from the defined limits version of this Act. Whatever authorized classes of investments or generally applicable limitations that a state chooses to adopt, the degree of financial strength exhibited by an insurer should have a direct bearing on its degree of investment freedom. Three points should be made to explain the value of these types of restrictions in the context of a defined standards investment law:

1. The ability to absorb investment risk varies inversely to the level of existing underwriting risk. The existence of restrictions of the type proposed for assets equal to liabilities plus a minimum surplus requirement will force a gradual transition to conservatism on the part of an insurer as its surplus position deteriorates. At the very least, this will check the worst excesses that can result from the well-known tendency of money-losing insurers to seek high-risk investment solutions to underwriting problems. It must be kept in mind that, while the risks of underwriting and investment closely relate to one another, the solutions to problems that can and do arise in either sphere of activity are mutually exclusive. Underwriting problems require underwriting solutions. Investment problems require investment solutions.

2. These limits exist for the regulator's guidance. Limits should not be set at the level one would willingly accord to the most skilled and most financially capable investor, but rather at the level at which the commissioner should be prompted to make an inquiry. There is a point at which responsible industry participants and the general public should want the commissioner's staff to make an inquiry about the activities of potentially irresponsible industry participants.

3. The proposed limits do not bar insurers with capital in excess of the minimum asset requirement from investing their discretionary capital as they please, subject to their own written investment policy.

Section 9

Annotation 7: This section recognizes that the ability to absorb investment risk varies inversely to the level of underwriting risk, and that this principle will generally apply to international operations as well as domestic operations.

If an insurer perceives that acceptable underwriting risks may be located in foreign nations with extremely unstable currencies and without suitable investment opportunities, the commissioner may waive requirements to hold the foreign-denominated securities that would otherwise be required through an order issued pursuant to Section 14B.

If alien requirements call for a larger investment in foreign-denominated assets than would otherwise count in satisfaction of the minimum asset requirement, Section 14C would authorize the commissioner to count these assets if doing so does not endanger the interests of insureds, creditors or the general public.

These exceptional circumstances do not undermine the principle that if an insurer has contracted to make payment in a given currency, it should have assets in that currency available to honor its obligations. Hedging will not normally be adequate in the case of significant, ongoing business commitments to a given alien insurance market.

Section 10

Annotation 8: Section 10B is a mechanism for the disposal of prohibited investments. It is not enough for a law merely to declare that certain investment practices or instruments are illegal. There must be a specific mechanism to effect a disposition or other resolution of the problem. Section 10B is one way, but not the only way, to respond to this necessity. For certain types of illegal investments or practices, a state might not want to include the hardship qualifications contemplated in this Act.

Section 11

Annotation 9: The crucial enforcement mechanism of this Act is that assets, which are not in compliance with this Act, do not count toward the minimum asset requirement. If an insurer does not meet the minimum asset requirement, then under Section 11D, the insurer may be deemed to be in financially hazardous condition, and the commissioner may commence delinquency proceedings against the insurer. The statutes enumerating the grounds for liquidation and rehabilitation should be modified to cross-reference to Section 11D if this Act is adopted by a state.

Section 12

Annotation 10: This Act does not specify sanctions that apply to concealment or falsification of records, or refusal to provide reports and replies (other than on the basis of one's rights under the constitution of the United States or of the constitution of this state). As the effectiveness of a discretion-based system depends upon the ability of the commissioner to acquire timely and accurate information, states should consider the need for appropriate sanctions applicable to violations of this section. For example, some state insurance codes provide, as an ultimate penalty, that concealment or falsification of records is one of the grounds for liquidation or rehabilitation.

Annotation 11: From time to time, persons, in following the law, will be called upon to make a report or reply that, answered with integrity, will place them in conflict with an insurer's board or management. It must be acknowledged that the limited immunity granted by this Act to persons making legally required communications or cooperating with an investigation would not fully protect persons from all possible forms of reprisal. This Act does not deal comprehensively with the question of legal immunities, or redress available to persons injured by unjustifiable reprisal. It is hoped that a broader consideration of these matters is to be found elsewhere within a state's laws. This Act concerns itself with providing a minimum level of protection from unjustifiable reprisals through the legal system. At a minimum, a person acting without malice should not be placed in legal jeopardy for complying with state law or cooperating with an investigation by governmental authorities.

Section 13

Annotation 12: The professional expertise and financial resources necessary to handle the review and investigation of most investment matters should be available through customary funding sources already in place. However, it is desirable that one option be to directly charge insurers to fund the cost of expert assistance on complex or highly technical investment questions that may arise in consequence of an insurer's investment plans or practices. It is difficult to anticipate the full extent of such special needs in the budget process. In addition, state governments often severely limit contingency funds in a conscientious effort to prevent waste. The funding mechanism for examinations is not necessarily sufficient, because it is not always feasible or desirable to call an examination when the matter at hand is limited in scope. Care should be taken to keep direct charges or other assessments made pursuant to this Act from being abused as blank checks, or as a form of ongoing taxation without explicit legislative approval.

Section 14

Annotation 13: Flexibility of response is critical to conscientious regulation of the insurance industry. Insurers vary by management quality, product mix, size, territory and reserving practices, to name only a few differences. A single set of standards cannot adequately encompass the investment requirements of every niche insurer in the industry, an industry filled with niche insurers. Regulations that do not consider this fragmentation of the industry will unduly restrict management initiative and judgment in certain lines of business, thereby raising the price and reducing the availability of insurance in certain lines.

Effective and ethical use of discretionary powers is essential to retain public confidence. The responsible regulator, much like the responsible insurance company executive, must keep the interests of insureds, creditors and the general public ever in mind. Even the most carefully designed investment laws will not protect the people of a state in which the regulators cannot or will not enforce the law.

The discretion provided to the commissioner in this Act is essential to permit regulation of an insurer's investments because of their complexities and uncertainties and because of competitive forces and changes in the insurance business and in the investment markets. This Act is not intended to be the sole source of the commissioner's regulatory authority, but is to be used in conjunction with and in harmony with the other regulatory tools available to the commissioner.

Section 16

Annotation 14: Transparency in financial and regulatory actions allows market and social forces to encourage both responsible insurance management and responsible insurance regulation. In addition, the hallmark of our free capital market is that few, if any, opportunities to establish a proprietary long-term competitive advantage can be found and preserved on an enduring basis. Accordingly, if a state has a strong open records law, care should be taken not to allow an overly broad construction of confidentiality beyond correspondence and communications of material that is clearly unique and proprietary. The investment policy of an insurer should be extended privileged status. However, mere reference, even detailed reference, to the subject of investment should not automatically result in classified status for the communication.

Section 17

Annotation 15: Well-designed laws are based upon careful consideration of the history of the jurisdiction to which they are intended to apply, and on an understanding of the legal climate in that jurisdiction. A state should not adopt this Act unless it has been adapted to meet the specific situation of the history, insurance industry, general economy, and legal precedents of the state. If a state's adoption of the regulatory approach suggested by this Act represents a significant departure from precedent, various conflicts of law are only to be expected despite the most diligent efforts to avoid them. This section suggests one way, but not the only way, of minimizing the impact of these situations.

INVESTMENTS OF INSURERS MODEL ACT

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What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-41-1 to 27-41-41 (1977/ 2013).
Alaska			ALASKA ADMIN. CODE tit. 3, § 21.211 (2001).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-531 to 20-562 (1954/2000).
Arkansas			ARK. CODE ANN. §§ 23-63-801 to 23-63-841 (1959/2015).
California			CAL. INS. CODE §§ 1170 to 1212 (1935/2009).
Colorado			COLO. REV. STAT. §§ 10-3-213 to 10-3-243 (1969/2015).
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, § 1333 (2011/2014).
District of Columbia			D.C. CODE §§ 31-1371.01 to 31-1375.01 (2002).
Florida	NO CURRENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. §§ 33-11-50 to 33-11-67 (2000/2008).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/126.1 to 5/126.32 (1997).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE § 508.33 (1963/2011) (life insurance).
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. §§ 304.7-010 to 304.7-473 (2000/2010).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 1101 to 1137 (1969/2002) (P/C); §§ 1151 to 1161 (1987/2010) (life insurance).
Maryland	NO CURRENT ACTIVITY		
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 63 to 68 (1817/2006).
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. STAT. §§ 60L.01 to 60L.15 (1998/2009).		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. CODE REGS. ANN. tit. 20, § 200-12.020 (2009/2015).
Montana			MONT. CODE ANN. §§ 33-12-101 to 33-12-312 (1999/2001).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska			NEB. REV. STAT. §§ 44-5101 to 44-5154 (1991/2009).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. §§ 58-7-165 to 58-7-205 (1991/2011).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3906.01 to 3906.15 (2014) (portions of model).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. §§ 733.510 to 733.780 (1959/2013).
Pennsylvania			40 PA. STAT. ANN. 504.2 (1986/ 2010) (life insurance).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. 20:06:26:01 (1995/2014).
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah			UTAH CODE ANN. § 31A-18-103 (1985) (protection against currency fluctuations).
Vermont			VT. STAT. ANN. tit. 8, §§ 3461 to 3472 (1967/2003).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-1400 to 38.2-1447 (1986/2014).
Washington	WASH. REV. CODE §§ 48.13.005 to 48.13.360 (2011/2015).		
West Virginia			W. VA. CODE §§ 33-8-1 to 33-8-32 (1957/2004).
Wisconsin	NO CURRENT ACTIVITY		WIS. STAT. §§ 620.01 to 620.32 (1971/1992); WIS. ADMIN. CODE INS. § 6.20 (1972/1997).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2001

INVESTMENTS OF INSURERS MODEL ACT (#283)
(Defined Standards Version)

Proposed amendments to the Investments of Insurers Model Act (Defined Standards Version) are before the Executive Committee at the 2001 Fall National Meeting to be considered for adoption. The amendments were adopted at the 2001 Summer National Meeting by the Financial Condition (E) Committee and were drafted by a subgroup of the Insurance Holding Company (E) Working Group.[1] The subgroup that drafted the amendments was chaired by Sara Waitt (TX). Other states that participated on the subgroup were Arkansas, California, Georgia, Illinois, New York, North Carolina and South Carolina. There was also substantial participation by insurance industry representatives in the drafting process. Representatives of the American Council of Life Insurance (ACLI), the American Insurance Association (AIA), individual insurance companies and law firms with insurance regulatory practices were regular participants in the subgroup meetings.

The specific charge to the working group arose out of the NAIC's initiative to address issues related to the implementation of the Gramm-Leach-Bliley Act (GLBA) in November 1999. The working group was appointed in February 2000. and is co-chaired by Commissioners Gross (VA) and Montemayor (TX). The charge to the working group was to "consider the implications of the Gramm-Leach-Bliley Act on the state-based solvency monitoring structure, including holding companies, financial examinations, financial analysis and coordination among state insurance departments." The amendments are intended to bring the model act into conformity with specific provisions of GLBA. Following is a section-by-section explanation of the proposed amendments:

8B This section provides for a similar general limitation on investments in any one entity. Section 306 of GLBA provides that the state of domicile of the insurer may limit the investment in the voting securities of a depository institution or its affiliates to 5% of admitted assets. This section should be amended to incorporate the requirement imposed by GLBA.

The first draft of proposed amendments was exposed on November 15, 1000. Two additional drafts were issued. There were no contentious issues with respect to the proposed amendments.

[1] The Insurance Holding Company (E) Working Group was formerly the Financial Services Holding Company Analysis/Examination/Review (E) Working Group.

DISCLOSURE OF MATERIAL TRANSACTIONS MODEL ACT

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Section 1. Report

A. Every insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements or material new ceded reinsurance agreements affecting in force life insurance business unless the acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements or material new ceded reinsurance agreements affecting in force life insurance business have been submitted to the commissioner for review, approval or information purposes pursuant to other provisions of the insurance code, laws, regulations, or other requirements.

B. The report required in Subsection A is due within fifteen (15) days after the end of the calendar month in which any of the foregoing transactions occur.

C. One complete copy of the report, including any exhibits or other attachments, shall be filed with:

(1) The insurance department of the insurer's state of domicile; and

(2) The National Association of Insurance Commissioners.

Section 2. Acquisitions and Dispositions of Assets

A. Materiality.

No acquisitions or dispositions of assets need be reported pursuant to Section 1 if the acquisitions or dispositions are not material. For purposes of this Act, a material acquisition (or the aggregate of any series of related acquisitions during any thirty-day period) or disposition (or the aggregate of any series of related dispositions during any thirty-day period) is one that is non-recurring and not in the ordinary course of business and involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

B. Scope.

(1) Asset acquisitions subject to this Act include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(2) Asset dispositions subject to this Act include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction or other disposition.

C. Information to be Reported.

(1) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(a) Date of the transaction;

(b) Manner of acquisition or disposition;

(c) Description of the assets involved;

(d) Nature and amount of the consideration given or received;

(e) Purpose of, or reason for, the transaction;

(f) Manner by which the amount of consideration was determined;

(g) Gain or loss recognized or realized as a result of the transaction; and

(h) Names of the persons from whom the assets were acquired or to whom they were disposed.

(2) Insurers are required to report material acquisitions and dispositions on a non-consolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

Section 3. Nonrenewals, Cancellations or Revisions of Ceded Reinsurance Agreements

A. Materiality and Scope.

(1) No nonrenewals, cancellations or revisions of ceded reinsurance agreements or new ceded reinsurance agreements affecting in force life insurance business need be reported pursuant to Section 1 if the nonrenewals, cancellations or revisions of ceded reinsurance agreements or new ceded reinsurance agreements affecting in force life insurance business are not material. For purposes of this Act, a material nonrenewal, cancellation or revision of a ceded reinsurance agreement or a material new ceded reinsurance agreement affecting in force life insurance business is one that affects:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(i) More than fifty percent (50%) of the insurer's total ceded written premium; or

(ii) More than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

(b) As respects life, annuity, and accident and health business: more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(c) As respects either property and casualty or life, annuity, and accident and health business, either of the following events shall constitute a material revision which must be reported:

(i) An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

(2) However, no filing shall be required if:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer: the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of its total written premium for direct and assumed business, or

(b) As respects life, annuity, and accident and health business: the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement prior to any cession.

B. Information to be reported.

(1) The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements or material new ceded reinsurance agreements affecting in force life insurance business:

(a) Effective date of the nonrenewal, cancellation, revision or new agreement;

(b) The description of the transaction with an identification of the initiator thereof;

(c) Purpose of, or reason for, the transaction; and

(d) If applicable, the identity of the replacement reinsurers.

(2) Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements or material new ceded reinsurance agreements affecting in force life insurance business on a non-consolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

Section 4. Confidentiality

A. All reports obtained by or disclosed to the commissioner pursuant to this Act in the possession or control of the Department of Insurance, shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action without the prior written consent of the insurer to which it pertains. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. After giving the insurer who would be affected notice and an opportunity to be heard, the commissioner may determine that the interest of policyholders, shareholders or the public will be served by publication of the information subject to Subsection A, in which event the commissioner may publish all or any part in the manner the commissioner may deem appropriate.

C. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

D. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection D(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D.

Section 5. Effective Date

This Act shall take effect on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1993 Proc. 1 8, 136, 276, 302, 304-306 (adopted).
1993 Proc. 2nd Quarter 12, 17, 24-26, 30, 101 (amended and reprinted).
1994 Proc. 3rd Quarter (amended and reprinted).
1999 Proc. 4th Quarter 15, 364, 369, 373-374 (amended).
2000 Proc. 4th Quarter 16, 17, 832, 965, 973-975 (amended and reprinted)

DISCLOSURE OF MATERIAL TRANSACTIONS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

DISCLOSURE OF MATERIAL TRANSACTIONS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE § 27-2A-1 (1996).		
Alaska	ALASKA STAT. § 21.09.300 (1995).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE ANN. §§ 23-63-1401 to 23-63-1406 (1995).		
California	CAL. INS. CODE §§ 1185 to 1187 (1995).		
Colorado	COLO. CODE REGS. § 702-3:3-1-13 (1996/2006).		
Connecticut	CONN. GEN. STAT. §§ 38a-67 to 38a-67a (1995/1998).		
Delaware	18 DEL. CODE REGS. § 306 (1995/2003).		
District of Columbia	D.C. CODE §§ 31-1001 to 31-1004 (1996/2005).		
Florida	FLA. STAT. § 624.448 (1997).		
Georgia	GA. CODE ANN. §§ 33-55-1 to 33-55-3 (1995).		

DISCLOSURE OF MATERIAL TRANSACTIONS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-170-1 to 16-170-3 (1997/2009).		
Idaho	IDAHO CODE ANN. §§ 41-345 to 41-347 (1995/2004).		
Illinois	215 ILL. COMP. STAT. 5/141.4 (1995).		
Indiana	IND. CODE §§ 27-2-18-1 to 27-2-18-14 (1995).		
Iowa	IOWA CODE §§ 521D.1 to 521D.4 (1994).		
Kansas	KAN. STAT. ANN. §§ 40-2,156 to 40-2,159 (1994/1997).		
Kentucky	KY. REV. STAT. ANN. § 304.24-415 (1996).		
Louisiana	LA. REV. STAT. ANN. § 22:574 (2008) (portions of model).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 423-C (1995).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. ADMIN. CODE r. 500.51 to 500.54 (1996).		
Minnesota	MINN. STAT. §§ 60A.135 to 60A.137 (1995).		
Mississippi	MISS. CODE ANN. § 83-5-351 (1996).		
Missouri	NO CURRENT ACTIVITY		
Montana	MONT. CODE ANN. §§ 33-3-701 to 33-3-704 (1995).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NEB. REV. STAT. §§ 44-6301 to 44-6306 (1994).		
Nevada	NEV. ADMIN. CODE §§ 681B.300 to 681B.335 (1996/2002).		
New Hampshire	N.H. REV. STAT. ANN. §§ 403-C:1 to 403-C:3 (1996).		
New Jersey	N.J. ADMIN. CODE §§ 11:1-39.1 to 11:1-39.6 (1995/2007).		
New Mexico	N.M. STAT. ANN. §§ 59A-34-44 to 59A-34-46 (1993).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-10-55 to 58-10-65 (1996).		
North Dakota	N.D. CENT. CODE §§ 26.1-10.1-01 to 26.1-10.1-03 (1995/2003).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3901.67 to 3901.70 (1995/2002).		
Oklahoma	OKLA. STAT. tit. 36, §§ 310A.1 to 310A.3 (1997).		
Oregon	OR. ADMIN. R. 836-011-0430 to 836-011-0460 (1995).		
Pennsylvania			31 PA. CODE §§ 27.1 to 27.5 (1998).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-56-1 to 27-56-3 (1995).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. §§ 38-13-400 to 38-13-420 (1995).		
South Dakota	S.D. CODIFIED LAWS §§ 58-5-143 to 58-5-153 (1995/2000).		
Tennessee	TENN. CODE ANN. §§ 56-10-301 to 56-10-303 (2008).		
Texas	TEX. INS. CODE ANN. §§ 402.001 to 402.104 (2005).		
Utah	UTAH CODE ANN. §§ 31A-5-701 to 31A-5-703 (1996).		
Vermont	VT. STAT. ANN. tit. 8, §§ 8101 to 8103 (1994).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-1301.1 (1994/2001).		
Washington	WASH. REV. CODE ANN. §§ 48.05.510 to 48.05.535 (1995).		
West Virginia	W. VA. CODE §§ 33-39-1 to 33-39-4 (1996/2003).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	WYO. STAT. ANN. §§ 26-3-401 to 26-3-403 (1994).		

PROTECTED CELL COMPANY MODEL ACT

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Section 1. Short Title

This Act may be cited as the "Protected Cell Company Act."

Section 2. Purpose

This Act is adopted to provide a basis for the creation of protected cells by a domestic insurer as one means of accessing alternative sources of capital and achieving the benefits of insurance securitization. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay the investors or both. The creation of protected cells is intended to be a means to achieve more efficiencies in conducting insurance securitizations.

Drafting Note: Under the terms of the typical debt instrument underlying an insurance securitization transaction, prepaid principal is repaid to the investor on a specified maturity date with interest, unless a trigger event occurs. The insurance securitization proceeds secure both the protected cell company's insurance obligations if a trigger event occurs, as well as the protected cell company's obligation to repay the insurance securitization investors if a trigger event does not occur. Insurance securitization transactions have been performed through alien companies in order to utilize efficiencies available to alien companies that are not currently available to domestic companies. This Act is adopted in order to create more efficiency in conducting insurance securitization, to allow domestic protected cell companies easier access to alternative sources of capital, and to promote the benefits of insurance securitization generally.

Section 3. Definitions

For the purposes of this Act, the following terms shall have the following meanings:

A. "Domestic insurer" means an insurer domiciled in the State of [insert state].

B. "Fair value" of an asset (or liability) means the amount at which that asset (or liability) could be bought (or incurred) or sold (or settled) in a current transaction between willing parties, that is, other than in a forced or liquidation sale. Quoted market prices in active markets are the best evidence of fair value and shall be used as the basis for the measurement, if available. If a quoted market price is available, the fair value is the product of the number of trading units times market price. If quoted market prices are not available, the estimate of fair value shall be based on the best information available. The estimate of fair value shall consider prices for similar assets and liabilities and the results of valuation techniques to the extent available in the circumstances. Examples of valuation techniques include the present value of estimated expected future cash flows using a discount rate commensurate with the risks involved, option-pricing models, matrix pricing, option-adjusted spread models, and fundamental analysis. Valuation techniques for measuring financial assets and liabilities and servicing assets and liabilities shall be consistent with the objective of measuring fair value. Those techniques shall incorporate assumptions that market participants would use in their estimates of values, future revenues, and future expenses, including assumptions about interest rates, default, prepayment, and volatility. In measuring financial liabilities and servicing liabilities at fair value by discounting estimated future cash flows, an objective is to use discount rates at which those liabilities could be settled in an arm's-length transaction. Estimates of expected future cash flows, if used to estimate fair value, shall be the best estimate based on reasonable and supportable assumptions and projections. All available evidence shall be considered in developing estimates of expected future cash flows. The weight given to the evidence shall be commensurate with the extent to which the evidence can

be verified objectively. If a range is estimated for either the amount or timing of possible cash flows, the likelihood of possible outcomes shall be considered in determining the best estimate of future cash flows.

C. "Fully funded" means that, with respect to any exposure attributed to a protected cell, the fair value of the protected cell assets, on the date on which the insurance securitization is effected, equals or exceeds the maximum possible exposure attributable to the protected cell with respect to such exposures.

D. "General account" means the assets and liabilities of a protected cell company other than protected cell assets and protected cell liabilities.

E. "Indemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered by its incurring a specified level of losses under its insurance or reinsurance contracts.

F. "Non-indemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered solely by some event or condition other than the individual protected cell company incurring a specified level of losses under its insurance or reinsurance contracts.

G. "Protected cell" means an identified pool of assets and liabilities of a protected cell company segregated and insulated by means of this Act from the remainder of the protected cell company's assets and liabilities.

Drafting Note: This term is meant to reference identification of statutorily segregated assets and liabilities through the accounting function. By attributing certain assets and liabilities to a protected cell on the protected cell company's books and records, and otherwise complying with the provisions of this Act, the protected cell company will receive statutory insulation of those assets and liabilities from the protected cell company's other assets and liabilities not identified in the accounting records as attributable to the protected cell.

H. "Protected cell account" means a specifically identified bank or custodial account established by a protected cell company for the purpose of segregating the protected cell assets of one protected cell from the protected cell assets of other protected cells and from the assets of the protected cell company's general account.

Drafting Note: This term is meant to reference a custodial account established to hold and invest protected cell assets, such that protected cell assets are also distinct and identifiable from the assets of the general account.

I. "Protected cell assets" means all assets, contract rights and general intangibles, identified with and attributable to a specific protected cell of a protected cell company.

J. "Protected cell company" means a domestic insurer that has one or more protected cells.

K. "Protected cell company insurance securitization" means the issuance of debt instruments, the proceeds from which support the exposures attributed to the protected cell, by a protected cell company where repayment of principal or interest, or both, to investors pursuant to the transaction terms is contingent upon the occurrence or nonoccurrence of an event with respect to which the protected cell company is exposed to loss under insurance or reinsurance contracts it has issued.

L. "Protected cell liabilities" means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell company.

Section 4. Establishment of Protected Cells

A. A protected cell company may establish one or more protected cells with the prior written approval of the commissioner of a plan of operation or amendments thereto submitted by the protected cell company with respect to each protected cell in connection with an insurance securitization. Upon the written approval of the commissioner of the plan of operation, which shall include, but not be limited to, the specific business objectives and investment guidelines of the protected cell, the protected cell company may, in accordance with the approved plan of operation, attribute to the protected cell insurance obligations with respect to its insurance business and obligations relating to the insurance securitization and assets to fund the obligations. A protected cell shall have its own distinct name or designation, which shall include the words "protected cell." The protected cell company shall transfer all assets attributable to a protected cell to one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets shall be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the plan of operation approved by the commissioner. No other attribution of assets or liabilities may be made by a protected cell company between the protected cell company's general account and its protected cells. Any attribution of assets and liabilities between the general account and a protected cell, or from investors in the form of principal on a debt instrument issued by a protected cell company in connection with a protected cell company securitization shall be in cash or in readily marketable securities with established market values.

C. The creation of a protected cell does not create, in respect of that protected cell, a legal person separate from the protected cell company. Amounts attributed to a protected cell under this Act, including assets transferred to a protected cell account, are owned by the protected cell company and the protected cell company may not be, nor hold itself out to be, a trustee with respect to those protected cell assets of that protected cell account. Notwithstanding the foregoing, the protected cell company may allow for a security interest to attach to protected cell assets or a protected cell account when in favor of a creditor of the protected cell and otherwise allowed under applicable law.

D. This Act shall not be construed to prohibit the protected cell company from contracting with or arranging for an investment advisor, commodity trading advisor, or other third party to manage the protected cell assets of a protected cell, provided that all remuneration, expenses and other compensation of the third party advisor or manager are payable from the protected cell assets of that protected cell and not from the protected cell assets of other protected cells or the assets of the protected cell company's general account.

E. (1) A protected cell company shall establish administrative and accounting procedures necessary to properly identify the one or more protected cells of the protected cell company and the protected cell assets and protected cell liabilities attributable to the protected cells. It shall be the duty of the directors of a protected cell company to:

(a) Keep protected cell assets and protected cell liabilities separate and separately identifiable from the assets and liabilities of the protected cell company's general account and;

(b) Keep protected cell assets and protected cell liabilities attributable to one protected cell separate and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells.

(2) Notwithstanding the foregoing, if this section is violated, the remedy of tracing shall be applicable to protected cell assets when commingled with protected cell assets of other protected cells or the assets of the protected cell company's general account. The remedy of tracing shall not be construed as an exclusive remedy.

F. The protected cell company shall, when establishing a protected cell, attribute to the protected cell assets with a value at least equal to the reserves and other insurance liabilities attributed to that protected cell.

Section 5. Use and Operation of Protected Cells

A. The protected cell assets of a protected cell may not be charged with liabilities arising out of any other business the protected cell company may conduct. All contracts or other documentation reflecting protected cell liabilities shall clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities.

B. The income, gains and losses, realized or unrealized, from protected cell assets and protected cell liabilities shall be credited to or charged against the protected cell without regard to other income, gains or losses of the protected cell company, including income, gains or losses of other protected cells. Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested without regard to any requirements or limitations of Section [insert reference applicable sections of the insurance code imposing limitations on insurance company investments] and the investments in a protected cell or cells shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the protected cell company.

C. Assets attributed to a protected cell shall be valued at their fair value on the date of valuation.

D. A protected cell company shall, in respect of any of its protected cells, engage in fully funded indemnity triggered insurance securitization to support in full the protected cell exposures attributable to that protected cell. A protected cell company insurance securitization that is non-indemnity triggered shall qualify as an insurance securitization under the terms of this Act only after the commissioner, in accordance with the authority granted under Section 9 of this Act, adopts regulations addressing the methods of funding of the portion of the risk that is not indemnity based, accounting, disclosure, risk based capital treatment, and assessing risks associated with such securitizations. A protected cell company insurance securitization that is not fully funded, whether indemnity triggered or non-indemnity triggered, is prohibited. Protected cell assets may be used to pay interest or other consideration on any outstanding debt or other obligation attributable to that protected cell, and nothing in this subsection shall be construed or interpreted to prevent a protected cell company from entering into a swap agreement or other transaction for the account of the protected cell that has the effect of guaranteeing interest or other consideration.

E. In all protected cell company insurance securitizations, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction will be attributed. In addition, the contracts or other documentation shall clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. Notwithstanding the foregoing, and subject to the provisions of this Act and any other applicable law or regulation, the failure to include such language in the contracts or other documentation shall not be used as the sole basis by creditors, reinsurers or other claimants to circumvent the provisions of this Act.

F. A protected cell company shall only be authorized to attribute to a protected cell account the insurance obligations relating to the protected cell company's general account. Under no circumstances shall a protected cell be authorized to issue insurance or reinsurance contracts directly to policyholders or reinsureds or have any obligation to the policyholders or reinsureds of the protected cell company's general account.

G. At the cessation of business of a protected cell in accordance with the plan approved by the commissioner, the protected cell company shall voluntarily close out the protected cell account.

Section 6. Reach of Creditors and Other Claimants

A. (1) Protected cell assets shall only be available to the creditors of the protected cell company that are creditors in respect to that protected cell and shall thereby be entitled, in conformity with the provisions of this Act, to have recourse to the protected cell assets attributable to that protected cell, and shall be absolutely protected from the creditors of the protected cell company that are not creditors in respect of that protected cell and who, accordingly, shall not be entitled to have recourse to the protected cell assets attributable to that protected cell. Creditors with respect to a protected cell shall not be entitled to have recourse against the protected cell assets of other protected cells or the assets of the protected cell company's general account.

(2) Protected cell assets shall only be available to creditors of a protected cell company after all protected cell liabilities have been extinguished or otherwise provided for in accordance with the plan of operation relating to that protected cell.

B. When an obligation of a protected cell company to a person arises from a transaction, or is otherwise imposed, in respect of a protected cell:

(1) That obligation of the protected cell company shall extend only to the protected cell assets attributable to that protected cell, and the person shall, with respect to that obligation, be entitled to have recourse only to the protected cell assets attributable to that protected cell; and

(2) That obligation of the protected cell company shall not extend to the protected cell assets of any other protected cell or the assets of the protected cell company's general account, and that person shall not, with respect to that obligation, be entitled to have recourse to the protected cell assets of any other protected cell or the assets of the protected cell company's general account.

C. When an obligation of a protected cell company relates solely to the general account, the obligation of the protected cell company shall extend only to, and that creditor shall, with respect to that obligation, be entitled to have recourse only to, the assets of the protected cell company's general account.

D. The activities, assets, and obligations relating to a protected cell are not subject to the provisions of Section [insert applicable sections of the insurance code addressing life and health and property and casualty guaranty or insolvency funds], and neither a protected cell nor a protected cell company shall be assessed by or otherwise be required to contribute to any guaranty fund or guaranty association in this state with respect to the activities, assets, or obligations of a protected cell. Nothing in this subsection shall affect the activities or obligations of an insurer's general account.

E. In no event shall the establishment of one or more protected cells alone constitute or be deemed to be a fraudulent conveyance, an intent by the protected cell company to defraud creditors, or the carrying out of business by the protected cell company for any other fraudulent purpose.

Section 7. Conservation, Rehabilitation or Liquidation of Protected Cell Companies

A. Notwithstanding any contrary provision in the insurance code of this state, the regulations promulgated under the insurance code of this state, or any other applicable law or regulation, upon any order of conservation, rehabilitation or liquidation of a protected cell company, the receiver shall be bound to deal with the protected cell company's assets and liabilities, including protected cell assets and protected cell liabilities, in accordance with the requirements set forth in this Act.

B. With respect to amounts recoverable under a protected cell company insurance securitization, the amount recoverable by the receiver shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation or liquidation with respect to the protected cell company notwithstanding any provisions to the contrary in the contracts or other documentation governing the protected cell company insurance securitization.

Drafting note: A number of states require a liquidator to cancel policies within a pre-specified time period in the event of a liquidation. While reviewing the Plan of Operation, commissioners should consider the termination provisions, if any, of the securitization instruments in the event of the cancellation of all of the insurance policies underlying the securitization in order to assess whether any portion of the risk premium relating to those underlying policies should equitably be returned to the estate of the general account.

Section 8. No Transaction of an Insurance Business

A protected cell company insurance securitization shall not be deemed to be an insurance or reinsurance contract. An investor in a protected cell company insurance securitization shall not, by sole means of this investment, be deemed to be transacting an insurance business in this state. The underwriters or selling agents (and their partners, directors, officers, members, managers, employees, agents, representatives and advisors) involved in a protected cell company insurance securitization shall not be deemed to be conducting an insurance or reinsurance agency, brokerage, intermediary, advisory or consulting business by virtue of their activities in connection therewith.

Section 9. Authority to Adopt Regulations

The commissioner may promulgate regulations necessary to effectuate the purposes of this Act.

Section 10. Effective Date

This Act shall become effective on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 3rd Quarter 24-25, 26, 194, 332-336 (adopted).

PROTECTED CELL COMPANY MODEL ACT

What are the state pages?

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Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROTECTED CELL COMPANY MODEL ACT

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 27-31B-22 (2006/2016).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1098.05 (2003/2005) (protected cell captives); ARIZ. ADMIN. CODE. § R20-6-2002 (2002/2011) (fees).
Arkansas	ARK. CODE ANN. §§ 23-63-1701 to 23-63-1709 (2001/2019).		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut			CONN. GEN. STAT. ANN. § 38a-91rr (2011/2018).
Delaware			DEL. CODE ANN. tit. 18, §§ 6931 to 6934 (2005) (protected cell captives).
District of Columbia			D.C. CODE §§ 31-3931.01 to 3931.05 (2005/2015).

PROTECTED CELL COMPANY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. §§ 33-41-100 to 33-41-106 (2019) (captive insurance).
Guam	22 GUAM CODE ANN. § 23106 (2018).		
Hawaii			HAW. REV. STAT. § 43:19-303 (2008/2010) (captive insurance).
Idaho	NO CURRENT ACTIVITY		
Illinois	215 ILL. COMP. STAT. §§ 5/179A-1 to 5/179A-40 (1999/2001).		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA CODE §§ 521G.1 to 521G.10 (2000/2007).		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. § 304.49-228 (2006/2010) (protected cell captives).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT tit. 24, § 6724 (2009/2017); ME. REV. STAT tit. 24, § 784-A (2007).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. COMP. LAWS ANN. §§ 500.4801 to 500.4813 (2008).		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		

PROTECTED CELL COMPANY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri			MO. ANN. STAT. § 379.1351 (2013) (captive insurance).
Montana			MONT. CODE ANN. §§ 33-28-301 to 33-28-310 (2003/2019) (captive insurance).
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. REV. STAT. ANN. § 694C.195 (2005/2013).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. REV. STAT. ANN. § 17:47B-17 (2011) (captive insurance).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-10-75 to 58-10-110 (2001).		N.C. GEN. STAT §§ 58-10-500 to 58-10-525 (2013/2016); N.C. GEN. STAT. §§ 58-10-335 to 58-10-496 (2016).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3964.17 to 3964.18 (2014) (captive insurance).
Oklahoma	OKLA. STAT. ANN. §§ 1691 to 1699 (2019).		OKLA. STAT. tit 36, §§ 6470.29 to 6470.31.1 (2004/2015) (captive insurance).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-64-1 to 27-64-12 (1999/2018).		

PROTECTED CELL COMPANY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. §§ 38-10-10 to 38-10-80 (2000/2012).		
South Dakota			S.D. CODIFIED LAWS § 58-46-27 (2013) (captive insurance).
Tennessee			TENN. CODE ANN. §§ 56-13-201 to 56-13-209 (2011/2019).
Texas	NO CURRENT ACTIVITY		
Utah			UTAH CODE ANN. §§ 31A-36-401 to 31A-36-403 (2003/2019) (captive insurance).
Vermont			VT. STAT. ANN. tit. 8, §§ 6031 to 6039 (2009/2019) (captive insurance).
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 1431 to 1437 (2001/2013).		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE §§ 33-31A-1 to 33-31A-9 (2004) (captive insurance).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

Table of Contents

Section 1. Purpose

The purpose of this Act is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate regulations of the commissioner.

Section 2. Definitions

As used in this act, the term

A. "Clearing corporation" means a corporation as defined in [Section 8-102(a)(5) of the Uniform Commercial Code], except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation may include a corporation which is organized or existing under the laws of any foreign country and is legally qualified under such laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes "Treasury/Reserve Automated Debt Entry Securities System" and "Treasury Direct" book-entry securities systems established pursuant to 31 U.S.C. § 3100 *et seq.*, 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301.

B. "Custodian" means a national bank, state bank, trust company or broker/dealer which participates in a clearing corporation.

C. "Securities" means instruments as defined in [Section 8-102(a)(15) of the Uniform Commercial Code].

Section 3. Use of Book-Entry Systems

A. Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any custodian through which an insurance company holds securities in a clearing corporation shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation without physical delivery of certificates representing such securities.

B. The Commissioner of Insurance is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations, including establishing standards for national banks, state banks, trust companies and brokers/dealers to qualify as custodians for insurance company securities.

Section 4. Deposit of Securities by Domestic Insurance Companies

Section _____ is amended by adding thereto a new paragraph as follows:

Notwithstanding any other provision of law, the securities qualified for deposit under this section may be deposited with a clearing corporation. Securities deposited with a clearing corporation and used to meet the deposit requirements set forth in this section shall be under the control of the Commissioner and shall not be withdrawn by the insurance company without the approval of the Commissioner. Any insurance company holding securities in such manner shall provide to the Commissioner evidence issued by its custodian through which such insurance company has deposited such securities in a clearing corporation, in order to establish that the securities are actually recorded in an account in the name of the custodian and that the records of the custodian reflect that such securities are held subject to the order of the Commissioner.

Drafting Note: Certain terms used in Section 4 are defined in Section 2 of this model Act.

Section 5. Deposit of Securities by Foreign Insurance Companies

Section _____ is amended by adding thereto a new paragraph as follows:

Notwithstanding any other provision of law, securities eligible for deposit under the insurance law of this state relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation. Securities deposited with a clearing corporation and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the Commissioner and shall not be withdrawn by the insurance company without the approval of the Commissioner. Any insurance company holding such securities in such manner shall provide to the Commissioner evidence issued by its custodian in order to establish that the securities are actually recorded in an account in the name of the custodian and evidence that the records of the custodian reflect that such securities are held subject to the order of the Commissioner.

Drafting Note: Certain terms used in Section 5 are defined in Section 2 of this Model Act.

Section 6. Effective Date

This Act shall become effective on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1981 Proc. I 47, 50, 175, 245, 246, 247-249 (adopted).
1981 Proc. II 27, 35, 309, 393, 395, 412-413 (amended and reprinted).
2004 Proc. 1st Quarter 926-927, 1049 1061-1063 (amended and reprinted, adopted by parent committee).
2004 Proc. 2nd Quarter 51 (adopted by Plenary).
2008 Proc. 3rd Quarter 3-359 to 3-364 (guideline amendments adopted).

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

The NAIC amended this model during the 2008 Fall National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2008 3rd Quarter Guideline Amendments are highlighted in grey.

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MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE § 27-6-3 (1981) (portions of model).		ALA. CODE § 27-41-4 (1981).
Alaska			ALASKA STAT. § 21.21.410 (1997/2007).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-537 (1959/1980).
Arkansas			ARK. CODE ANN. § 23-69-134 (1959/1999).
California			CAL. INS. CODE § 1194.5 (1983); § 1104.9 (1988/1996).
Colorado	COLO. REV. STAT. §§ 10-3-1201 to 10-3-1203 (1983); 3 COLO. CODE REGS. § 702-3:3-1-16 (2006) (portions of model).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. STAT. § 628.511 (1982).		

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. § 33-11-10 (1960/1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO CODE ANN. §§ 41-2869 to 41-2871 (1981).		IDAHO CODE ANN.§ 41-804 (1961/2004) (department deposits).
Illinois			215 ILL. COMP. STAT. 5/404.1 (1983) (department deposits).
Indiana	IND. CODE § 27-1-20-8 (1981).		
Iowa	IOWA CODE § 511.8(21) (1982/1985) (portions of model).		
Kansas			KAN. STAT. ANN. §§ 40-2a20 (1975); 40-2b20 (1986/1996).
Kentucky	KY. REV. STAT. ANN. § 304.7-360 (1982).		
Louisiana			LA. REV. STAT. ANN. § 22:68 (1979/2004).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 3408 (1969/1981).
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. §§ 60A11 (10) to (11) (1967/2008); § 61A.282 (1) (1982/2011); § 60A.10 (1967/1986) (department deposits).
Mississippi	MISS. CODE ANN. §§ 83-67-1 to 83-67-5 (2001).		
Missouri	NO CURRENT ACTIVITY		

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. CODE ANN. §§ 33-3-451 to 33-3-453 (2003).		
Nebraska			NEB. REV. STAT. § 44-5109 (1991/2005).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. STAT. ANN. §§ 17:20-1 to 17:20-4 (1990); §§ 17B:18-37 to 17B:18-39.1 (1990) (department deposits).
New Mexico	N.M. STAT. ANN. § 59A-10-3 (1984) (portion of model).		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota			N.D. CENT. CODE § 26.1-05-35 (1987) (authority to promulgate regulations).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3901.51 to 3901.52 (1990/2004).
Oklahoma	OKLA. STAT. tit. 36, § 1628 (1983).		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS § 27-1-5 (1986/1990).
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS §§ 58-27-78 to 58-27-84 (1983/1997).

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee			TENN. CODE ANN. § 56-2-104 (1935/2013).
Texas	NO CURRENT ACTIVITY		
Utah	UTAH CODE ANN. § 31A-2-206 (1985/1986) (department deposits).		BULLETIN 2008-6 (2008).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE ANN. §§ 48.13.450 to 48.13.490 (2000) (portions of model).		
West Virginia	W. VA. CODE §§ 33-8A-1 to 33-8A-7 (2002/2005) (combines model act and regulation).		
Wisconsin			WIS. STAT. § 601.13 (1969/1980) (department deposits).
Wyoming	WYO. STAT. ANN. §§ 26-8-201 to 26-8-204 (2004).		

PROJECT HISTORY - 2008

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#295)

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#298)

1. Project Description

The FHLB Custodial Subgroup of the Examination Oversight (E) Task Force was created at the 2007 Summer National Meeting of the NAIC. This Subgroup was created to work on a charge given to the Task Force by the Financial Condition (E) Committee. The Subgroup was to consider the Federal Home Loan Banks' (FHLBanks) request to be included in the Model Regulation on Custodial Agreements and the Use of Clearing Corporations and provide a recommendation to the Financial Condition (E) Committee. This charge was prompted by a comment letter received from the FHLBanks dated February 16, 2007.

2. Group Responsible for Drafting the Regulation

The project to review the FHLBanks request was given to the Examination Oversight (E) Task Force and assigned to the FHLB Custodial Subgroup. The following states participated in the subgroup:

Kansas, Chair	Alabama
New York	Tennessee

3. Charge Authorizing the Project

The Financial Condition (E) Committee approved the following charge for the Examination Oversight (E) Task Force through an e-mail vote completed on April 30, 2007:

The Examination Oversight (E) Task Force shall consider the FHLB request to be included in the Model Regulation on Custodial Agreements and the Use of Clearing Corporations and provide its recommendation to the Financial Condition (E) Committee.

4. General Description of the Drafting Process and Due Process

To begin reviewing the FHLBanks' request, the Subgroup had some questions about the FHLBanks' process to handle custodial assets and how that process is reviewed by its federal regulator. Initial questions were communicated to the FHLBanks in a memo dated July 26, 2007. The FHLBanks responded to the questions through their memo dated August 28, 2007. A conference call between the Subgroup and members of the FHLBanks was held September 5, 2007 to discuss the issues in greater detail. Finally, additional information was requested by the Subgroup through a memo dated September 24, 2007, and another response was received from the FHLB on November 30, 2007.

Through investigating answers to questions relating to the controls and regulation of custodial services offered by the FHLBanks, the Subgroup was able to reach a conclusion that the FHLBanks should be permitted to function as authorized custodians as outlined in the Model Act and Regulation on Custodial Agreements and the Use of Clearing Corporations. After concluding that the FHLBanks should be allowed to function as authorized custodians, the Subgroup turned its attention to proposing revisions to the Model Act on Custodial Agreements and the Use of Clearing Corporations (#295) and the Model Regulation on Custodial Agreements and the Use of Clearing Corporations (#298). Both of these models included language describing authorized custodians that would exclude the FHLBanks. However, based on a review of the NAIC's Model Law Development Framework, it was determined that changes to these models would not meet the criteria included in the framework. As such, the Subgroup determined that revisions should be made to the models and offered as guidelines to the states.

The Subgroup held a conference call on February 21, 2008, and conducted business via e-mail on March 7, 2008 to complete its work in proposing guideline revisions to the models. The guideline revisions were referred to the Examination Oversight (E) Task Force at its March 31, 2008, meeting. The Examination Oversight (E) Task Force exposed the proposed guideline revisions for a 45-day comment period during which no comments were received. On June 1, 2008, the Examination Oversight (E) Task Force adopted the proposed guideline changes to Model #295 and #298.

5. Discussion of Key Issues

The FHLB Custodial Subgroup conducted an in-depth review of the capital requirements, regulatory oversight and custodial controls and standards in place at the FHLBanks to reach a determination that the FHLBanks should be allowed to operate as authorized custodians of insurance company securities. As such, guideline revisions have been proposed to the Model Act on Custodial Agreements and the Use of Clearing Corporations (#295) and the Model Regulation on Custodial Agreements and the Use of Clearing Corporations (#298) to allow the FHLBanks to meet the definition of an authorized custodian.

6. Any Other Important Information

No other items identified at this time.

Exhibit A: Illustrative Timeline on Due Process and Drafting Process– FHLB Custody Issue

February 2007	Letter received from the FHLBanks requesting permission to act as authorized custodians of insurance company securities.
March 2007	(Spring National Meeting) The Examination Oversight (E) Task Force refers the letter along with its comments to the Financial Condition (E) Committee for review.
April 2007	The Financial Condition (E) Committee approves a charge for the Examination Oversight (E) Task Force to work on the project.
June 2007	(Summer National Meeting) The Examination Oversight (E) Task Force creates the FHLB Custodial Subgroup to work on the charge.
July 2007	A letter requesting information from the FHLBanks is sent by the FHLB Custodial Subgroup.
August 2007	The FHLBanks response to the information request is received by the FHLB Custodial Subgroup.
September 5, 2007	A conference call of the FHLB Custodial Subgroup is held to discuss the information received from the FHLBanks and to gather additional information regarding the custodial function and controls in place at the FHLBanks.
September 24, 2007	An additional information request letter is sent from the FHLB Custodial Subgroup to the FHLBanks.
November 30, 2007	The FHLBanks response to the second information request letter is received by the FHLB Custodial Subgroup.
February 21, 2008	A conference call of the FHLB Custodial Subgroup is held to discuss potential changes to Model #295 and #298 to allow the FHLBanks to act as authorized custodians of insurance company securities.
March 7, 2008	The FHLB Custodial Subgroup conducts business via email to adopt a referral to the Examination Oversight (E) Task Force recommending revisions to Model #295 and #298.
March 31, 2008	The Examination Oversight (E) Task Force receives the referral of the FHLB Custodial Subgroup and votes to expose the proposed revisions to Model #295 and #298 for a 45-day comment period.
June 1, 2008	The Examination Oversight (E) Task Force adopts the proposed revisions as guideline changes to Model #295 and #298.
June 2, 2008	The Financial Condition (E) Committee adopts the proposed revisions as guideline changes to Model #295 and #298.

PROJECT HISTORY - 2004

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OFCLEARING CORPORATIONS (#295)

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#298)

1. Description of the Project, Issues Addressed, etc.

The Model Act to Permit the Use of Clearing Corporations and the Federal Book Entry System by Insurance Companies (the Model Act) and the Model Regulation on the Use of Clearing Corporations and Federal Book Entry by Insurance Companies (the Model Regulation) have been revised to permit the use of broker/dealers as custodian for insurance company assets. The titles of the Model Act and Model Regulation have also been revised to more clearly identify the items discussed in the models. The revised titles are the Model Act on the Use of Custodial Agreements and Clearing Corporations and the Model Regulation on the Use of Custodial Agreements and Clearing Corporations.

2. Name of Group Responsible for Drafting the Model and States Participating

The Custodial Assets Working Group of the Financial Condition (E) Committee originally developed and adopted this revision. The working group includes: New York (Chair), Arkansas, Iowa, Oregon, and Texas.

3. Project Authorized by What Charge and Date First Given to the Group

The 2004 charge of the working group is, "The Custodial Assets Working group will revise the appropriate model laws, acts and handbook guidance to allow broker/dealers that meet certain standards to be authorized NAIC custodians for insurance company investments."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open as the Custodial Assets Working Group solicited comments from all interested parties, including interested regulators and industry representatives. At the 2003 Fall National Meeting, the Financial Condition (E) Committee voted to allow broker/dealers to act as custodians for insurance company assets. At that time, the Committee instructed the Custodial Assets Working Group to develop revisions to the applicable models. The revisions to the Model Act and Model Regulation were first discussed during an open conference call of the working group on November 19, 2003. At that time, the working group voted to expose the proposed revisions for comment. The revisions to the Model Act and Model Regulation were adopted during an open conference call of the working group on February 26, 2004.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The working group received comment letters from interested parties on whether broker dealers should be allowed to act as custodians for insurance companies. Comments were discussed in open forum at the Fall 2002, Winter 2002, and Spring 2003 National Meetings. The revisions to the models were exposed for a public comment for a sixty-day period. The working group discussed comments received in an open forum.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

One significant issue was discussed by the working group and interested parties. One of the comment letters received discussed concern that the proposed revisions did not require broker/dealers to provide insurance coverage in excess of that provided by the Securities Investor Protection Corporation (SIPC). After some discussion, the working group voted to require that broker/dealers acting as custodians for insurance company assets hold insurance coverage in excess to that provided by SIPC in an amount equal to or greater than the largest, single insurance company customer deposit.

7. Any Other Important Information (e.g., amending an accreditation standard)

On January 1, 2003, the Financial Regulation Standards and Accreditation (F) Committee exposed for a two-year period the Model Act and Model Regulation as possible accreditation standards. If the revisions to the Model Act and Model Regulation are adopted by the NAIC membership, the Financial Regulation Standards and Accreditation (F) Committee will review the revised Model Act and Model Regulation for further consideration. In addition, the working group will send a referral to the Financial Examiners Handbook Technical Group to consider applicable revisions to the NAIC *Financial Condition Examiners Handbook*.

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

Table of Contents

Section 1. Definitions

When used in this regulation, the term

A. "Agent" means a national bank, state bank, trust company or broker/dealer that maintains an account in its name in a clearing corporation or that is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation, including the Treasury/Reserve Automated Debt Entry Securities System (TRADES) or Treasury Direct systems, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "agent" may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities.

B. "Clearing corporation" means a corporation as defined in [Section 8-102(a)(5) of the Uniform Commercial Code] that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" may include a corporation that is organized or existing under the laws of a foreign country and which is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes "Treasury/Reserve Automated Debt Entry Securities System" and "Treasury Direct" book-entry securities systems established pursuant to 31 U.S.C. § 3100 *et seq.*, 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301.

C. "Custodian" means:

(1) A national bank, state bank or trust company that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by United States banking regulators and that is regulated by either state banking laws or is a member of the Federal Reserve System and that is legally qualified to accept custody of securities in accordance with the standards set forth below, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "custodian" may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by international banking authorities and that is legally qualified to accept custody of securities; or

(2) A broker/dealer that shall be registered with and subject to jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, and has a tangible net worth equal to or greater than two hundred fifty million dollars ($250,000,000).

D. "Custodied securities" means securities held by the custodian or its agent or in a clearing corporation, including the Treasury/Reserve Automated Debt Equity Securities System (TRADES) or Treasury Direct systems.

E. "Tangible net worth" means shareholders equity, less intangible assets, as reported in the broker/dealer's most recent Annual or Transition Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 (S.E.C. Form 10-K) filed with the Securities and Exchange Commission.

F. "Treasury/Reserve Automated Debt Entry Securities System" ("TRADES") and "Treasury Direct" mean the book entry securities systems established pursuant to 31 U.S.C. § 3100 *et seq*., 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301. The operation of TRADES and Treasury Direct are subject to 31 C.F.R. pt. 357 *et seq*

G. "Security" has the same meaning as that defined in [Section 8-102(a)(15) of the Uniform Commercial Code].

H. "Securities' certificate" has the same meaning as that defined in [Section 8-102(a)(16) of the Uniform Commercial Code].

Section 2. Custody Agreement; Requirements

A. An insurance company may, by written agreement with a custodian, provide for the custody of its securities with that custodian. The securities that are the subject of the agreement may be held by the custodian or its agent or in a clearing corporation.

B. The agreement shall be in writing and shall be authorized by a resolution of the board of directors of the insurance company or of an authorized committee of the board. The terms of the agreement shall comply with the following:

(1) Securities' certificates held by the custodian shall be held separate from the securities' certificates of the custodian and of all of its other customers.

(2) Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurance company. The records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, the records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation and if through an agent, the name of the agent.

(3) All custodied securities that are registered shall be registered in the name of the company or in the name of a nominee of the company or in the name of the custodian or its nominee or, if in a clearing corporation, in the name of the clearing corporation or its nominee.

(4) Custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except that custodied securities used to meet the deposit requirements set forth in Section [section of the state statute requiring deposit of securities as a condition of doing business] of this Insurance Law shall, to the extent required by that section, be under the control of the [appropriate insurance regulatory authority] and shall not be withdrawn by the insurance company without the approval of the [appropriate insurance regulatory authority].

(5) The custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. In addition, the custodian shall be required to furnish no less than monthly the insurance company with reports of holdings of custodied securities at times and containing information reasonably requested by the insurance company. The custodian's trust committee's annual reports of its review of the insurer's trust accounts shall also be provided to the insurer. Reports and verifications may be transmitted in electronic or paper form.

Drafting Note: The annual reports referred to in this subsection may be referred to also as single audits, directors' examinations, internal reports or audits or other similar terms. This is intended to refer to an audit of an insurer's assets only and not to the custodian's assets. (The drafters suggest that a reference to 12 C.F.R. 9.8 and 12 C.F.R. 9.9 may be useful here also; however, such a reference is not intended to limit the scope of this subsection to reports required only by the Comptroller of the Currency.)

(6) During the course of the custodian's regular business hours, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, the custodian's records relating to custodied securities, but only upon furnishing the custodian with written instructions to that effect from an appropriate officer of the insurance company.

(7) The custodian and its agents shall be required to send to the insurance company:

(a) All reports which they receive from a clearing corporation on their respective systems of internal accounting control, and

(b) Reports prepared by outside auditors on the custodians or its agent's internal accounting control of custodied securities that the insurance company may reasonably request.

(8) The custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's annual statement and supporting schedules and information required in an audit of the financial statements of the insurance company.

(9) The custodian shall provide, upon written request from an appropriate officer of the insurance company, the appropriate affidavits, substantially in the form attached to this regulation, with respect to custodied securities.

(10) A national bank, state bank or trust company shall secure and maintain insurance protection in an adequate amount covering the bank's or trust company's duties and activities as custodian for the insurer's assets, and shall state in the custody agreement that protection is in compliance with the requirements of the custodian's banking regulator. A broker/dealer shall secure and maintain insurance protection for each insurance company's custodied securities in excess of that provided by the Securities Investor Protection Corporation in an amount equal to or greater than the market value of each respective insurance company's custodied securities. The commissioner may determine whether the type of insurance is appropriate and the amount of coverage is adequate.

Drafting Note: The following subsections provide alternate standards of custodial liability. The standard in the first alternative is equivalent to that of a bailee for hire under New York law. The second alternative is more strict.

(11) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities, except that the custodian shall not be so obligated to the extent that the loss was caused by other than the negligence or dishonesty of the custodian.

(12) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction.]

(13) In the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in Paragraph (11) above, the custodian shall promptly replace the securities or the value thereof and the value of any loss of rights or privileges resulting from the loss of securities.

(14) The agreement may provide that the custodian will not be liable for a failure to take an action required under the agreement in the event and to the extent that the taking of the action is prevented or delayed by war (whether declared or not and including existing wars), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosion, stoppage of labor, strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control.

(15) In the event that the custodian gains entry in a clearing corporation through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian. However, if the agent shall be subject to regulation under the laws of a jurisdiction that is different from the jurisdiction the laws of which regulate the custodian, the Commissioner of Insurance of the state of domicile of the insurance company may accept a standard of liability applicable to the agent that is different from the standard of liability applicable to the custodian.

(16) The custodian shall provide written notification to the insurer's domiciliary commissioner if the custodial agreement with the insurer has been terminated or if 100% of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the insurance commissioner within three (3) business days of the receipt by the custodian of the insurer's written notice of termination or within three (3) business days of the withdrawal of 100% of the account assets.

Section 3. Deposit with Affiliates; Requirements

A. Nothing in this regulation shall prevent an insurance company from depositing securities with another insurance company with which the depositing insurance company is affiliated, provided that the securities are deposited pursuant to a written agreement authorized by the board of directors of the depositing insurance company or an authorized committee thereof and that the receiving insurance company is organized under the laws of one of the states of the United States of America or of the District of Columbia. If the respective states of domicile of the depositing and receiving insurance companies are not the same, the depositing insurance company shall have given notice of the deposit to the insurance commissioner in the state of its domicile and the insurance commissioner shall not have objected to it within thirty (30) days of the receipt of the notice.

B. The terms of the agreement shall comply with the following:

(1) The insurance company receiving the deposit shall maintain records adequate to identify and verify the securities belonging to the depositing insurance company.

(2) The receiving insurance company shall allow representatives of an appropriate regulatory body to examine records relating to securities held subject to the agreement.

(3) The depositing insurance company may authorize the receiving insurance company:

(a) To hold the securities of the depositing insurance company in bulk, in certificates issued in the name of the receiving insurance company or its nominee, and to commingle them with securities owned by other affiliates of the receiving insurance company, and

(b) To provide for the securities to be held by a custodian, including the custodian of securities of the receiving insurance company or in a clearing corporation.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1981 Proc. II 27, 35, 309, 393, 395, 403-405) (adopted).
1995 Proc. 1st Quarter 7, 10, 223, 347, 361-365 (amended and reprinted).
2001 Proc. 2nd Quarter 12, 14, 322, 594, 614-617 (amended and model reprinted).
2004 Proc. 1st Quarter 926-927, 1049, 1051-1057 (amended and reprinted, adopted by parent committee).
2004 Proc. 2nd Quarter 51 (adopted by Plenary).
2008 Proc. 3rd Quarter 3-365 to 3-377 (guideline amendments adopted).

FORM A

CUSTODIAN AFFIDAVIT

[For use by a custodian where securities entrusted to its care have not been redeposited elsewhere.]

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ _____ having a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the schedule attached hereto is a true and complete statement of securities (other than those caused to be deposited with The Depository Trust Company or like entity or a Federal Reserve Bank under the TRADES or Treasury Direct systems) which were in the custody of the corporation for the account of the insurance company as of the close of business on _____; that, unless otherwise indicated on the schedule, the next maturing and all subsequent coupons were then either attached to coupon bonds or in the process of collection; and that, unless otherwise shown on the schedule, all such securities were in bearer form or in registered form in the name of the insurance company or its nominee or of the corporation or its nominee, or were in the process of being registered in such form;

That the corporation as custodian has the responsibility for the safekeeping of such securities as that responsibility is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

FORM B

CUSTODIAN AFFIDAVIT

(For use in instances where a custodian corporation maintains securities on deposit with The Depository Trust Company or like entity.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ having a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the corporation has caused certain of such securities to be deposited with _____ and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, and which were so deposited on such date;

That the corporation as custodian has the responsibility for the safekeeping of the securities both in the possession of the corporation or deposited with _____ as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

FORM C

CUSTODIAN AFFIDAVIT

(For use where ownership is evidenced by book entry at a Federal Reserve Bank.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ with a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That it has caused certain securities to be credited to its book entry account with the Federal Reserve Bank of _____ under the TRADES or Treasury Direct systems; and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, which were in a "general" book entry account maintained in the name of the corporation on the books and records of the Federal Reserve Bank of _____ at such date;

That the corporation has the responsibility for the safekeeping of such securities both in the possession of the corporation or in the "general" book entry account as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

The NAIC amended this model during the 2008 Fall National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2008 3rd Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Definitions

When used in this regulation, the term

A. "Agent" means a national bank, state bank, trust company or broker/dealer that maintains an account in its name in a clearing corporation or that is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation, including the Treasury/Reserve Automated Debt Entry Securities System (TRADES) or Treasury Direct systems, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "agent" may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities.

B. "Clearing corporation" means a corporation as defined in [Section 8-102(a)(5) of the Uniform Commercial Code] that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" may include a corporation that is organized or existing under the laws of a foreign country and which is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes "Treasury/Reserve Automated Debt Entry Securities System" and "Treasury Direct" book-entry securities systems established pursuant to 31 U.S.C. § 3100 *et seq.*, 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301.

C. "Custodian" means:

(1) A national bank, state bank, federal home loan bank or trust company that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by the regulator charged with establishing standards for, and assessing, the institution's solvency and that is regulated by either federal or state banking laws or the Federal Home Loan Bank Act, as amended, or is a member of the Federal Reserve System and that is legally qualified to accept custody of securities in accordance with the standards set forth below, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "custodian" may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by international banking authorities and that is legally qualified to accept custody of securities; or

(2) A broker/dealer that shall be registered with and subject to jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, and has a tangible net worth equal to or greater than two hundred fifty million dollars ($250,000,000).

D. "Custodied securities" means securities held by the custodian or its agent or in a clearing corporation, including the Treasury/Reserve Automated Debt Equity Securities System (TRADES) or Treasury Direct systems.

E. "Tangible net worth" means shareholders equity, less intangible assets, as reported in the broker/dealer's most recent Annual or Transition Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 (S.E.C. Form 10-K) filed with the Securities and Exchange Commission.

F. "Treasury/Reserve Automated Debt Entry Securities System" ("TRADES") and "Treasury Direct" mean the book entry securities systems established pursuant to 31 U.S.C. § 3100 *et seq.*, 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301. The operation of TRADES and Treasury Direct are subject to 31 C.F.R. pt. 357 *et seq*

G. "Security" has the same meaning as that defined in [Section 8-102(a)(15) of the Uniform Commercial Code].

H. "Securities' certificate" has the same meaning as that defined in [Section 8-102(a)(16) of the Uniform Commercial Code].

Section 2. Custody Agreement; Requirements

A. An insurance company may, by written agreement with a custodian, provide for the custody of its securities with that custodian. The securities that are the subject of the agreement may be held by the custodian or its agent or in a clearing corporation.

B. The agreement shall be in writing and shall be authorized by a resolution of the board of directors of the insurance company or of an authorized committee of the board. The terms of the agreement shall comply with the following:

(1) Securities' certificates held by the custodian shall be held separate from the securities' certificates of the custodian and of all of its other customers.

(2) Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurance company. The records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, the records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation and if through an agent, the name of the agent.

(3) All custodied securities that are registered shall be registered in the name of the company or in the name of a nominee of the company or in the name of the custodian or its nominee or, if in a clearing corporation, in the name of the clearing corporation or its nominee.

(4) Custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except that custodied securities used to meet the deposit requirements set forth in Section [section of the state statute requiring deposit of securities as a condition of doing business] of this Insurance Law shall, to the extent required by that section, be under the control of the [appropriate insurance regulatory authority] and shall not be withdrawn by the insurance company without the approval of the [appropriate insurance regulatory authority].

(5) The custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. In addition, the custodian shall be required to furnish no less than monthly the insurance company with reports of holdings of custodied securities at times and containing information reasonably requested by the insurance company. The custodian's trust committee's annual reports of its review of the insurer's trust accounts shall also be provided to the insurer. Reports and verifications may be transmitted in electronic or paper form.

Drafting Note: The annual reports referred to in this subsection may be referred to also as single audits, directors' examinations, internal reports or audits or other similar terms. This is intended to refer to an audit of an insurer's assets only and not to the custodian's assets. (The drafters suggest that a reference to 12 C.F.R. 9.8 and 12 C.F.R. 9.9 may be useful here also; however, such a reference is not intended to limit the scope of this subsection to reports required only by the Comptroller of the Currency.)

(6) During the course of the custodian's regular business hours, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, the custodian's records relating to custodied securities, but only upon furnishing the custodian with written instructions to that effect from an appropriate officer of the insurance company.

(7) The custodian and its agents shall be required to send to the insurance company:

(a) All reports which they receive from a clearing corporation on their respective systems of internal accounting control, and

(b) Reports prepared by outside auditors on the custodians or its agent's internal accounting control of custodied securities that the insurance company may reasonably request.

(8) The custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's annual statement and supporting schedules and information required in an audit of the financial statements of the insurance company.

(9) The custodian shall provide, upon written request from an appropriate officer of the insurance company, the appropriate affidavits, substantially in the form attached to this regulation, with respect to custodied securities.

(10) A national bank, state bank, federal home loan bank or trust company shall secure and maintain insurance protection in an adequate amount covering the bank's or trust company's duties and activities as custodian for the insurer's assets, and shall state in the custody agreement that protection is in compliance with the requirements of the custodian's banking regulator. A broker/dealer shall secure and maintain insurance protection for each insurance company's custodied securities in excess of that provided by the Securities Investor Protection Corporation in an amount equal to or greater than the market value of each respective insurance company's custodied securities. The commissioner may determine whether the type of insurance is appropriate and the amount of coverage is adequate.

Drafting Note: The following subsections provide alternate standards of custodial liability. The standard in the first alternative is equivalent to that of a bailee for hire under New York law. The second alternative is more strict.

(11) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities, except that the custodian shall not be so obligated to the extent that the loss was caused by other than the negligence or dishonesty of the custodian.

(12) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction.]

(13) In the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in Paragraph (11) above, the custodian shall promptly replace the securities or the value thereof and the value of any loss of rights or privileges resulting from the loss of securities.

(14) The agreement may provide that the custodian will not be liable for a failure to take an action required under the agreement in the event and to the extent that the taking of the action is prevented or delayed by war (whether declared or not and including existing wars), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosion, stoppage of labor, strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control.

(15) In the event that the custodian gains entry in a clearing corporation through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian. However, if the agent shall be subject to regulation under the laws of a jurisdiction that is different from the jurisdiction the laws of which regulate the custodian, the Commissioner of Insurance of the state of domicile of the insurance company may accept a standard of liability applicable to the agent that is different from the standard of liability applicable to the custodian.

(16) The custodian shall provide written notification to the insurer's domiciliary commissioner if the custodial agreement with the insurer has been terminated or if 100% of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the insurance commissioner within three (3) business days of the receipt by the custodian of the insurer's written notice of termination or within three (3) business days of the withdrawal of 100% of the account assets.

Section 3. Deposit with Affiliates; Requirements

A. Nothing in this regulation shall prevent an insurance company from depositing securities with another insurance company with which the depositing insurance company is affiliated, provided that the securities are deposited pursuant to a written agreement authorized by the board of directors of the depositing insurance company or an authorized committee thereof and that the receiving insurance company is organized under the laws of one of the states of the United States of America or of the District of Columbia. If the respective states of domicile of the depositing and receiving insurance companies are not the same, the depositing insurance company shall have given notice of the deposit to the insurance commissioner in the state of its domicile and the insurance commissioner shall not have objected to it within thirty (30) days of the receipt of the notice.

B. The terms of the agreement shall comply with the following:

(1) The insurance company receiving the deposit shall maintain records adequate to identify and verify the securities belonging to the depositing insurance company.

(2) The receiving insurance company shall allow representatives of an appropriate regulatory body to examine records relating to securities held subject to the agreement.

(3) The depositing insurance company may authorize the receiving insurance company:

(a) To hold the securities of the depositing insurance company in bulk, in certificates issued in the name of the receiving insurance company or its nominee, and to commingle them with securities owned by other affiliates of the receiving insurance company, and

(b) To provide for the securities to be held by a custodian, including the custodian of securities of the receiving insurance company or in a clearing corporation.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1981 Proc. II 27, 35, 309, 393, 395, 403-405) (adopted).
1995 Proc. 1st Quarter 7, 10, 223, 347, 361-365 (amended and reprinted).
2001 Proc. 2nd Quarter 12, 14, 322, 594, 614-617 (amended and model reprinted).
2004 Proc. 1st Quarter 926-927, 1049, 1051-1057 (amended and reprinted, adopted by parent committee).
2004 Proc. 2nd Quarter 51 (adopted by Plenary).
2008 Proc. 3rd Quarter 3-365 to 3-377 (guideline amendments adopted).

FORM A

CUSTODIAN AFFIDAVIT

[For use by a custodian where securities entrusted to its care have not been redeposited elsewhere.]

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ _____ having a place of business at _____ _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the schedule attached hereto is a true and complete statement of securities (other than those caused to be deposited with The Depository Trust Company or like entity or a Federal Reserve Bank under the TRADES or Treasury Direct systems) which were in the custody of the corporation for the account of the insurance company as of the close of business on _____; that, unless otherwise indicated on the schedule, the next maturing and all subsequent coupons were then either attached to coupon bonds or in the process of collection; and that, unless otherwise shown on the schedule, all such securities were in bearer form or in registered form in the name of the insurance company or its nominee or of the corporation or its nominee, or were in the process of being registered in such form;

That the corporation as custodian has the responsibility for the safekeeping of such securities as that responsibility is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

FORM B

CUSTODIAN AFFIDAVIT

(For use in instances where a custodian corporation maintains securities on deposit with The Depository Trust Company or like entity.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ having a place of business at _____ _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the corporation has caused certain of such securities to be deposited with _____ and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, and which were so deposited on such date;

That the corporation as custodian has the responsibility for the safekeeping of the securities both in the possession of the corporation or deposited with _____ as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

FORM C

CUSTODIAN AFFIDAVIT

(For use where ownership is evidenced by book entry at a Federal Reserve Bank.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ with a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That it has caused certain securities to be credited to its book entry account with the Federal Reserve Bank of _____ under the TRADES or Treasury Direct systems; and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, which were in a "general" book entry account maintained in the name of the corporation on the books and records of the Federal Reserve Bank of _____ at such date;

That the corporation has the responsibility for the safekeeping of such securities both in the possession of the corporation or in the "general" book entry account as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-077 (1996/2003).		
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 21.865 to 21.899 (2008).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	CODE ARK. R. 054.00.26 (1987/2002).		
California			CAL. CODE REGS. tit. 10, § 2509.14 (1983) (workers' comp. deposits).
Colorado	3 COLO. CODE REGS. § 702-3:3-1-16 (2017).		
Connecticut		BULLETIN FS-2 (#2) (2002).	
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-143.041 to 69O.143.042 (1986).		

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. COMP. R. & REGS. 120-2-69 (1996).		GA. COMP. R. & REGS. 120-2-35 (1996) (department deposits).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-32 (508) (1983).
Kansas			KAN. ADMIN. REGS. § 40-1-47 (2002) (department deposits).
Kentucky	806 KY. ADMIN. REGS. 7:090 (1982).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.10501 to XIII.10511 (2005).		LA. REV. STAT. ANN. § 22:39 (1979/2004) (authority to adopt regulations).
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. §§ 31.04.09.01 to 31.04.09.04 (1968/2004).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. CODE REGS. ANN. tit. 20, § 200-7.200 (1980/1990) (affidavit forms).
Montana	NO CURRENT ACTIVITY		

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska			NEB. REV. STAT. § 44-5109 (1991/2005) (definitions); § 44-5154 (1991/2005) (authority to adopt regulation).
Nevada	210 NEV. ADMIN. CODE §§ 81-001 to 81-004 (2005).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. CODE R. INS. §§ 11:2-32.1 to 11:2-32.5 (1991/2001) (department deposits).
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. CIRCULAR LETTER Nos. 1975-1 (1975); 1976-13 (1976); 1977-2 (1977) (affidavits).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. ADMIN. CODE §§ 45-03-23-01 to 45-03-23-03 (1987/2012).		
Nothern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. STAT. tit. 36, § 1628 (1983).		
Oregon			OR. ADMIN. R. § 836-027-0200 (1998/2006).
Pennsylvania			31 PA. CODE §§ 148a.1 to 148a.5 (2002).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	TENN. COMP. R. & REGS. 0780-01-46 (1980/2013).		
Texas			TEX. ADMIN. CODE § 7.86 (1996/2002).
Utah	UTAH ADMIN. CODE r. 590-178 (1996/2006).		BULLETIN 2008-6 (2008).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE §§ 33-8A-1 to 33-8A-7 (2002) (combines model act and regulation).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	WY. RULES AND REGULATIONS 044.0002.57 §§ 1 to 6 (2006).		

PROJECT HISTORY - 2008

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#295)

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#298)

1. Project Description

The FHLB Custodial Subgroup of the Examination Oversight (E) Task Force was created at the 2007 Summer National Meeting of the NAIC. This Subgroup was created to work on a charge given to the Task Force by the Financial Condition (E) Committee. The Subgroup was to consider the Federal Home Loan Banks' (FHLBanks) request to be included in the Model Regulation on Custodial Agreements and the Use of Clearing Corporations and provide a recommendation to the Financial Condition (E) Committee. This charge was prompted by a comment letter received from the FHLBanks dated February 16, 2007.

2. Group Responsible for Drafting the Regulation

The project to review the FHLBanks request was given to the Examination Oversight (E) Task Force and assigned to the FHLB Custodial Subgroup. The following states participated in the subgroup:

Kansas, Chair	Alabama
New York	Tennessee

3. Charge Authorizing the Project

The Financial Condition (E) Committee approved the following charge for the Examination Oversight (E) Task Force through an e-mail vote completed on April 30, 2007:

The Examination Oversight (E) Task Force shall consider the FHLB request to be included in the Model Regulation on Custodial Agreements and the Use of Clearing Corporations and provide its recommendation to the Financial Condition (E) Committee.

4. General Description of the Drafting Process and Due Process

To begin reviewing the FHLBanks' request, the Subgroup had some questions about the FHLBanks' process to handle custodial assets and how that process is reviewed by its federal regulator. Initial questions were communicated to the FHLBanks in a memo dated July 26, 2007. The FHLBanks responded to the questions through their memo dated August 28, 2007. A conference call between the Subgroup and members of the FHLBanks was held September 5, 2007 to discuss the issues in greater detail. Finally, additional information was requested by the Subgroup through a memo dated September 24, 2007, and another response was received from the FHLB on November 30, 2007.

Through investigating answers to questions relating to the controls and regulation of custodial services offered by the FHLBanks, the Subgroup was able to reach a conclusion that the FHLBanks should be permitted to function as authorized custodians as outlined in the Model Act and Regulation on Custodial Agreements and the Use of Clearing Corporations. After concluding that the FHLBanks should be allowed to function as authorized custodians, the Subgroup turned its attention to proposing revisions to the Model Act on Custodial Agreements and the Use of Clearing Corporations (#295) and the Model Regulation on Custodial Agreements and the Use of Clearing Corporations (#298). Both of these models included language describing authorized custodians that would exclude the FHLBanks. However, based on a review of the NAIC's Model Law Development Framework, it was determined that changes to these models would not meet the criteria included in the framework. As such, the Subgroup determined that revisions should be made to the models and offered as guidelines to the states.

The Subgroup held a conference call on February 21, 2008, and conducted business via e-mail on March 7, 2008 to complete its work in proposing guideline revisions to the models. The guideline revisions were referred to the Examination Oversight (E) Task Force at its March 31, 2008, meeting. The Examination Oversight (E) Task Force exposed the proposed guideline revisions for a 45-day comment period during which no comments were received. On June 1, 2008, the Examination Oversight (E) Task Force adopted the proposed guideline changes to Model #295 and #298.

5. Discussion of Key Issues

The FHLB Custodial Subgroup conducted an in-depth review of the capital requirements, regulatory oversight and custodial controls and standards in place at the FHLBanks to reach a determination that the FHLBanks should be allowed to operate as authorized custodians of insurance company securities. As such, guideline revisions have been proposed to the Model Act on Custodial Agreements and the Use of Clearing Corporations (#295) and the Model Regulation on Custodial Agreements and the Use of Clearing Corporations (#298) to allow the FHLBanks to meet the definition of an authorized custodian.

6. Any Other Important Information

No other items identified at this time.

Exhibit A: Illustrative Timeline on Due Process and Drafting Process– FHLB Custody Issue

February 2007	Letter received from the FHLBanks requesting permission to act as authorized custodians of insurance company securities.
March 2007	(Spring National Meeting) The Examination Oversight (E) Task Force refers the letter along with its comments to the Financial Condition (E) Committee for review.
April 2007	The Financial Condition (E) Committee approves a charge for the Examination Oversight (E) Task Force to work on the project.
June 2007	(Summer National Meeting) The Examination Oversight (E) Task Force creates the FHLB Custodial Subgroup to work on the charge.
July 2007	A letter requesting information from the FHLBanks is sent by the FHLB Custodial Subgroup.
August 2007	The FHLBanks response to the information request is received by the FHLB Custodial Subgroup.
September 5, 2007	A conference call of the FHLB Custodial Subgroup is held to discuss the information received from the FHLBanks and to gather additional information regarding the custodial function and controls in place at the FHLBanks.
September 24, 2007	An additional information request letter is sent from the FHLB Custodial Subgroup to the FHLBanks.
November 30, 2007	The FHLBanks response to the second information request letter is received by the FHLB Custodial Subgroup.
February 21, 2008	A conference call of the FHLB Custodial Subgroup is held to discuss potential changes to Model #295 and #298 to allow the FHLBanks to act as authorized custodians of insurance company securities.
March 7, 2008	The FHLB Custodial Subgroup conducts business via email to adopt a referral to the Examination Oversight (E) Task Force recommending revisions to Model #295 and #298.
March 31, 2008	The Examination Oversight (E) Task Force receives the referral of the FHLB Custodial Subgroup and votes to expose the proposed revisions to Model #295 and #298 for a 45-day comment period.
June 1, 2008	The Examination Oversight (E) Task Force adopts the proposed revisions as guideline changes to Model #295 and #298.
June 2, 2008	The Financial Condition (E) Committee adopts the proposed revisions as guideline changes to Model #295 and #298.

PROJECT HISTORY - 2004

MODEL ACT ON CUSTODIAL AGREEMENTS AND THE USE OFCLEARING CORPORATIONS (#295)

MODEL REGULATION ON CUSTODIAL AGREEMENTS AND THE USE OF CLEARING CORPORATIONS (#298)

1. Description of the Project, Issues Addressed, etc.

The Model Act to Permit the Use of Clearing Corporations and the Federal Book Entry System by Insurance Companies (the Model Act) and the Model Regulation on the Use of Clearing Corporations and Federal Book Entry by Insurance Companies (the Model Regulation) have been revised to permit the use of broker/dealers as custodian for insurance company assets. The titles of the Model Act and Model Regulation have also been revised to more clearly identify the items discussed in the models. The revised titles are the Model Act on the Use of Custodial Agreements and Clearing Corporations and the Model Regulation on the Use of Custodial Agreements and Clearing Corporations.

2. Name of Group Responsible for Drafting the Model and States Participating

The Custodial Assets Working Group of the Financial Condition (E) Committee originally developed and adopted this revision. The working group includes: New York (Chair), Arkansas, Iowa, Oregon, and Texas.

3. Project Authorized by What Charge and Date First Given to the Group

The 2004 charge of the working group is, "The Custodial Assets Working group will revise the appropriate model laws, acts and handbook guidance to allow broker/dealers that meet certain standards to be authorized NAIC custodians for insurance company investments."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open as the Custodial Assets Working Group solicited comments from all interested parties, including interested regulators and industry representatives. At the 2003 Fall National Meeting, the Financial Condition (E) Committee voted to allow broker/dealers to act as custodians for insurance company assets. At that time, the Committee instructed the Custodial Assets Working Group to develop revisions to the applicable models. The revisions to the Model Act and Model Regulation were first discussed during an open conference call of the working group on November 19, 2003. At that time, the working group voted to expose the proposed revisions for comment. The revisions to the Model Act and Model Regulation were adopted during an open conference call of the working group on February 26, 2004.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The working group received comment letters from interested parties on whether broker dealers should be allowed to act as custodians for insurance companies. Comments were discussed in open forum at the Fall 2002, Winter 2002, and Spring 2003 National Meetings. The revisions to the models were exposed for a public comment for a sixty-day period. The working group discussed comments received in an open forum.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

One significant issue was discussed by the working group and interested parties. One of the comment letters received discussed concern that the proposed revisions did not require broker/dealers to provide insurance coverage in excess of that provided by the Securities Investor Protection Corporation (SIPC). After some discussion, the working group voted to require that broker/dealers acting as custodians for insurance company assets hold insurance coverage in excess to that provided by SIPC in an amount equal to or greater than the largest, single insurance company customer deposit.

7. Any Other Important Information (e.g., amending an accreditation standard)

On January 1, 2003, the Financial Regulation Standards and Accreditation (F) Committee exposed for a two-year period the Model Act and Model Regulation as possible accreditation standards. If the revisions to the Model Act and Model Regulation are adopted by the NAIC membership, the Financial Regulation Standards and Accreditation (F) Committee will review the revised Model Act and Model Regulation for further consideration. In addition, the working group will send a referral to the Financial Examiners Handbook Technical Group to consider applicable revisions to the NAIC *Financial Condition Examiners Handbook*.

PROJECT HISTORY - 2001

MODEL REGULATION ON THE USE OF CLEARING CORPORATIONS AND FEDERAL RESERVE BOOK-ENTRY SYSTEM BY INSURANCE COMPANIES (#298)

1. Project Description

The Financial Examiners Handbook Technical Group was charged with modifying the Model Regulation on the Use of Clearing Corporations and Federal Reserve Book-Entry System by Insurance Companies (Model Law) to require a notice of termination by the custodian to the insurance department in the event an insurer withdraws a significant percentage of the assets in custody.

2. Group Responsible for the Report

The project was assigned to the Financial Examiners Handbook Technical Group. The members of the technical group at that time were: Ramon Calderon (CA), Chair; Thomas Burke (NH); John Coleman (DC); Karen Mitchell (NJ); David Delbiondo (PA); Leman McLean (MN); James Gorman (CT); Neeraj Gupta (OR); Bill Hosea (TN); Dave Krumm (NE); Peter Medley (WI); Darryl Reese (DE); William Rossback (OH); Danny Saenz (TX); Lester Schott (MD); Ken Skiera (IL); and Robert Stanfield (NC).

3. Charge Authorizing the Project

In 1999, the Ad Hoc Task Force on Solvency and Anti-Fraud (Task Force) was established to gather input on possible improvements to regulatory programs and practices as a result of the alleged fraud scheme involving Martin Frankel and a number of insurance companies. The final report of the Task Force outlined various initiatives to strengthen current financial solvency tools. From this report the Task Force requested that the Model Regulation on the Use of Clearing Corporations and Federal Reserve Book-Entry System by Insurance Companies be reviewed. The Task Force referred this charge to the Financial Condition (E) Committee as a level-one recommendation in June 2000. The Financial Condition (E) Committee then referred this charge to the Financial Examiners Handbook Technical Group for completion.

4. General Description of the Drafting Process and Discussion of Key Issues

A draft of revisions to the Model Law was prepared on December 5, 2000, by NAIC Staff. The technical group exposed those amendments for comments from interested parties for a period of sixty days after the NAIC 2000 Winter National Meeting. The technical group reviewed the interested party comments and adopted additional amendments during a closed conference call on March 21, 2001. These amendments were then exposed for comments from interested parties for an additional forty-five days. The Model Law amendments were adopted on June 11, 2001, during the NAIC Summer National Meeting. Additional insignificant amendments were made at this time, but further exposure was not deemed necessary. The adopted amendments require written notification to the insurer's domiciliary commissioner if the custodial agreement with the insurer has been terminated or if 100% of the account assets in any one custody account have been withdrawn. The notification is required to be remitted within three business days of the receipt by the custodian of the insurer's written notice of termination or within three business days of the withdrawal of 100% of the account assets.

The Model Law was presented and adopted by the Examination Oversight (E) Task Force at the NAIC 2001 Summer National Meeting.

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT

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Section 1. Purpose and Scope

A. The purpose of this Act is to:

(1) Provide the Insurance Commissioner a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

(2) Outline the requirements for completing a corporate governance annual disclosure with the Insurance Commissioner.

(3) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

B. Nothing in this act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this act shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under [INSERT EXAMINATION CITATION]

C. The requirements of this Act shall apply to all insurers domiciled in this state.

Drafting Note: The requirements of this Act are intended to apply to all commercial risk bearing entities subject to oversight by state insurance departments. Therefore, modifications may be necessary to ensure that all entities intended to be subject to the Act, but not meeting the state's legal definition of "insurer," are appropriately referenced.

Section 2. Definitions

A. "Commissioner." The Insurance Commissioner of the State.

B. "Corporate Governance Annual Disclosure (CGAD)." A Corporate Governance Annual Disclosure shall mean a confidential report filed by the insurer or insurance group made in accordance with the requirements of this Act.

C. "Insurance group." For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in [insert state law equivalent to the model Insurance Holding Company System Regulatory Act.]

D. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

E. "ORSA Summary Report." The term "ORSA Summary Report" shall mean the report filed in accordance with [insert applicable statutory reference to the Risk Management and Own Risk and Solvency Assessment Model Act.]

Section 3. Disclosure Requirement

A. An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in Section 5B below. Notwithstanding any request from the Commissioner made pursuant to Subsection C, if the insurer is a member of an insurance group, the insurer shall submit the report required by this Section to the Commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

B. The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer not required to submit a CGAD under this section shall do so upon the Commissioner's request.

D. For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in Paragraph A of this section.

F. Insurers providing information substantially similar to the information required by this Act in other documents provided to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this Department shall not be required to duplicate that information in the CGAD, but shall only be required to cross reference the document in which the information is included.

Section 4. Rules and Regulations

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 5. Contents of Corporate Governance Annual Disclosure

A. The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information that he or she deems material and necessary to provide the Commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

B. Notwithstanding Subsection A of this section, the CGAD shall be prepared consistent with the Corporate Governance Annual Disclosure Model Regulation [INSERT CITATION]. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

Section 6. Confidentiality

A. Documents, materials or other information including the CGAD, in the possession or control of the Department of Insurance that are obtained by, created by or disclosed to the Commissioner or any other person under this Act, are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to Subsection C below to assist in the performance of the Commissioner's regular duties.

Drafting Note: States should consider whether to specifically invoke their examination statute as applicable additional confidentiality protection for documents submitted pursuant to this Model Act.

B. Neither the Commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

(1) May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], with the NAIC, and with third party consultants pursuant to Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

D. The sharing of information and documents by the Commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the Commissioner under this section or as a result of sharing as authorized in this Act.

Section 7. NAIC and Third-party Consultants

A. The Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the CGAD and related information or the insurer's compliance with this Act.

B. Any persons retained under Subsection A shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

C. The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

D. As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this Act.

E. A written agreement with the NAIC and/or a third-party consultant governing sharing and use of information provided pursuant to this Act shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this Act:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this Act.

(2) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality.

(3) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department of Insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

(4) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

(5) A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(6) A requirement that the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Act.

Section 8. Sanctions

Any insurer failing, without just cause, to timely file the CGAD as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day's delay, to be recovered by the Commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Section 9. Severability Clause

If any provision of this Act other than Section 6, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act, with the exception of Section 6, are severable.

Section 10. Effective Date

The requirements of this Act shall become effective on January 1, 2016. The first filing of the CGAD shall be in 2016.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2014 Proc. 3rd Quarter Vol. I 121-122, 135-140, 239-252, 267 (adopted).

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE § 27-29B (2019).		
Alaska	ALASKA STAT. ANN. §§ 21.09.400 to 21.09.460 (2019).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-492 to 20-492.06 (2019).		
Arkansas	23-63 ARK. CODE R. §§ 2001 to 2010 (2019).		
California	CAL. INS. CODE §§ 936.1 to 936.9 (2015).		
Colorado	COLO. REV. STAT. ANN. §§ 10-3-1601 to 10-3-1608 (2019).		
Connecticut	CONN. GEN. STAT. § 38a-142a (2016).		
Delaware	DEL. CODE ANN. tit. 18, §§ 8502 to 8511 (2017).		
District of Columbia	26-A DCMR § 2500 D.C. MUN. REGS. tit. 26-A, §§ 2500 to 2599 (2022).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. ANN. § 628.8015 (2016/2018).		
Georgia	GA. CODE ANN. §§ 33-65-1 to 33-65-11 (2019).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3G-101 to 431:3G-109 (2019).		
Idaho	IDAHO CODE §§ 41-6401 to 41-6406 (2017).		
Illinois	215 ILL. COMP. STAT. ANN. 5/130.1 to 5/130.7 (2019) (portions of model).		
Indiana	IND. CODE ANN. § 27-1-4.1 (2015/2018).		
Iowa	IOWA CODE ANN. § 521H (2015).		
Kansas	KAN. STAT. ANN. § 40-2,203 (2017).		
Kentucky	KY. REV. STAT. ANN. § 304.3-235 (2019).		
Louisiana	LA. REV. STAT. §§ 22:691.51 to 22:691.58 (2016).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 423-G (2017).		
Maryland	MD. CODE ANN., INS. §§ 4–501 to 4–509 (2019).		
Massachusetts	MASS. GEN. LAWS ch. 176W, §§ 1 to 8 (2018).		
Michigan	MICH. COMP. LAWS §§ 500.1751 to 500.1767 (2018).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. ANN. § 60A.1391 (2019).		
Mississippi	MISS. CODE ANN. §§ 83-5-701 to 83-5-717 (2019).		
Missouri	MO. REV. STAT. §§ 382.600 to 382.640 (2018).		
Montana	MONT. CODE ANN. §§ 33-2-2101 to 33-2-2109 (2017).		
Nebraska	NEB. REV. STAT. §§ 44-9101 to 44-9109 (2016).		
Nevada	NEV. REV. STAT. §§ 692c.3501 to 692c.3509 (2018).		
New Hampshire	N.H. REV. STAT. ANN. §§ 401-D:1 to 401-D:9 (2016/2018).		
New Jersey	P.L. 2019, ch. 350 (A6007) (2020).		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-10-755 to 790 (2019).		
North Dakota	N.D. CENT. CODE § 26.1-10.3 (2019).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3901.072 to 3901.078 (2016).		
Oklahoma	OKLA. STAT. ANN. tit. 36, §§ 1534 to 1541 (2019).		
Oregon	OR. REV. STAT. §§ 732.680 to 732.689 (2017).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	40 PA. CONS. STAT. §§ 3901 to 3911 (2018).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-1.2-1 to 27-1.2-9 (2016).		
South Carolina	S.C. CODE ANN. §§ 38-13-1000 to 38-13-1080 (2019).		
South Dakota	H.B. 1017 (2020).		
Tennessee	TENN. CODE ANN. §§ 56-2-901 to 56-2-910 (2018).		
Texas	TEX. INS. CODE ANN. §§ 831.0001 to 831.0014 (2019).		
Utah	UTAH CODE ANN. §§ 31A-16b-101 to 31A-16b-108 (2019).		
Vermont	VT. STAT. ANN. tit. 8, § 3316 (2015).		
Virgin Islands	V.I. tit. 22, §§ 498 to 498i (2019).		
Virginia	VA. CODE ANN. §§ 38.2-1334.11 to 38.2-1334.17 (2017).		
Washington	WASH. REV. CODE §§ 48.195.005 to 48.195.100 (2019).		
West Virginia	W. VA. CODE §§ 33-52-1 to 33-52-9 (2019).		
Wisconsin	WIS. STAT. ANN. § 610.80 (2018).		BULLETIN 5-31-2018 (2018).
Wyoming	WYO. STAT. ANN. §§ 26-54-101 to 26-54-108 (2018); § 26-29-239 (2018).		

PROJECT HISTORY - 2014

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT (#305)

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION (#306)

1. Project Description

In light of the 2008 financial crisis, growing regulatory needs and various international developments, U.S. insurance regulators, working together through the NAIC, concluded that a greater regulatory focus on corporate governance was necessary and formed the Corporate Governance (E) Working Group in September 2009 to address these matters. The Working Group received a charge to outline high-level corporate governance principles for use in U.S. insurance regulation. To do so, the Working Group analyzed the existing statutory requirements, regulatory initiatives and review practices of the state insurance departments, international supervisors, other U.S. functional regulators and the insurance industry. The Working Group was also asked to determine the appropriate method to ensure adherence with such principles, giving due consideration to development of a model law and to development of additional regulatory guidance, including detailed best practices for the corporate governance of insurers.

In completing work on this charge, the Working Group developed a summary of existing corporate governance requirements found within NAIC/insurance-specific sources and within more general, broadly based sources. The goal was to identify potential changes in the existing insurance regulatory structure that could be affected through the NAIC Solvency Modernization Initiative. The Working Group then compared those existing U.S. requirements to regulatory needs, best practices and principles outlined in the Insurance Core Principles adopted by the International Association of Insurance Supervisors (IAIS). The results of this comparative analysis indicated a need to collect additional information from insurers regarding corporate governance practices on an annual basis, to facilitate the review and assessment of this information through the solvency-monitoring process.

The Working Group investigated several options for collecting confidential information from insurers on corporate governance practices before proceeding with the development of the Corporate Governance Annual Disclosure Model Act (Model Act) authorizing the collection and protection of governance information. In addition to the Model Act, the Working Group identified a need to develop a Corporate Governance Annual Disclosure Model Regulation (Model Regulation) outlining the detailed disclosure requirements.

2. Group Responsible for Drafting the Model Act and Regulation

The project to develop the Model Act and Model Regulation was given to the Corporate Governance (E) Working Group. The Working Group created a Drafting (E) Subgroup to develop an initial draft of the Model Act for the Working Group to consider, which was originally supported by a draft guidance manual. Members of the Subgroup included Vermont (chair), California, Indiana, Ohio and Pennsylvania. After the initial draft was developed by the Subgroup, it was later reviewed and revised by the full Working Group, whose members included Vermont (chair), New York (vice chair), Alabama, California, Connecticut, Florida, Iowa, Indiana, Louisiana, Missouri, New Hampshire, Ohio, Oklahoma, Pennsylvania, Virginia and Washington.

3. Charge Authorizing the Project

On April 8, 2013, the Financial Condition (E) Committee adopted a request for model law development to develop the Model Act. The Executive (EX) Committee adopted this request July 26, 2013. The Financial Condition (E) Committee delegated the assignment of developing the Model Act to the Corporate Governance (E) Working Group, and drafting work began soon after the 2013 Summer National Meeting.

4. General Description of the Drafting Process and Due Process

- During September and October 2013, the Drafting (E) Subgroup met via conference call in regulator-to-regulator session to develop an initial draft of the Model Act, supported by a guidance manual.
- After finalizing an initial draft of the Model Act and guidance manual, the Subgroup referred the draft to the Corporate Governance (E) Working Group for its review on a Nov. 8, 2013, conference call.

- The Working Group discussed the draft on its Nov. 8, 2013, conference call and received verbal comments from interested parties. Interested parties voiced objections to the use of a guidance manual to house the filing instructions. Based on the discussions held, the Working Group agreed to develop modifications to the Model Act and the guidance manual before exposing the drafts for public comment.
- Updated drafts of the Model Act and guidance manual were presented to the Working Group at its Dec. 16, 2013, meeting at the 2013 Fall National Meeting. The updated draft of the guidance manual limited its purpose, restricted the frequency with which changes could be made and prohibited the addition of new sections to the guidance manual without updating the Model Act. The drafts of the Model Act and guidance manual were then exposed for a 45-day public comment period ending Jan. 31, 2014.
- At the conclusion of the public comment period, a number of comment letters were received, including additional objections from interested parties regarding the use of a guidance manual to house the annual filing instructions.
- In February 2014, the Working Group instructed NAIC staff to develop a draft Model Regulation to house the annual filing requirements in lieu of the guidance manual.
- A Model Regulation housing annual disclosure instructions was presented to the Working Group for review during its March 6, 2014, conference call. The Model Regulation was then exposed for a 45-day public comment period ending April 21, 2014.
- The Model Act was then revised to refer to the Model Regulation, which led to discussions at the Working Group's March 30, 2014, meeting at the 2014 Spring National Meeting and a brief exposure of the updated Model Act for a public comment period ending April 21, 2014.
- Comment letters were received on both the Model Act and the Model Regulation, which were discussed on conference calls held June 19 and July 1, 2014. Much of the discussion related to the confidentiality language included in the Model Act, which was finalized on these calls.
- The Model Act and Model Regulation were adopted by the Corporate Governance (E) Working Group Aug. 17, 2014. The Model Act and Model Regulation were adopted by the Financial Condition (E) Committee Aug. 18, 2014.

5. Discussion of Key Issues

A number of key issues were raised during the development of the Model Act and Model Regulation. These issues included confidentiality protection for the governance information to be disclosed, the level at which the disclosure should be completed, the contents of the annual disclosure, the placement of disclosure instructions and the removal of potential redundancies in other areas of insurance regulation created by the disclosure.

As demonstrated above, the most significant debate in developing both models revolved around the placement of instructions for the annual disclosure. Initially, regulators proposed the use of a guidance manual to house instructions that would ensure consistency across the states and to allow the ability to make modifications when necessary to address new and emerging corporate governance issues. Interested parties objected on the grounds that a guidance manual could allow for frequent and significant changes to the disclosure requirements without such changes being subject to sufficient due process. Ultimately, regulators and interested parties agreed to compromise by presenting the disclosure instructions in the Model Regulation supporting the Model Act.

Together, the Model Act and Model Regulation require an insurer (or group of insurers) to provide a confidential disclosure regarding its corporate governance practices to the lead state and/or domestic regulator annually by June 1. The insurer (or group of insurers) may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, based on its determination of the level at which decisions are made, oversight is provided and governance accountability is assessed in relation to the insurance activities of the insurer.

The insurer has discretion regarding the appropriate format for providing the information and is permitted to customize the communication to provide the most relevant information necessary to permit the domiciliary commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer. However, at a minimum, the disclosure is required to address:

- The insurer's corporate governance framework and structure;
- The policies and practices of its board of directors and significant committees;
- The policies and practices directing senior management; and
- The processes by which the board of directors, its committees and senior management ensure an appropriate level of oversight to the critical risk areas impacting the insurer's business activities.

In completing the annual disclosure, the insurer may reference other existing documents (e.g., the Own Risk and Solvency Assessment (ORSA) Summary Report, holding company Form B or Form F filings, U.S. Securities and Exchange Commission (SEC) proxy statements, foreign regulatory reporting requirements, etc.) to the regulator in fulfillment of the information requested in various areas.

All information provided in the annual disclosure is recognized as being proprietary to the insurer and containing trade secrets. Therefore, confidentiality language was included in the Model Act stating that all such information is deemed confidential by law and privileged, is not subject to subpoena and is not subject to discovery or admissible in evidence in any private civil action. However, the domiciliary commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

Some state insurance regulators expressed concern that the confidentiality language included in the Model Act (i.e., the ability to restrict discovery from the insurer) is overly broad and extends beyond the authority typically granted to the insurance department. However, the Working Group noted that the same confidentiality language has been included in multiple NAIC models and the industry argued strongly on its behalf. Therefore, the Working Group agreed to keep the standard wording in the Model Act, but recognized the fact that individual states may have to modify the confidentiality language, if necessary, in the process of adopting the Model Act.

The requirements of the Model Act and Model Regulation are intended to be effective Jan. 1, 2016. The first annual disclosure is scheduled to be due by June 1, 2016.

6. Any Other Important Information

No other items identified at this time.

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

Table of Contents

Section 1. Authority

These regulations are promulgated pursuant to the authority granted by Sections [insert applicable sections] and [insert applicable section] of the Insurance Law.

Section 2. Purpose

The purpose of these regulations is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the [Commissioner] to carry out the provisions of [insert reference to Corporate Governance Annual Disclosure Model Act].

Section 3. Definitions.

A. "Commissioner." The Insurance Commissioner of the State.

B. "Insurance group." For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in [insert state law equivalent to the model Insurance Holding Company System Regulatory Act.]

C. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

D. "Senior Management." The term "senior management" shall mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

Section 4. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by the [insert reference to Corporate Governance Annual Disclosure Model Act], shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described in Section 5 of these regulations.

B. The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter "Board") or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in Section 3 of the Corporate Governance Annual Disclosure Model Act, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in Section 5. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

G. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

Section 5. Contents of Corporate Governance Annual Disclosure

A. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

B. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following.

(1) The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

(2) The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chairman of the Board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.

(2) How an appropriate amount of independence is maintained on the Board and its significant committees.

(3) The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.

(4) How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

(a) Whether a nomination committee is in place to identify and select individuals for consideration.

(b) Whether term limits are placed on directors.

(c) How the election and re-election processes function.

(d) Whether a Board diversity policy is in place and if so, how it functions.

(5) The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

D. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

(1) Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(a) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

(b) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(2) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(a) Compliance with laws, rules, and regulations; and

(b) Proactive reporting of any illegal or unethical behavior.

(3) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(a) The Board's role in overseeing management compensation programs and practices.

(b) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(c) How compensation programs are related to both company and individual performance over time;

(d) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(e) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

(f) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) The insurer's or insurance group's plans for CEO and Senior Management succession.

E. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

(1) How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;

(2) How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that Senior Management is taking to monitor and manage those risks;

(3) How reporting responsibilities are organized for each critical risk area. The description should allow the Commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:

(a) Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(b) Actuarial function;

(c) Investment decision-making processes;

(d) Reinsurance decision-making processes;

(e) Business strategy/finance decision-making processes;

(f) Compliance function;

(g) Financial reporting/internal auditing; and

(h) Market conduct decision-making processes.

Section 6. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2014 Proc. 3rd Quarter, Vol. I 121-122, 135-140, 243-249 (adopted).
2015 Proc. 1st Quarter (editorial changes).

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-166 (2020).		
Alaska	ALASKA ADMIN. CODE tit. 3, § 21.790 (2019) (portions of model).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R. 20-6-310 to 20-6-310.04 (2019).		
Arkansas	ARK. ADMIN. CODE § 054.00.8 (RULE 8) (2019).		
California	CAL. INS. CODE §§ 936.1to 936.9 (2015).		NOTICE 4-25-16 (2016).
Colorado	3 COLO. CODE REGS. § 702-3:3-1-17 (2020).		
Connecticut	CONN. GEN. STAT. § 38a-142a (2017).		
Delaware	18 DEL. CODE REGS. §§ 307-1.0 to 307-6.0 (2018).		
District of Columbia	D.C. MUN. REGS. tit. 26-A, §§ 2500 to 2599 (2022).		

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. ANN. § 628.8015 (2016/2018) (portions of model).		
Georgia	GA. COMP R. & REGS § 120-2-105 (2020).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. ADMIN. CODE §§ 16-186-101 to 16-186-105 (2019).		
Idaho	IDAHO ADMIN. CODE r. 18.07.12.012 (2017/2019).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 630.10 to 630.40 (2020).		
Indiana	IND. CODE § 27-1-4.1-10 (2015).		
Iowa	IOWA ADMIN. CODE r. 191-111.1 to 191-111.5 (2016).		
Kansas	KAN. STAT. ANN. § 40-2,203 (2022).		
Kentucky	806 KY. ADMIN. REGS. 3:240 (2019).		
Louisiana	LA. ADMIN CODE. tit. 37, Pt. XIII, §§ 201 to 209 (2015).		
Maine	02-031 ME. CODE R. § 705 (2019).		
Maryland	MD. CODE ANN., INS. § 4-501-509 (2019).		
Massachusetts	MASS. GEN. LAWS ANN. ch. 176W, §§ 1 to 8 (2018).		
Michigan	MICH. COMP. LAWS ANN. §§ 500.1751 to 500.1767 (2020).		
Minnesota	MINN. STAT. § 60A.1391 (2019).		

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	MISS. CODE ANN. §§ 83-5-701 to 83-5-717 (2019).		
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 200-21.300 to 200-21.600 (2019).		
Montana	MONT. ADMIN. R. 6.6.8701 to 6.6.8705 (2017/2020).		
Nebraska	210 NEB. ADMIN. CODE §§ 88-001 to 88-006 (2016).		
Nevada	NEV. ADMIN. CODE §§ 692C.3501 to 692C.3509 (2018).		
New Hampshire	N.H. CODE ADMIN. R. INS. 4502 (2018).		
New Jersey	N.J. INS. ORDER NO. A20-2 (2020).		
New Mexico	N.M. ADMIN. CODE 13.2.10.1 to 13.2.10.12 (2020).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 90.1 to 90.4 (2020).		
North Carolina	N.C. GEN. STAT. §§ 58-10-755 to 58-10-790 (2019).		
North Dakota	N.D. ADMIN. CODE § 45-03-25 (2019).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-3-19 (2017).		
Oklahoma	OKLA. ADMIN. CODE 365:25-7-90 to 365 :25-7-95 (2019).		
Oregon	OR. ADMIN. R. 836-011-0024 (2018).		
Pennsylvania	40 PA. CONS. STAT. §§ 3901 to 3911 (2018).		

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. §§ 20-45-11.1 to 20-45-11.6 (2017).		
South Carolina	S.C. CODE ANN. REGS. 69-80 (2019).		
South Dakota	S.D. ADMIN. R. 20:06:60 (2020).		
Tennessee	TENN. COMP. R. & REGS. 0780-01-35 (2018).		
Texas	28 TEX. ADMIN. CODE §§ 7.88 to 7.89 (2020).		
Utah	UTAH ADMIN. CODE R590-284 (2020).		
Vermont	4-3 VT. CODE R. §§ 56:1 to 56:7 (Rule 56) (2016).		
Virgin Islands	BULLETIN 2020-02 (2020).		
Virginia	14 VA. ADMIN. CODE §§ 5-265-10 to 5-265-50 (2017).		
Washington	WASH. ADMIN. CODE §§ 284-07-700 to 284-07-740 (2018).		
West Virginia	W. WA. CODE R. §§ 33-52-1 to 33-52-9 (2019).		
Wisconsin	WIS. ADMIN. CODE 53.02 (2020).		
Wyoming	WYO. ADMIN. CODE 044.0002.70 §§ 1 to 6 (2019).		

PROJECT HISTORY - 2014

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT (#305)

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION (#306)

1. Project Description

In light of the 2008 financial crisis, growing regulatory needs and various international developments, U.S. insurance regulators, working together through the NAIC, concluded that a greater regulatory focus on corporate governance was necessary and formed the Corporate Governance (E) Working Group in September 2009 to address these matters. The Working Group received a charge to outline high-level corporate governance principles for use in U.S. insurance regulation. To do so, the Working Group analyzed the existing statutory requirements, regulatory initiatives and review practices of the state insurance departments, international supervisors, other U.S. functional regulators and the insurance industry. The Working Group was also asked to determine the appropriate method to ensure adherence with such principles, giving due consideration to development of a model law and to development of additional regulatory guidance, including detailed best practices for the corporate governance of insurers.

In completing work on this charge, the Working Group developed a summary of existing corporate governance requirements found within NAIC/insurance-specific sources and within more general, broadly based sources. The goal was to identify potential changes in the existing insurance regulatory structure that could be affected through the NAIC Solvency Modernization Initiative. The Working Group then compared those existing U.S. requirements to regulatory needs, best practices and principles outlined in the Insurance Core Principles adopted by the International Association of Insurance Supervisors (IAIS). The results of this comparative analysis indicated a need to collect additional information from insurers regarding corporate governance practices on an annual basis, to facilitate the review and assessment of this information through the solvency-monitoring process.

The Working Group investigated several options for collecting confidential information from insurers on corporate governance practices before proceeding with the development of the Corporate Governance Annual Disclosure Model Act (Model Act) authorizing the collection and protection of governance information. In addition to the Model Act, the Working Group identified a need to develop a Corporate Governance Annual Disclosure Model Regulation (Model Regulation) outlining the detailed disclosure requirements.

2. Group Responsible for Drafting the Model Act and Regulation

The project to develop the Model Act and Model Regulation was given to the Corporate Governance (E) Working Group. The Working Group created a Drafting (E) Subgroup to develop an initial draft of the Model Act for the Working Group to consider, which was originally supported by a draft guidance manual. Members of the Subgroup included Vermont (chair), California, Indiana, Ohio and Pennsylvania. After the initial draft was developed by the Subgroup, it was later reviewed and revised by the full Working Group, whose members included Vermont (chair), New York (vice chair), Alabama, California, Connecticut, Florida, Iowa, Indiana, Louisiana, Missouri, New Hampshire, Ohio, Oklahoma, Pennsylvania, Virginia and Washington.

3. Charge Authorizing the Project

On April 8, 2013, the Financial Condition (E) Committee adopted a request for model law development to develop the Model Act. The Executive (EX) Committee adopted this request July 26, 2013. The Financial Condition (E) Committee delegated the assignment of developing the Model Act to the Corporate Governance (E) Working Group, and drafting work began soon after the 2013 Summer National Meeting.

4. General Description of the Drafting Process and Due Process

- During September and October 2013, the Drafting (E) Subgroup met via conference call in regulator-to-regulator session to develop an initial draft of the Model Act, supported by a guidance manual.
- After finalizing an initial draft of the Model Act and guidance manual, the Subgroup referred the draft to the Corporate Governance (E) Working Group for its review on a Nov. 8, 2013, conference call.

- The Working Group discussed the draft on its Nov. 8, 2013, conference call and received verbal comments from interested parties. Interested parties voiced objections to the use of a guidance manual to house the filing instructions. Based on the discussions held, the Working Group agreed to develop modifications to the Model Act and the guidance manual before exposing the drafts for public comment.
- Updated drafts of the Model Act and guidance manual were presented to the Working Group at its Dec. 16, 2013, meeting at the 2013 Fall National Meeting. The updated draft of the guidance manual limited its purpose, restricted the frequency with which changes could be made and prohibited the addition of new sections to the guidance manual without updating the Model Act. The drafts of the Model Act and guidance manual were then exposed for a 45-day public comment period ending Jan. 31, 2014.
- At the conclusion of the public comment period, a number of comment letters were received, including additional objections from interested parties regarding the use of a guidance manual to house the annual filing instructions.
- In February 2014, the Working Group instructed NAIC staff to develop a draft Model Regulation to house the annual filing requirements in lieu of the guidance manual.
- A Model Regulation housing annual disclosure instructions was presented to the Working Group for review during its March 6, 2014, conference call. The Model Regulation was then exposed for a 45-day public comment period ending April 21, 2014.
- The Model Act was then revised to refer to the Model Regulation, which led to discussions at the Working Group's March 30, 2014, meeting at the 2014 Spring National Meeting and a brief exposure of the updated Model Act for a public comment period ending April 21, 2014.
- Comment letters were received on both the Model Act and the Model Regulation, which were discussed on conference calls held June 19 and July 1, 2014. Much of the discussion related to the confidentiality language included in the Model Act, which was finalized on these calls.
- The Model Act and Model Regulation were adopted by the Corporate Governance (E) Working Group Aug. 17, 2014. The Model Act and Model Regulation were adopted by the Financial Condition (E) Committee Aug. 18, 2014.

5. Discussion of Key Issues

A number of key issues were raised during the development of the Model Act and Model Regulation. These issues included confidentiality protection for the governance information to be disclosed, the level at which the disclosure should be completed, the contents of the annual disclosure, the placement of disclosure instructions and the removal of potential redundancies in other areas of insurance regulation created by the disclosure.

As demonstrated above, the most significant debate in developing both models revolved around the placement of instructions for the annual disclosure. Initially, regulators proposed the use of a guidance manual to house instructions that would ensure consistency across the states and to allow the ability to make modifications when necessary to address new and emerging corporate governance issues. Interested parties objected on the grounds that a guidance manual could allow for frequent and significant changes to the disclosure requirements without such changes being subject to sufficient due process. Ultimately, regulators and interested parties agreed to compromise by presenting the disclosure instructions in the Model Regulation supporting the Model Act.

Together, the Model Act and Model Regulation require an insurer (or group of insurers) to provide a confidential disclosure regarding its corporate governance practices to the lead state and/or domestic regulator annually by June 1. The insurer (or group of insurers) may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, based on its determination of the level at which decisions are made, oversight is provided and governance accountability is assessed in relation to the insurance activities of the insurer.

The insurer has discretion regarding the appropriate format for providing the information and is permitted to customize the communication to provide the most relevant information necessary to permit the domiciliary commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer. However, at a minimum, the disclosure is required to address:

- The insurer's corporate governance framework and structure;
- The policies and practices of its board of directors and significant committees;
- The policies and practices directing senior management; and
- The processes by which the board of directors, its committees and senior management ensure an appropriate level of oversight to the critical risk areas impacting the insurer's business activities.

In completing the annual disclosure, the insurer may reference other existing documents (e.g., the Own Risk and Solvency Assessment (ORSA) Summary Report, holding company Form B or Form F filings, U.S. Securities and Exchange Commission (SEC) proxy statements, foreign regulatory reporting requirements, etc.) to the regulator in fulfillment of the information requested in various areas.

All information provided in the annual disclosure is recognized as being proprietary to the insurer and containing trade secrets. Therefore, confidentiality language was included in the Model Act stating that all such information is deemed confidential by law and privileged, is not subject to subpoena and is not subject to discovery or admissible in evidence in any private civil action. However, the domiciliary commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

Some state insurance regulators expressed concern that the confidentiality language included in the Model Act (i.e., the ability to restrict discovery from the insurer) is overly broad and extends beyond the authority typically granted to the insurance department. However, the Working Group noted that the same confidentiality language has been included in multiple NAIC models and the industry argued strongly on its behalf. Therefore, the Working Group agreed to keep the standard wording in the Model Act, but recognized the fact that individual states may have to modify the confidentiality language, if necessary, in the process of adopting the Model Act.

The requirements of the Model Act and Model Regulation are intended to be effective Jan. 1, 2016. The first annual disclosure is scheduled to be due by June 1, 2016.

6. Any Other Important Information

No other items identified at this time.

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

Table of Contents

Section 1. Definitions

As used in this Act, these terms shall have the following meanings:

A. "Adjusted RBC Report" means an RBC report which has been adjusted by the commissioner in accordance with Section 2E.

B. "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Domestic insurer" means any insurance company domiciled in this state.

D. "Foreign insurer" means any insurance company which is licensed to do business in this State under [cite appropriate statute] but is not domiciled in this State.

Drafting Note: The drafting committee does not recommend application of the risk-based capital model act to any insurance company organized under the laws of any state of the United States if such company (1) has a provision in its certificate of incorporation (or like corporate instrument) prohibiting the doing of insurance business with persons or entities which are citizens or residents of, or organized or located within, the United States and (2) does not, in fact, do insurance business with such persons or entities, so that none of its insurance liabilities are to any such person or entity.

E. "NAIC" means the National Association of Insurance Commissioners.

F. "Life and/or health insurer" means any insurance company licensed under Section [cite appropriate statute], or a licensed property and casualty insurer writing only accident and health insurance.

Drafting Note: The drafting committee did not specifically examine, and expresses no opinion with respect to, the application of the risk-based capital formula to health service organizations, dental service organizations, health maintenance organizations, dental plan organizations or mutual benefit associations (including without limitation Blue Cross/Blue Shield organizations). States may wish to consider the application of the risk-based capital model act to these entities, or any of them.

G. "Fraternal benefit society" means any insurance company ("insurer") licensed under Section [cite appropriate statute].

H. "Property and casualty insurer" means any insurance company licensed under Section [cite appropriate statute] but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

Drafting Note: The drafting committee did not specifically examine, and expresses no opinion with respect to, the application of the risk-based capital formula to farm and county mutuals, health service organizations, dental service organizations, health maintenance organizations, dental plan organizations or any single state specialty insurer not subject to rules and regulations applicable to property and casualty insurers. States may wish to consider the application of the risk-based capital model act to these entities, or any of them.

I. "Negative trend" means, with respect to a life and/or health insurer or a fraternal benefit society, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life or Fraternal RBC Instructions.

J. "RBC instructions" means the RBC Report including risk-based capital instructions adopted by the NAIC, as such RBC Instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

K. "RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(1) "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;

(2) "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;

(3) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

(4) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

L. "RBC Plan" means a comprehensive financial plan containing the elements specified in Section 3B. If the commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "Revised RBC Plan."

M. "RBC Report" means the report required in Section 2.

N. "Total adjusted capital" means the sum of:

(1) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under [cite appropriate statute]; and

(2) Such other items, if any, as the RBC instructions may provide.

Section 2. RBC Reports

A. Every domestic insurer shall, on or prior to each March 1 (the "filing date"), prepare and submit to the commissioner a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC Report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC Report not later than the later of:

(a) Fifteen (15) days from the receipt of notice to file its RBC Report with that state; or

(b) The filing date.

B. A life and health insurer's or fraternal benefit society's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between) the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions.

C. A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions.

D. An excess of capital over the amount produced by the risk-based capital requirements contained in the Act and the formulas, schedules and instructions referenced in this Act is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this Act. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Act.

E. If a domestic insurer files an RBC Report which in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC Report as so adjusted is referred to as an "Adjusted RBC Report."

Section 3. Company Action Level Event

A. "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer which indicates that:

(a) The insurer's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(b) If a life and/or health insurer or a fraternal benefit society, the insurer or society has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend; or

(c) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions;

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates an event in Paragraph (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 7; or

(3) If, pursuant to Section 7, an insurer challenges an Adjusted RBC Report that indicates the event in Paragraph (1) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

B. In the event of a Company Action Level Event, the insurer shall prepare and submit to the commissioner an RBC Plan which shall:

(1) Identify the conditions which contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. (The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted

(1) Within forty-five (45) days of the Company Action Level Event; or

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 7, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

D. Within sixty (60) days after the submission by an insurer of an RBC Plan to the commissioner, the commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the Revised RBC Plan to the commissioner:

(1) Within forty-five (45) days after the notification from the commissioner; or

(2) If the insurer challenges the notification from the commissioner under Section 7, within forty-five (45) days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

E. In the event of a notification by the commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under Section 7, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic insurer that files an RBC Plan or Revised RBC Plan with the commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has an RBC provision substantially similar to Section 8A; and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(a) Fifteen (15) days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

(b) The date on which the RBC Plan or Revised RBC Plan is filed under Section 3C and 3D.

Section 4. Regulatory Action Level Event

A. "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(2) The notification by the commissioner to an insurer of an Adjusted RBC Report that indicates the event in Paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 7;

(3) If, pursuant to Section 7, the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(5) The failure of the insurer to submit an RBC Plan to the commissioner within the time period set forth in Section 3C;

(6) Notification by the commissioner to the insurer that

(a) The RBC Plan or revised RBC Plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(b) Such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under Section 7;

(7) If, pursuant to Section 7, the insurer challenges a determination by the commissioner under Paragraph (6), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge;

(8) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 7; or

(9) If, pursuant to Section 7, the insurer challenges a determination by the commissioner under Paragraph (8), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event the commissioner shall:

(1) Require the insurer to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "corrective order").

C. In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC Plan or Revised RBC Plan shall be submitted:

(1) Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 7 and the challenge is not frivolous in the judgment of the commissioner within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(3) If the insurer challenges a Revised RBC Plan pursuant to Section 7 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

D. The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the commissioner.

Section 5. Authorized Control Level Event

A. "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in Paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 7;

(3) If, pursuant to Section 7, the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph (1), notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the insurer has not challenged the corrective order under Section 7); or

(5) If the insurer has challenged a corrective order under Section 7 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

B. In the event of an Authorized Control Level Event with respect to an insurer, the commissioner shall:

(1) Take such actions as are required under Section 4 regarding an insurer with respect to which an Regulatory Action Level Event has occurred; or

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under [insert reference to relevant insurance company rehabilitation and liquidation act]. In the event the commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take action under [insert same reference], and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in [insert same reference]. In the event the commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Section [insert reference] pertaining to summary proceedings.

Section 6. Mandatory Control Level Event

A. "Mandatory Control Level Event" means any of the following events:

(1) The filing of an RBC Report which indicates that the insurer's total adjusted capital is less than its Mandatory Control Level RBC;

(2) Notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in Paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 7; or

(3) If, pursuant to Section 7, the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph (1), notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

B. In the event of a Mandatory Control Level Event:

(1) With respect to a life insurer or fraternal benefit society, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under [insert reference to relevant insurance company rehabilitation and liquidation act]. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under [insert same reference], and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in [insert same reference]. If the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of Section [insert reference] pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

(2) With respect to a property and casualty insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under [insert reference to relevant insurance company rehabilitation and liquidation act], or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under [insert same reference] and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in [insert same reference]. If the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of Section [insert reference] pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

Section 7. Hearings

Upon any of the following the insurer shall have the right to a confidential departmental hearing, on a record, at which the insurer may challenge any determination or action by the commissioner. The insurer shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under Subsection A, B, C or D. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request.

A. Notification to an insurer by the commissioner of an Adjusted RBC Report; or

B. Notification to an insurer by the commissioner that

(1) The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

(2) Such notification constitutes a Regulatory Action Level Event with respect to such insurer; or

C. Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

D. Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

Section 8. Confidentiality; Prohibition on Announcements, Prohibition on Use in Ratemaking

A. All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer that are in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection C(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

E. It is the judgment of the legislature that the comparison of an insurer's Total Adjusted Capital to any of its RBC Levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's Total Adjusted Capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurers' RBC Levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

F. It is the further judgment of the legislature that the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or an affiliate is authorized to write.

Section 9. Supplemental Provisions; Rules; Exemption

A. The provisions of this Act are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, [cite rehabilitation and liquidation law and law pertaining to insurers in hazardous financial condition].

B. The commissioner may adopt reasonable rules necessary for the implementation of this Act.

C. The commissioner may exempt from the application of this Act any domestic property and casualty insurer which;

(1) Writes direct business only in this state;

(2) Writes direct annual premiums of [$X] or less; and

(3) Assumes no reinsurance in excess of five percent (5%) of direct premium written.

Drafting Note: It is the drafters' intent that the domiciliary commissioner have the ability to exempt certain insurers doing business only within the commissioner's jurisdiction. The intent is to limit this exemption to insurers that do not write in excess of $2,000,000 in annual premiums.

Section 10. Foreign Insurers

A. Any foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC Report as of the end of the calendar year just ended the later of:

(1) The date an RBC Report would be required to be filed by a domestic insurer under this Act; or

(2) Fifteen (15) days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC statute is in force in that state, under the provisions of this Act), if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under Section 3 hereof), the commissioner may require the foreign insurer to file an RBC Plan with the commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

C. In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the [cite appropriate state court] permitted under the [cite rehabilitation and liquidation statute] with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

Section 11. Immunity

There shall be no liability on the part of, and no cause of action shall arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this Act.

Section 12. Severability Clause

If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act are severable.

Section 13. Notices

All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

Section 14. Phase-In Provision

A. For RBC Reports required to be filed by life insurers with respect to 1993, the following requirements shall apply in lieu of the provisions of Section 3, 4, 5 and 6:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(2) In the event of an Regulatory Action Level Event under Section 4A(1), (2) or (3) the commissioner shall take the actions required under Section 3.

(3) In the event of an Regulatory Action Level Event under Section 4A(4), (5), (6), (7), (8) or (9) or an Authorized Control Level Event, the commissioner shall take the actions required under Section 4 with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the commissioner shall take the actions required under Section 5 with respect to the insurer.

Drafting Note: This provision should be included for states which adopt the model law in 1993 for implementation in 1994 (based on 1993 annual statements).

B. For RBC Reports required to be filed by property and casualty insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of Section 3, 4, 5 and 6:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(2) In the event of an Regulatory Action Level Event under Section 4A(1), (2) or (3) the commissioner shall take the actions required under Section 3.

(3) In the event of an Regulatory Action Level Event under Section 4A(4), (5), (6), (7), (8) or (9) or an Authorized Control Level Event, the commissioner shall take the actions required under Section 4 with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the commissioner shall take the actions required under Section 5 with respect to the insurer.

Drafting Note: This provision should be included for states which adopt the model law as amended to include property and casualty insurers or which adopt the property and casualty amendments in 1994 for implementation in 1995 (based on 1994 annual statements).

Section 15. Effective Date

This Act shall become effective immediately upon its enactment.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. I 8, 137, 275-276, 556-557, 559-565, (adopted model applying only to life and health insurers).
1993 Proc. 4th Quarter 16, 20, 163, 390-398 (amended to include property and casualty insurers and reprinted).
1994 Proc. 3rd Quarter 14, 58, 264, 316, 347-356 (amended and reprinted).
1999 Proc. 4th Quarter 15, 364, 369, 375-376 (amended).
2006 Proc. 1st Quarter 36, 44-52 (amended).
2011 Proc. 3rd Quarter, Vol. I 114, 131-137, 185-192, 339-340 (amended).

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-2B-1 to 27-2B-14.1 (1996/2014).		
Alaska	ALASKA STAT. §§ 21.14.010 to 21.14.200 (1994/2015).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-488 to 20-488.11 (1995/2013) (portions of model).		
Arkansas	ARK. CODE ANN. §§ 23-63-1301 to 23-63-1316 (1995/2015).		
California	CAL. INS. CODE §§ 739 to 739.12 (1997/2015).		
Colorado	3 COLO. CODE REGS. § 702-3:3-1-11 (1994/2013).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-72-1 to 38a-72-13 (1994/2014).		CONN. AGENCIES REGS. §§ 38a-193-1 to 38a-193-13 (2000).
Delaware	DEL. CODE ANN. tit.18, §§ 5801 to 5813 (1995/2012).		

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. CODE §§ 31-2001 to 31-2013 (1997/2017).		D.C. CODE §§ 31-3451.01 to 31-3841.13 (2002/2005).
Florida	FLA. STAT. § 624.4085 (1997/2014) (does not apply to fraternal benefit societies).		
Georgia	GA. CODE ANN. §§ 33-56-1 to 33-56-13 (1996/2000).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3-401 to 431:3-413 (1994/2013).		
Idaho	IDAHO CODE ANN. §§ 41-5401 to 41-5413 (1996/2014).		
Illinois	215 ILL. COMP. STAT. 5/35A-1 to 5/35A-70 (1995/2013).		
Indiana	IND. CODE §§ 27-1-36-1 to 27-1-36-56 (1996/2013).		
Iowa	IOWA CODE §§ 521E.1 to 521E.12 (1996/2013).		IOWA CODE §§ 521F.1 to 521F.13 (2000/2011).
Kansas	KAN. STAT. ANN. §§ 40-2c01 to 40-2c29 (1994/2015) (does not apply to fraternal benefit societies).		KAN. STAT. ANN. §§ 40-2d01 to 40-2d30 (2013); KAN. ADMIN. REGS. § 40-1-48 (2006/2012).
Kentucky	806 KY. ADMIN. REGS. § 3:190 (1997/2012); § 38:100 (2000/2012).		
Louisiana	LA. REV. STAT. ANN. §§ 22:611 to 22:620 (1995/2012) (does not apply to fraternal benefit societies).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 6451 to 6461 (1994/2013) (does not apply to fraternal benefit societies).		

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland	MD. CODE ANN., INS. §§ 4-301 to 4-314 (1995/2013).		
Massachusetts	211 MASS. CODE REGS. 25.01 to 25.13 (2008) (does not apply to fraternal benefit societies).		
Michigan	BULLETIN 2013-21-INS (2013).		MICH. COMP. LAWS § 550:1204a (2003).
Minnesota	MINN. STAT. §§ 60A.60 to 60A.696 (1996/2013).		
Mississippi	MISS. CODE. ANN. §§ 83-5-401 to 83-5-427(1995/2013) (does not apply to fraternal benefit societies).		
Missouri	MO. REV. STAT. §§ 375.1250 to 375.1275 (1993/2014) (portions of model).		
Montana	MONT. CODE ANN. §§ 33-2-1901 to 33-2-1913 (1995/2015).		
Nebraska	NEB. REV. STAT. §§ 44-6001 to 44-6026 (1993/2014).		
Nevada	NEV. ADMIN. CODE §§ 681B.400 to 681B.595 (1998/2014) (different formula for fraternal benefit societies).		NEV. ADMIN. CODE § 695D.300 (1988/2004) (dental organization).
New Hampshire	N.H. REV. STAT. ANN. §§ 404-F:1 to 404-F:14 (1995/2014).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-39.1 to 11:2-39.15 (1993/2012).		BULLETIN 2011-30 (2011); ORDER NO. A15-102 (2015).
New Mexico	N.M. STAT. ANN. §§ 59A-5A-1 to 59A-5A-13 (1995/2014).		

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York	N.Y. INS. LAW § 1322 (1993/2014); § 1324 (1993/2014).		N.Y. INS. LAW § 1325 (2008); CIRCULAR LETTER 2009-24 (2009).
North Carolina	N.C. GEN. STAT. §§ 58-12-2 to 58-12-70 (1996/2015) (does not apply to fraternal benefit societies).		
North Dakota	N.D. CENT. CODE §§ 26.1-03.1-01 to 26.1-03.1-13 (1995/2015).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3903.81 to 3903.93 (1995/2015).		
Oklahoma	OKLA. STAT. tit. 36, §§ 1521 to 1533 (1997/2013).		OKLA. STAT. tit. 36, §§ 6937 to 6951 (2003/2011).
Oregon	OR. ADMIN. R. 836-011-0305 TO 836-011-0390 (2011) (does not apply to fraternal benefit societies).		OR. ADMIN. R. 836-011-0500 to 836-011-0600 (2002); OR. REV. STAT.§ 731.554 (1993) (references NAIC RBC standards).
Pennsylvania	40 PA. STAT. §§ 221.1-A to 221.15-A (1997/2012); 40 PA. STAT. §§ 221.1-B to 221.15-B (2000/2012).		
Puerto Rico			P.R. Laws ANN. tit. 26, §§ 4501 to 4513 (2008).
Rhode Island	R.I. GEN. LAWS §§ 27-4.6-1 to 27-4.6-13 (1994/2010) (does not apply to fraternal benefit societies); §§ 27-4.7-1 to 27-4.7-16 (2000/2002).		R.I. GEN. LAWS § 27-41-2; § 27-41-13 (1983/1999) (NAIC standards).
South Carolina	S.C. CODE ANN. §§ 38-9-310 to 38-9-460 (1996/2016).		

RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	S.D. ADMIN. R. §§ 20:06:36:01 to 20:06:36:28 (1997/2014).		
Tennessee	TENN. CODE ANN. §§ 56-46-101 to 56-46-113 (1997/2014) (does not apply to fraternal benefit societies).		
Texas	28 TEX. ADMIN. CODE § 7.402 (2008/2014).		BULLETIN B-0005-11 (2011).
Utah	UTAH CODE ANN. §§ 31A-17-601 to 31A-17-613 (1996/2014).		
Vermont	VT. STAT. ANN. tit. 8, §§ 8301 to 8313 (1994/2013).		VT. ADMIN. CODE 4-3-31 (1997/2014) (Reg. 97-2).
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 470 to 483 (2016).		
Virginia	VA. CODE ANN. §§ 38.2-5500 to 38.2-5513 (1995/2014).		
Washington	WASH. REV. CODE §§ 48.05.430 to 48.05.485 (1995/2012) (does not apply to fraternal benefit societies); §§ 48.43.300 to 48.43.370 (1998/2012) (does not apply to fraternal benefit societies).		WASH. ADMIN. CODE 284-36A-005 to 284-36A-065 (1996/1998) (RBC for fraternal).
West Virginia	W. VA. CODE §§ 33-40-1 to 33-40-13 (1994/2013) (does not apply to fraternal benefit societies).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 51.01 to 51.65 (1997/2014).		
Wyoming	WYO. STAT. ANN. §§ 26-48-101 to 26-48-112 (1994/2012) (does not apply to fraternal benefit societies).		

PROJECT HISTORY - 2011

RISK-BASED CAPITAL FOR INSURERS MODEL ACT (#312)
(Revisions to the Fraternal Benefit Societies)

1. Project Description

To add fraternal benefit societies to the life sections of the *Risk-Based Capital for Insurers Model Act*. (#312). The request was developed based upon the need for regulatory authority to take corrective actions as a result of a fraternal society having less than the minimum amount of capital as calculated by the fraternal RBC formula.

2. Group Responsible for Drafting Model and States Participating

The Capital Adequacy (E) Task Force was responsible for drafting the revisions of the model. James J. Wrynn represented by Lou Felice (NY) chairs the Task Force. Ted Nickel represented by Peter Medley (WI) is the vice chair of the Task Force. The following states are Task Force members: Alabama, California, Connecticut, District of Columbia, Delaware, Florida, Illinois, Iowa, Kansas, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, Utah and Washington.

3. Charge Authorizing Project

A Sept. 17, 2009, referral letter from the NAIC president on behalf of the NAIC officers was received by the Capital Adequacy (E) Task Force suggesting that "the Capital Adequacy Task Force consider development of a new risk-based capital model law for fraternal benefit societies."

4. A General Description of Drafting Process and Due Process

A request for a new model law development was adopted by the Executive (EX) Committee at the 2009 Winter National Meeting. Discussions were held by the Task Force over the next several national meetings regarding the need for a fraternal RBC model act.

At the 2011 Spring National Meeting, the Task Force requested changing the current *Risk-Based Capital for Insurers Model Act* (#312) rather than developing a new model. This request was subsequently adopted by the Financial Condition (E) Committee and Executive (EX) Committee at the 2011 Spring National Meeting.

NAIC staff were asked to draft a proposal to add fraternal benefit societies to the existing model act. The fraternal proposal was released for comment for a 30-day period at a July 14, 2011, Task Force conference call. No comment letters were received during the comment period. The Task Force unanimously adopted the draft fraternal changes to the model act at the Sept. 14, 2011, conference call. The fraternal changes to the model act were then adopted at the Financial Condition (E) Committee's Sept. 19 meeting.

5. Significant Issues Raised

A concern was raised about whether the change to add fraternal benefit societies would become an accreditation standard. The Task Force will recommend to the Financial Regulation Standards and Accreditation (F) Committee that the changes to add fraternal benefit societies to the model act would not become an accreditation standard at this point in time.

An issue was raised regarding whether the RBC trend test would also apply to fraternal RBC. The model act draft was modified to incorporate the same trend test language and level as used for life.

PROJECT HISTORY - 2011

RISK-BASED CAPITAL FOR INSURERS MODEL ACT (#312)
(Revisions to the Life RBC Trend Test Level)

1. Project Description

To change the trend test level for the *Risk-Based Capital for Insurers Model Act* (#312). The request was developed to change the level where the Life RBC trend test is triggered to be raised from 2.5 of the authorized control level amount to 3.0. This would change the level to be the same level as that used for the property and casualty RBC and health RBC trend tests.

2. Group Responsible for Drafting Model and States Participating

The Capital Adequacy (E) Task Force was responsible for drafting the revisions of the model. James J. Wrynn represented by Lou Felice (NY) chairs the Task Force. Ted Nickel represented by Peter Medley (WI) is the vice chair of the Task Force. The following states are Task Force members: Alabama, California, Connecticut, District of Columbia, Delaware, Florida, Illinois, Iowa, Kansas, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, Utah and Washington.

3. Charge Authorizing Project

A March 27, 2007, letter from Steve Johnson (PA) was received by the Capital Adequacy (E) Task Force that suggested: "Raising the trigger for the Life RBC Trend Test from 250 to 300. This change would be consistent with the Property/Casualty Trend Test and would result in more effective efforts to correct negative trends before they create a solvency concern." The item was added to the Task Force's working agenda assigned to the Life Risk-Based Capital (E) Working Group.

4. A General Description of Drafting Process and Due Process

At the 2008 Fall National Meeting, the Life Risk-Based Capital (E) Working Group reviewed year-end 2003 to 2007 data of additional companies that would be triggered by the change in the trend test level. The Capital Adequacy (E) Task Force decided to keep the issue on the working agenda in order to review data for companies that would have triggered the trend test during the 2008 financial crisis. The Working Group reviewed data for year-end 2005 through 2009 at the 2010 Fall National Meeting. The Working Group recommendation was to consider this change when another change was being made to the model act.

At the 2010 Fall National Meeting, with one state objecting, the Task Force decided to release for a comment period of 30 days a draft model law request form to change the life trend test level. One comment letter was received and discussed on a Dec. 13, 2010, Task Force conference call, where the model law request was adopted with four states opposing the motion. The model law request form was then adopted by the Financial Condition (E) Committee. The request to amend the model law was adopted by the Executive (EX) Committee at the 2011 Spring National Meeting.

The trend test change to the model act was released for comment for a 30-day period at a July 14, 2011, Task Force conference call. No comment letters were received during the comment period. The Task Force unanimously adopted the life trend test change to the model act on the Sept. 14, 2011, conference call. The life trend test changes to the model act were then adopted at the Financial Condition (E) Committee's Sept. 19 meeting.

5. Significant Issues Raised

The Life Risk-Based Capital (E) Working Group had a concern about whether the relatively small number of additional companies that would trigger the trend test would justify changing the model act for just this item. The Capital Adequacy (E) Task Force later decided to make changes to the model for fraternal benefit societies in addition to the trend test change.

A Nov. 29, 2010, comment letter from the American Council of Life Insurers (ACLI) requested further analysis of the need for and the impact of the proposed change. Regulator-only reports of the companies that would have been affected for year-end 2005 to 2009 were distributed to the Task Force. The ACLI eventually agreed to not oppose implementation of the change.

PROJECT HISTORY - 2006

RISK-BASED CAPITAL FOR INSURERS MODEL ACT (#312)
(Incorporation of the Property and Casualty Trend Test)

1. Project Description

The Capital Adequacy (E) Task Force adopted the following Property/Casualty (P/C) "trend test" to be effective for year-end 2005 RBC reporting:

> If the combined ratio is greater than 120% and the RBC is between 200-300, then the RBC company action level is triggered.

However, the trend test is "Informational Only" and the company action level is not legally triggered until states implement modifications to their RBC for Insurers Model Act. The major change proposed to the Model Act is to cite the P/C trend test as a way for the company action level to be triggered. Some minor editorial changes are made to distinguish the Life/Health Trend Test that is already in the Model Act with this new P/C trend test.

History

At the September 2004 meeting in Anchorage, AK, the Capital Adequacy (E) Task Force exposed a formula, called a dual trend test, as recommended by the P/C RBC Subgroup:

> If the RBC is between 200-300 and the combined ratio is greater than 120% OR
> If the RBC is between 300-350 and the combined ratio is greater than 134%,
> Then the RBC company action level is triggered.

Steve Johnson (PA) noted that the Task Force would also need to draft a revised RBC model Act for the trend test to be enforceable.

At the December 22, 2004, conference call of the Task Force, the higher tier (at the 300-350 RBC level) of the trend test for the P/C RBC formula was removed and the revised trend test was released for comment. The Task Force noted that the results of the trend test, if adopted, would not be utilized to move an insurer's result to the Company Action Level RBC in the 2005 formula until an amendment to the RBC Model Law is implemented.

The changes to the P/C RBC formula were adopted at the Jan 27, 2005, conference call of the Capital Adequacy Task Force and at the E Committee in March.

At the June 2005 meeting, Mr. Johnson suggested taking the opportunity to amend the RBC Model Act to exempt monoline bail/immigration bond insurers from filing the property RBC calculation. With this additional amendment, the proposed changes to the RBC Model Act were exposed. During the Task Force's August 9, 2005 conference call, the exemption of monoline bail/immigration bond insurers was removed, some editorial changes were made, and the revised RBC Model Act was adopted. The revised RBC Model Act is anticipated to be adopted by the E Committee in December.

2. Group Responsible for Drafting Model and States Participating

The Capital Adequacy (E) Task Force was responsible for drafting the revisions to the model. Lou Felice (New York) chaired the Task Force. The following states were members: Minnesota, Alabama, California, Connecticut, District Columbia, Florida, Kansas, Missouri, New Jersey, New Mexico, Ohio, Texas, Washington, and Wisconsin.

3. Charge Authorizing Project

The Capital Adequacy (E) Task Force was charged to consider refinements to the RBC calculations and to maintain the Risk-Based Capital For Insurers Model Act.

4. Significant Issues Raised

There were no serious issues raised with the Model Act. Likely, this is because there is already precedence from the Life/Health Trend Test that is already included in the Model Act.

There were some concerns with the underlying formula and the impact of "false positives" (where the company action level would be triggered for a company when the RBC would not trend toward the company action level in subsequent years), but the formula itself is not included in the Model Act.

RISK-BASED CAPITAL (RBC) FOR HEALTH ORGANIZATIONS MODEL ACT

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Drafting Note: The effectiveness of RBC is based on the reliability of the underlying data. The efficacy of RBC as a regulatory instrument is greatly improved if (a) an actuarial opinion supporting the estimated claims and loss adjustment reserves is required, and (b) the health organization be required to submit audited financial statements with the RBC calculation amended to reflect any significant audit adjustments. Additionally, the formula was developed for use in conjunction with the most current NAIC Health Maintenance Organization Annual Statement Blank. States should consider requiring the filing of this statement in order to verify the calculation upon examination.

Section 1. Definitions

As used in this Act, these terms shall have the following meanings:

A. "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with Section 2D.

B. "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Domestic health organization" means a health organization domiciled in this state.

D. "Foreign health organization" means a health organization that is licensed to do business in this state under [cite appropriate statute] but is not domiciled in this state.

Drafting Note: The drafting committee does not recommend application of the risk-based capital model act to an insurance company organized under the laws of a state of the United States if the company (1) has a provision in its certificate of incorporation (or like corporate instrument) prohibiting the doing of insurance business with persons or entities that are citizens or residents of, or organized or located within, the United States and (2) does not, in fact, do insurance business with these persons or entities, so that none of its insurance liabilities are to any such person or entity.

E. "NAIC" means the National Association of Insurance Commissioners.

F. "Health organization" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under Section [cite appropriate statute]. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under Section [cite appropriate statute] and that is otherwise subject to either the life or property and casualty RBC requirements.

Drafting Note: The formula was designed for use with provider sponsored organizations, and other similar risk-bearing entities (e.g., hospitals, doctors, limited liability corporations, networks, dental practices, etc.). In order to apply consistent regulatory treatment for similar organizations, States are encouraged to license these entities wherever possible under existing HMO laws or other laws specifically enacted to govern managed care plans.

Drafting Note: It is noted by the working group that when implementing this model law, a commissioner may wish to consider whether a licensed property/casualty or life and health insurer should be subject to the existing Property/Casualty RBC or Life RBC formulas as opposed to being defined as a health organization subject to the Health Organizations RBC formula. Such consideration may require legislative changes or present reporting or other practical problems when attempting to identify insurers by business segment vs. license status.

G. "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

H. "RBC level" means a health organization's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(1) "Company Action Level RBC" means, with respect to any health organization, the product of 2.0 and its Authorized Control Level RBC;

(2) "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;

(3) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

(4) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

I. "RBC plan" means a comprehensive financial plan containing the elements specified in Section 3B. If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

J. "RBC report" means the report required in Section 2.

K. "Total adjusted capital" means the sum of:

(1) A health organization's statutory capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under [cite appropriate statute]; and

(2) Such other items, if any, as the RBC instructions may provide.

Drafting Note: The RBC formula adopted by the Health Organizations Risk-Based Capital Working Group was developed using current NAIC guidance contained in the HMO Model Act, and tested using current state practices regarding the assumption of admissibility of health care delivery assets. If the admissibility of these assets is reduced in a given jurisdiction, then that jurisdiction should consider this reduction in total adjusted capital when evaluating action levels described in Sections 3 through 6.

Section 2. RBC Reports

A. A domestic health organization shall, on or prior to each March 1 (the "filing date"), prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

(a) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(b) The filing date.

Drafting Note: In jurisdictions where the required annual statement filing date is later than March 1, the due date of the RBC report may be adjusted.

B. A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions.

C. An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in the Act and the formulas, schedules and instructions referenced in this Act is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the RBC levels required by this Act. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Act.

D. If a domestic health organization files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

Section 3. Company Action Level Event

Drafting Note: Risk-based capital is a method of establishing the minimum amount of capital appropriate for a health organization to support its overall business operations in consideration of its size, structure and risk profile. Typically, the formula result is compared to total adjusted capital to determine if any action is necessary. The domiciliary commissioner may wish to determine whether other financial resources (e.g. parental guarantees, letters of credit) provide adequate safeguards to consumers based on the dynamics of the market in their particular state, although the working group did not specifically examine, and expresses no opinion on the merits of any such alternative financial resources. Rather, the working group acknowledges that these arrangements may fall within the statutory or regulatory discretion that is available to a regulator in a given jurisdiction. However, this discretion should not be used to mask the reporting of any action level under the provisions of this Act, but may be used in evaluating an RBC plan submitted pursuant to Sections 3 through 5.

A. "Company Action Level Event" means any of the following events:

(1) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(a) If a health organization has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Health RBC instructions;

(2) Notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in Paragraph (1) of this subsection, provided the health organization does not challenge the adjusted RBC report under Section 7; or

(3) If, pursuant to Section 7, a health organization challenges an adjusted RBC report that indicates the event in Paragraph (1) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

B. In the event of a Company Action Level Event, the health organization shall prepare and submit to the commissioner an RBC plan that shall:

(1) Identify the conditions that contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the health organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the health organization's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC plan shall be submitted

(1) Within forty-five (45) days of the Company Action Level Event; or

(2) If the health organization challenges an adjusted RBC report pursuant to Section 7, within forty-five (45) days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

D. Within sixty (60) days after the submission by a health organization of an RBC plan to the commissioner, the commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(1) Within forty-five (45) days after the notification from the commissioner; or

(2) If the health organization challenges the notification from the commissioner under Section 7, within forty-five (45) days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

E. In the event of a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the health organization's right to a hearing under Section 7, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) The state has an RBC provision substantially similar to Section 8A; and

(2) The insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(a) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(b) The date on which the RBC plan or revised RBC plan is filed under Subsections C and D of this section.

Section 4. Regulatory Action Level Event

A. "Regulatory Action Level Event" means, with respect to a health organization, any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(2) Notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in Paragraph (1), provided the health organization does not challenge the adjusted RBC report under Section 7;

(3) If, pursuant to Section 7, the health organization challenges an adjusted RBC report that indicates the event in Paragraph (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(5) The failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in Section 3C;

(6) Notification by the commissioner to the health organization that:

(a) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(b) Notification constitutes a Regulatory Action Level Event with respect to the health organization, provided the health organization has not challenged the determination under Section 7;

(7) If, pursuant to Section 7, the health organization challenges a determination by the commissioner under Paragraph (6), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(8) Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under Section 7; or

(9) If, pursuant to Section 7, the health organization challenges a determination by the commissioner under Paragraph (8), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event the commissioner shall:

(1) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "corrective order").

C. In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

(2) If the health organization challenges an adjusted RBC report pursuant to Section 7 and the challenge is not frivolous in the judgment of the commissioner within forty-five (45) days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(3) If the health organization challenges a revised RBC plan pursuant to Section 7 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

D. The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the commissioner.

Section 5. Authorized Control Level Event

A. "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(2) The notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in Paragraph (1), provided the health organization does not challenge the adjusted RBC report under Section 7;

(3) If, pursuant to Section 7, the health organization challenges an adjusted RBC report that indicates the event in Paragraph (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the health organization has not challenged the corrective order under Section 7); or

(5) If the health organization has challenged a corrective order under Section 7 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

B. In the event of an Authorized Control Level Event with respect to a health organization, the commissioner shall:

(1) Take such actions as are required under Section 4 regarding a health organization with respect to which an Regulatory Action Level Event has occurred; or

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under [insert reference to relevant health organization rehabilitation and liquidation act]. In the event the commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take action under [insert same reference], and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in [insert same reference]. In the event the commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of Section [insert reference] pertaining to summary proceedings.

Section 6. Mandatory Control Level Event

A. "Mandatory Control Level Event" means any of the following events:

(1) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its Mandatory Control Level RBC;

(2) Notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in Paragraph (1), provided the health organization does not challenge the adjusted RBC report under Section 7; or

(3) If, pursuant to Section 7, the health organization challenges an adjusted RBC report that indicates the event in Paragraph (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

B. In the event of a Mandatory Control Level Event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control under [insert reference to relevant health organization rehabilitation and liquidation act]. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under [insert same reference], and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in [insert same reference]. If the commissioner takes actions pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of Section [insert reference] pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

Drafting Note: States may want to consider allowing a health organization that is not writing new business by order of the commissioner to run-off its existing business under the supervision of the commissioner. The committee does not necessarily recommend this approach, but does acknowledge that there are states that use this approach when the possibility of harm to the policyholders and the public due to the run-off is minimal.

Section 7. Hearings

Upon the occurrence of any of the following events the health organization shall have the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under Subsection A, B, C or D. Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten (10) nor more than thirty (30) days after the date of the health organization's request. The events include:

A. Notification to a health organization by the commissioner of an adjusted RBC report;

B. Notification to a health organization by the commissioner that:

(1) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(2) Notification constitutes a Regulatory Action Level Event with respect to the health organization;

C. Notification to a health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the Company Action Level Event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

D. Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

Section 8. Confidentiality; Prohibition on Announcements, Prohibition on Use in Ratemaking

A. All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health organization performed pursuant to this statute and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to a domestic health organization or foreign health organization that are in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection C(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Paragraph (3).

E. It is the judgment of the legislature that the comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization, and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business

would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the health organizations' RBC levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

F. It is the further judgment of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

Section 9. Supplemental Provisions; Rules; Exemption

A. The provisions of this Act are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, [cite rehabilitation and liquidation law and law pertaining to health organizations in hazardous financial condition].

B. The commissioner may adopt reasonable rules necessary for the implementation of this Act.

C. The commissioner may exempt from the application of this Act a domestic health organization that:

(1) Writes direct business only in this state;

(2) Assumes no reinsurance in excess of five percent (5%) of direct premium written; and

(3) Writes direct annual premiums for comprehensive medical business of [$X] or less; or

(4) Is a limited health service organization that covers less than [X] lives.

Drafting Note: It is the drafters' intent that the domiciliary commissioner have the ability to exempt certain health organizations doing business only within the commissioner's jurisdiction. The intent is to limit this exemption to health organizations that do not write in excess of $2,000,000 in annual premiums and limited health service organizations that cover less than 2,000 lives.

Section 10. Foreign Health Organizations

A. (1) A foreign health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

(a) The date an RBC report would be required to be filed by a domestic health organization under this Act; or

(b) Fifteen (15) days after the request is received by the foreign health organization.

(2) A foreign health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization (or, if no RBC statute is in force in that state, under the provisions of this Act), if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under Section 3 of this Act), the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state.

Drafting Note: Nothing in this section should be construed as limiting the commissioner's authority to regulate the health insurance market in his or her state. It is not the intention of the working group to infer that the commissioner is required to accept an RBC plan filed with the domiciliary commissioner by a health organization, especially given the potential for statutory or regulatory discretion discussed in the drafting note in Section 3.

C. In the event of a Mandatory Control Level Event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner may make application to the [cite appropriate state court] permitted under the [cite rehabilitation and liquidation statute] with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

Section 11. Immunity

There shall be no liability on the part of, and no cause of action shall arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this Act.

Section 12. Severability Clause

If any provision of this Act, or its application to any person or circumstance, is held invalid, that determination shall not affect the provisions or applications of this Act that can be given effect without the invalid provision or application, and to that end the provisions of this Act are severable.

Section 13. Notices

All notices by the commissioner to a health organization that may result in regulatory action under this Act shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization's receipt of notice.

Section 14. Phase-In Provision

For RBC reports required to be filed by health organizations with respect to 1998, the following requirements shall apply in lieu of the provisions of Section 3, 4, 5 and 6:

A. In the event of a Company Action Level Event with respect to a domestic health organization, the commissioner shall take no regulatory action under this Act.

B. In the event of an Regulatory Action Level Event under Section 4A(1), (2) or (3) the commissioner shall take the actions required under Section 3.

C. In the event of an Regulatory Action Level Event under Section 4A(4), (5), (6), (7), (8) or (9) or an Authorized Control Level Event, the commissioner shall take the actions required under Section 4 with respect to the health organization.

D. In the event of a Mandatory Control Level Event with respect to a health organization, the commissioner shall take the actions required under Section 5 with respect to the health organization.

Drafting Note: This provision should be included for states that adopt the model law in 1998 for implementation in 1999 (based on 1998 annual statements).

Drafting Note: RBC is designed to interact with other operational requirements and regulatory frameworks that exist under state licensure laws. The working group drafted this section under the assumption that the state has a requirement for the filing of a comprehensive business plan in its application requirement. A comprehensive business plan would include some, if not all, of the following: feasibility studies and marketing plan; description of the proposed service area, provider contracts; provider access; plan administration and, if applicable, management contracts; minimum of three years of financial projections; description of any financial guarantees; and a summary of the benefits to be offered (and/or the benefit contracts). States are encouraged to implement these requirements if this information is not part of the application requirement. This section is not intended to limit initial capital to the first year RBC calculation. States should also consider start up losses and other contingencies when determining an appropriate level of initial capital funding for a health organization. A health organization that has just commenced operations and has only partial year data should estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The underwriting, credit (capitation risk only), and business risk sections of the first RBC report submitted pursuant to Section 2 of this Act should be completed using the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports the RBC results for all of the formula components should be calculated using actual data.

Section 15. Effective Date

This Act shall become effective immediately upon its enactment.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1998 Proc. 2nd Quarter 12, 13, 159, 407, 466-474 (adopted).
1999 Proc. 4th Quarter 15, 364, 369, 376-378 (amended).
2009 Proc. 3rd Quarter Vol. I 299-303 (amended).
2013 (typographical error correction).

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-2B-1 to 27-2B-14 (1996/2014).		
Alaska	ALASKA STAT. §§ 21.14.010 to 21.14.200 (1994/2015).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-488 to 20-488.11 (1995/2013).		
Arkansas	ARK. CODE ANN. §§ 23-63-1501 to 23-63-1513 (1999/2011).		
California	NO CURRENT ACTIVITY		
Colorado	3 COLO. CODE REGS. § 702-3:3-1-12 (2013).	3 COLO. CODE REGS. § 702-3:3-1-11 (1994/2013).	
Connecticut	CONN. AGENCIES REGS. §§ 38a-193-1 to 38a-193-13 (2000/2010).		
Delaware	DEL. CODE ANN. tit.18, §§ 5820 to 5832 (2014).		
District of Columbia	D.C. CODE §§ 31-3451.01 to 31-3451.01.13 (2002/2017).		

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. § 624.4085 (1997/2014).		
Georgia	GA. CODE ANN. §§ 33-56-1 to 33-56-13 (1996/2016).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3-401 to 431:3-414 (1994/2013).		
Idaho	IDAHO CODE ANN. §§ 41-5401 to 41-5413 (1996/2014).		
Illinois	215 ILL. COMP. STAT. 5/35A-1 to 5/35A-70 (2017).		
Indiana	IND. CODE §§ 27-1-36-1 to 27-1-36-56 (1996/2013).		
Iowa	IOWA CODE §§ 521F.1 to 521F.13 (2000/2011).		
Kansas	KAN. STAT. ANN. §§ 40-2d01 to 40-2d30 (2000/2014).		
Kentucky	806 KY. ADMIN. REGS. 38:100 (2000/2014).		
Louisiana	LA. REV. STAT. ANN. §§ 22:631 to 22:642 (2003/2014).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 6451 to 6461 (1994/2010).		
Maryland	MD. CODE ANN., INS. §§ 4-301 to 4-314 (1995/2013).		
Massachusetts	211 MASS. CODE REGS. §§ 25.01 to 25.13 (2007/2015).		
Michigan	BULLETIN 2013-21-INS (2013).	MICH. COMP. LAWS § 550:1204a (2003).	

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. §§ 60A.50 to 60A.592 (2004).		
Mississippi	MISS. CODE ANN. §§ 83-5-401 to 83-5-427 (1996/2016).		
Missouri	MO. REV. STAT. §§ 375.1250 to 375.1275 (1993/2014) (portions of model).		
Montana	MONT. CODE ANN. §§ 33-2-1901 to 33-2-1913 (2017).		
Nebraska	NEB. REV. STAT. §§ 44-6001 to 44-6026 (1993/2014).		
Nevada	NEV. ADMIN. CODE §§ 681B.400 to 681B.595 (1998/2014).		NEV. ADMIN. CODE § 695D.300 (1988/2004) (dental organization).
New Hampshire	N.H. REV. STAT. ANN. §§ 404-F:1 to 404-F:14 (1995/2014).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-39.1 to 11:2-39.15 (1993/2012).		N.J. REV. STAT. §§ 26:2J-18.2 to 26:2J-18.6 (2005); ORDER NO. A15-102 (2015).
New Mexico	N.M. STAT. ANN. §§ 59A-5A-1 to 59A-5A-13 (1995/2014).		
New York	N.Y. INS. LAW § 1322 (1993/2014).		
North Carolina	N.C. GEN. STAT. §§ 58-12-2 to 58-12-70 (1996/2015).		
North Dakota	N.D. CENT. CODE §§ 26.1-03.2-01 to 26.1-03.2-13 (1999/2011).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 1753.31 to 1753.43 (2010).		

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. STAT. tit. 36, §§ 6937 to 6951 (2003/2004).		
Oregon	OR. ADMIN. R. 836-011-0500 to 836-011-0545 (2002/2010).		
Pennsylvania	40 PA. STAT. ANN. §§ 221.1-B to 221.15-B (2012).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-4.7-1 to 27-4.7-16 (2000/2010).		R.I. GEN. LAWS § 27-41-2 (1983); § 27-41-13 (1983/1999) (NAIC standards).
South Carolina	S.C. CODE ANN. §§ 38-9-310 to 38-9-460 (1996/2014).		
South Dakota	S.D. ADMIN. R. §§ 20:06:36:01 to 20:06:36:28 (1997/2014).		
Tennessee	TENN. CODE ANN. §§ 56-46-101 to 56-46-113 (1997/2014).		
Texas	28 TEX. ADMIN. CODE 7.402 (2008/2014).		BULLETIN B-0005-11 (2011).
Utah	UTAH CODE ANN. §§ 31A-17-601 to 31A-17-613 (1996/2014).		
Vermont	VT. STAT. ANN. tit. 8, §§ 8301 to 8313 (1994/2013).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-5500 to 38.2-5514 (1995/2014).		
Washington	WASH. REV. CODE ANN. §§ 48.43.300 to 48.43.370 (1998).		

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE ANN. §§ 33-40A-1 to 33-40A-12 (1994/2016).		
Wisconsin			WIS. ADMIN. CODE INS. §§ 51.01 to 51.80 (1997/2014).
Wyoming	WYO. STAT. ANN. §§ 26-48-201 to 26-48-212 (2007/2012).		

PROJECT HISTORY - 2009

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS MODEL ACT (#315)
TO INCORPORATE THE HEALTH TREND TEST

1. Project Description

To establish a trend test wherein the RBC company action level is triggered when the combined ratio is greater than 105% and the RBC is between 200-300%.

The trend test has been established within the RBC formula but would be considered "Information Only" until states adopt legislation that conforms their statutes to the modifications included in this change to the RBC for Health Organizations Model Act. The major change to the Model Act is to cite the health trend test as a way for the company action level to be triggered.

2. Group Responsible for Drafting Model and States Participating

The Health Risk-Based Capital (E) Working Group was responsible for drafting the revisions of the model. Dennis Julnes (Washington) chaired the Working Group. The following states were members: Alabama, Minnesota, New York, Pennsylvania, and Texas.

3. Charge Authorizing Project

The Capital Adequacy (E) Task Force originally charged the Health Risk-Based Capital (E) Working Group in 2006 with the creation of the health trend test and to consider refinements to the RBC calculations and to maintain the Risk-Based Capital for Health Organizations Model Act.

4. Description of Drafting Process

During a March 5, 2008, conference call of the Health Risk-Based Capital (E) Working Group, the American Academy of Actuaries (AAA) and the Working Group began work to create the Health Trend Test. The AAA worked with blinded data from the NAIC and the default proposal consisted of a HRBC ratio between 200-300% and a combined ratio greater than 105%. The AAA submitted a report containing three proposed tests to the Health Risk-Based Capital (E) Working Group on August 26, 2008. The report proposed three different trend tests, they were:

Trend Test 1: If 200 percent < HRBCbase year ≤ 300 percent and combined ratiobase year > 105 percent
(straw man benchmark trend test)

Trend Test 2: If net income before FIT/(TAC - 2*ACL) ≤ -1, where
TAC = total adjusted capital in the base year
ACL = authorized control level (100 percent RBC)

Trend Test 3: If net income before FIT/(TAC -1.5*ACL) ≤ -1

Lou Felice (NY) noted that a change would also need to be made to the RBC for Health Organizations Model Act for the trend test to be enforceable.

5. Description of Due Process

The Health Risk-Based Capital (E) Working Group discussed the report on an October 10, 2008, conference call. The Trend Test 1 proposal for the health RBC formula was released for comment for a 30-day period. A comment letter was received from America's Health Insurance Plans (AHIP) to create a trend test that looks at trends over a time period and not only at one point in time.

The changes to the Health RBC formula for trend test 1 were adopted at the November 12, 2008, conference call of the Health Risk-Based Capital (E) Working Group. At the same time, a model review request to make changes to the RBC for Health Organizations Model Act was also approved. The Capital Adequacy (E) Task Force and Financial Condition (E) Committee adopted the health RBC trend test formula changes and Request for RBC for Health Organizations Model Act changes at the 2008 Winter National Meeting.

Authorization to consider changes to the RBC for Health Organizations Model Act was given by the Executive (EX) Committee at the 2009 Spring National Meeting. The revised RBC for Health Organizations Model Act language was released for comment on a March 31, 2009, conference call of the Health Risk-Based Capital (E) Working Group. No comments were received, and the Health Risk-Based Capital (E) Working Group adopted the model act changes at the May 7, 2009, Working Group conference call. The Capital Adequacy (E) Task Force and Financial Condition (E) Committee adopted the RBC for Health Organizations (E) Model Act changes at the 2009 Summer National Meeting.

6. Significant Issues Raised

There were no serious issues raised with the Model Act.

There were some concerns of the trend test only looked at only one point in time and not at trends over a time period. There were also concerns expressed about the test producing false positive results. The Working Group found that an RBC action level had not resulted in the next year for those companies because of capital infusions.

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

Table of Contents

Section 1. Short Title

This Act may be cited as the Business Transacted with Producer Controlled Insurer Act.

Section 2. Definitions

As used in this Act:

A. "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners (NAIC).

B. "Control" or "controlled" has the meaning ascribed in [cite insurance law section incorporating NAIC Model Insurance Holding Company Act];

C. "Controlled insurer" means a licensed insurer that is controlled, directly or indirectly, by a producer.

D. "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

E. "Licensed insurer" or "insurer" means a person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following, among others, are not licensed insurers for the purposes of this Act:

(1) All residual market pools and joint underwriting authorities or associations; and

(2) All captive insurers other than risk retention groups as defined in 15 U.S.C. Section 3901 et seq. and 42 U.S.C. Section 9671 (for the purposes of this Act, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and group members and their affiliates).

F. "Producer" means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, the person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of an insurance contract on behalf of an insured other than the person, firm, association or corporation.

Drafting Note: The term "producer" as used in this Act is not intended to include an exclusive agent or any independent agent acting on behalf of the controlled insurer and a subagent or representative of the agent, who acts as such in the solicitation of, negotiation for, or procurement or making of an insurance contract, if the agent is not also acting in the capacity of an insurance broker in the transaction in question. States that define both insurance agent and insurance broker should substitute the term "insurance broker" and an appropriate definition for the term "producer," and rename the Act accordingly.

Section 3. Applicability

This Act shall apply to licensed insurers as defined in Section 2 of this Act, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurance Holding Company Act, to the extent they are not superseded by this Act, shall continue to apply to all parties within holding company systems subject to this Act.

Section 4. Minimum Standards

A. Applicability of section.

(1) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding Paragraph (1) of this subsection, the provisions of this section shall not apply if:

(a) The controlling producer:

(i) Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(ii) Accepts insurance placements only from non-affiliated subproducers, and not directly from insureds; and

(b) The controlled insurer, except for insurance business written through a residual market facility such as [cite example], accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

B. Required contract provisions. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, the contract has been approved by the board of directors of the insurer, and it contains the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer.

(3) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of a policy placed with the controlled insurer under this contract.

(4) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. (However, funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction).

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(6) The contract shall not be assigned in whole or in part by the controlling producer.

(7) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(8) The contract shall specify the rates and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and Paragraph (7) of this subsection, examples of "comparable business" includes the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits and similar quality of business.

(9) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then the compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to Subsection D(1) of this section.

(10) The contract shall specify a limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or sub-line of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(11) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

C. Audit Committee. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

Drafting Note: Insert the appropriate title for the chief insurance regulatory official wherever the term commissioner appears.

D. Reporting requirements.

(1) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary (or other independent loss reserve specialist acceptable to the commissioner) reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the producer; and

(2) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

Section 5. Disclosure

Prior to the effective date of the policy, the producer shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his or her records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

Section 6. Penalties

A. (1) If the commissioner believes that the controlling producer or any other person has not materially complied with this Act, or any regulation or order promulgated under this Act, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer; and

(2) If it is found that because of such material non-compliance the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder, or other appropriate relief.

B. If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to [insert state's rehabilitation and liquidation statute], and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this Act, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

C. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the Insurance Law.

D. Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

Section 7. Effective Date

This Act shall take effect on [insert date]. Controlled insurers and controlling producers who are not in compliance with Section 4 of this Act on its effective date shall have sixty (60) days to come into compliance and shall comply with Section 5 beginning with all policies written or renewed on or after [insert a date 60 days after the effective date of this Act].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1989 Proc. I 14, 913-915, 915-918 (adopted at special plenary session September 1988).
1991 Proc. II 25, 58, 1091, 1096-1099 (amended and reprinted).
2012 Proc. 3rd Quarter, Vol. I 113, 117, 392-400 (amended).

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-6B-1 to 27-6B-6 (1993).		
Alaska		ALASKA STAT. § 21.27.570 (1995).	
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-487 to 20-487.04 (1991/1993).		
Arkansas		ARK. CODE ANN. §§ 23-63-1101 to 23-63-1106 (1993/2009).	
California	CAL. INS. CODE §§ 1216 to 1216.6 (1993/2013).		
Colorado		COLO. REV. STAT. §§ 10-4-1201 to 10-4-1206 (1992).	
Connecticut	CONN. GEN. STAT. §§ 38a-91 to 38a-91d (1993/2014).		
Delaware		DEL. CODE ANN. tit. 18, §§ 1650 to 1655 (1992/2014).	

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia		D.C. CODE §§ 31-401 to 31-408 (1993).	
Florida		FLA. STAT. § 626.7491 (1992/2012).	
Georgia		GA. CODE ANN. §§ 33-48-1 to 33-48-4 (1991); GA. COMP. R. & REGS. 120-2-64 (1993).	DIRECTIVE 93-RS-5 (1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:11A-101 to 431:11A-105 (1992).		
Idaho		IDAHO CODE ANN. §§ 41-1701 to 41-1706 (1993).	
Illinois		215 ILL. COMP. STAT. 107/1 to 107/99 (1992/2010).	
Indiana		IND. CODE §§ 27-1-35-1 to 27-1-35-19 (1994).	
Iowa		IOWA CODE §§ 510A.1 to 510A.6 (1992/1993).	
Kansas		KAN. STAT. ANN. §§ 40-37a01 to 40-37a06 (1992/2005).	
Kentucky	KY. REV. STAT. §§ 304.3-400 to 304.3-430 (1992/2015).		
Louisiana		LA. REV. STAT. ANN. §§ 22:551 to 22:556 (1992/2009).	
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 6401 to 6406 (1993).		
Maryland		MD. CODE ANN., INS. §§ 8-101 to 8-109 (1991/2002).	MD. CODE REGS. §§ 31.04.13.01 to 31.04.13.03 (1993).
Massachusetts		MASS. GEN. LAWS ch. 175, §§ 174F to 174K (1993).	

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.1451 to 500.1459 (1994).	
Minnesota		MINN. STAT. §§ 60J.06 to 60J.11 (1992).	
Mississippi		MISS. CODE ANN. §§ 83-59-1 to 83-59-11 (1992).	
Missouri		MO. REV. STAT. §§ 382.400 to 382.410 (1993/2009).	
Montana	MONT. CODE ANN. 33-2-1501 to 33-2-1517 (1993/2013).		
Nebraska	NEB. REV. STAT. §§ 44-5701 to 44-5708 (1992).		
Nevada		NEV. ADMIN. CODE §§ 693A.600 to 693A.770 (1996).	
New Hampshire		N.H. REV. STAT. ANN. §§ 402-G:1 to 402-G:5 (1993).	
New Jersey		N.J. REV. STAT. §§ 17:22D-1 to 17:22D-5 (1993/1996).	N.J. ADMIN. CODE §§ 11:2-37.1 to 11:2-37.7 (1993/2001).
New Mexico		N.M. STAT. ANN. §§ 59A-12C-1 to 59A-12C-7 (1993).	
New York		N.Y. ADMIN. CODE tit. 11, §§ 80-2.0 to 80-2.5 (Reg. 52-A) (1992/1997).	
North Carolina	N.C. GEN. STAT. § 58-3-165 (1991).		
North Dakota		N.D. CENT. CODE §§ 26.1-26.5-01 to 26.1-26.5-07 (1993).	
Northern Marianas	NO CURRENT ACTIVITY		

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio		OHIO REV. CODE ANN. §§ 3905.61 to 3905.65 (1991).	
Oklahoma		OKLA. STAT. tit. 36, §§ 1671 to 1676 (1992).	
Oregon		OR. REV. STAT. §§ 732.810 to 732.814 (1993/2013).	
Pennsylvania		40 PA. STAT. ANN. §§ 991.1301 to 991.1305.	
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		R.I. GEN. LAWS §§ 27-48-1 to 27-48-6 (1992).	
South Carolina		S.C. CODE ANN. § 38-21-95 (1993).	
South Dakota		S.D. CODIFIED LAWS §§ 58-44-1 to 58-44-16 (1992).	
Tennessee	TENN. CODE ANN. §§ 56-6-601 to 56-6-604 (1991/2014).		
Texas	NO CURRENT ACTIVITY		
Utah		UTAH CODE ANN. §§ 31A-23a-701 to 31A-23a-704 (1992/2003).	
Vermont	VT. STAT. ANN. tit. 8, §§ 4815 to 4824 (1992).	VT. ADMIN. CODE 4-3-25:1 (Regulation 94-2) (1994).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		VA. CODE ANN. §§ 38.2-1341 to 38.2-1346 (1993).	
Washington		WASH. REV. CODE ANN. §§ 48.97.005 to 48.97.900 (1993).	
West Virginia		W. VA. CODE §§ 33-36-1 to 33-36-7 (1992/1993).	

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Wisconsin		WIS. ADMIN. CODE INS. §§ 45.01 to 45.07 (1993).	
Wyoming		WYO. STAT. ANN. §§ 26-45-101 to 26-45-108 (1992).	

PROJECT HISTORY - 2012

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED PROPERTY/CASUALTY INSURER ACT (#325)

1. Description of the Project, Issues Addressed, etc.

The original request was from the Financial Regulation Standards and Accreditation (F) Committee (FRSAC), which noted that RRGs are specifically excluded in the definition of "licensed insurer" in the *Business Transacted with Producer Controlled Property/Casualty Insurer Act* (#325). The FRSAC requested that the Property and Casualty Insurance (C) Committee review Model #325 to determine if the exclusion of RRGs and other residual market mechanisms from the definition of insurer is appropriate and should remain in the model. Until this matter is resolved, FRSAC decided that accredited jurisdictions would not be deemed as failing the Part A Standards applicable to RRGs if they have not adopted a regulatory framework similar to that in Model #325. Ultimately, the Property and Casualty Insurance (C) Committee adopted a revision to the Act removing the exemption for RRGs.

2. Name of Group Responsible for Drafting the Model and States Participating

The Property and Casualty Insurance (C) Committee. The Risk Retention (C) Working Group did the actual drafting. States participating included: California, Delaware, District of Columbia, Florida, Hawaii, Louisiana, Mississippi, Missouri, Nevada, New York, Oklahoma, South Carolina, Utah, Vermont and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

The Property and Casualty Insurance (C) Committee was asked by the Financial Regulation Standards and Accreditation (F) Committee (FRSAC) in 2011 to give its opinion on RRGs being specifically excluded in the definition of "licensed insurer" in Model #325.

Formal permission to open the model for revision was granted by the Executive (EX) Committee on Aug. 12, 2012. The Risk Retention (C) Working Group had already discussed the matter and recommended the removal of the RRG exemption. The Property and Casualty Insurance (C) Committee agreed with this recommendation and adopted this revision to Model #325 on Aug. 13, 2012.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Risk Retention (C) Working Group discussed the matter on two conference calls and the Risk Retention Handbook and Model Law Amendment (C) Subgroup discussed it on one conference call. The Working group decided in December 2011 that the *Business Transacted with Producer Controlled Property/Casualty Insurer Act* (#325) should be applicable to RRGs and the RRG exemption should be removed from the current version of the Act.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Risk Retention (C) Working Group discussed the matter on an open conference call on Nov. 4, 2011, and the Risk Retention Handbook and Model Law Amendment (C) Subgroup discussed it on an open conference call on Nov. 17, 2011. The revised law was posted on the Working Group's webpage and distributed to members, interested regulators and interested parties on Nov. 23, 2011. No comments were received and the Working Group held a conference call on Dec. 14, 2011, followed by an electronic vote to approve the recommendation.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The project came about because RRGs were specifically excluded in the definition of "licensed insurer" in Model #325. The NAIC Legal Division researched this issue and concurred that the model excludes RRGs. However, the Legal Division also noted Model #325 excludes other entities such as joint underwriting pools and residual market mechanisms. The Legal Division's conclusion was there may have been an oversight when the model was revised in 1991 to amend the penalty provisions. In the original version of Model #325, the penalty was that the controlling producer would be liable to reimburse the state guaranty fund. However, RRGs are not protected by guaranty funds, thus it seems this is why RRGs, and the other

entities not covered by guaranty funds were excluded from the original version of the model. The 1991 revisions to Model #325 changed the penalty provision so the receiver may maintain a civil cause of action against the controlling producer. This would seem to eliminate the original reasoning in excluding RRGs, but the exclusion of RRGs has remained in the model.

NAIC Legal Division also explained that Model #325 refers to RRGs as defined under both the federal Liability Risk Retention Act (LRRA) and the Superfund Amendments Reauthorization Act of 1986 (SARA). The Legal Division stated in a memo that "It appears likely that the drafters of Model #325 may have considered SARA-RRGs and LRRA-RRGs to be two different types of entities, thus causing the distinction in the model." SARA created a separate classification of RRGs dealing with pollution risks for underground storage tanks, and is probably the reason for the separate language originally in Model #325. Working Group members did not think there were any existing RRGs, as defined by SARA, writing exclusively pollution liability insurance.

The Working Group decided Model #325 should apply to all RRGs, even though it is unlikely that RRGs would meet the model's criteria for producer-controlled insurer given that they are owned by their member insureds. The removal of the exemption from the model will allow the Part A Standards of the NAIC Financial Regulation Standards and Accreditation Program to become effective for captive RRGs, including a requirement that state enactments of a regulatory framework similar to Model #325 apply to RRGs.

7. Any Other Important Information (e.g., amending an accreditation standard).

This project affects an accreditation standard. The Part A Standards of the NAIC Financial Regulation Standards and Accreditation Program became effective for captive RRGs on January 1, 2011, and included a requirement that Model #325 should apply to RRGs. One of these standards is entitled Producer Controlled Insurers and requires that states provide evidence of a regulatory framework similar to that contained in Model #325 or similar provisions. The FRSAC postponed the applicability of this standard to RRGs until this matter is resolved.

INVESTMENTS IN MEDIUM AND LOWER GRADE OBLIGATIONS MODEL REGULATION

Table of Contents

Section 1. Short Title

This may be cited as the Investments in Medium Grade and Lower Grade Obligations Regulation.

Section 2. Purposes

The purposes of this regulation are:

A. To protect the interests of the insurance-buying public by establishing limitations on the concentration of medium grade and lower grade obligations in which a domestic insurer can invest; and

B. To implement section [insert section of the insurance law specifying allowable investments] of the insurance law by regulating the acts and practices of domestic insurers with respect to the concentration of investments in medium grade and lower grade obligations.

Section 3. Preamble

A. The insurance department is concerned that changes in economic conditions and other market variables could adversely affect domestic insurers having a high concentration of these investments. Accordingly, the Department has concluded that a limitation on the percentage of total admitted assets that a domestic insurer may prudently invest in such obligations is reasonable, necessary and required in order to carry out the Department's responsibilities under relevant statutory law.

B. The department understands that medium grade and lower grade obligations can have a place in a well-diversified portfolio. However, it is also understood that the special risks associated with these investments require a high degree of management even when they are held within an aggregate limit. While this regulation will leave all domestic insurers with authority to invest a substantial portion of their assets in medium grade and lower grade obligations, the prudent management of the attendant risks will remain an essential element of such investing.

Section 4. Definitions

As used in this regulation:

A. "Medium grade obligations" means obligations which are rated three by the Securities Valuation Office of the National Association of Insurance Commissioners.

B. "Lower grade obligations" means obligations which are rated four, five or six by the Securities Valuation Office of the National Association of Insurance Commissioners.

C. "Admitted assets" means the amount as of the last day of the most recently concluded annual statement year, computed in the same manner as "admitted assets" in Section [insert section] of the Insurance Law.

D. "Aggregate amount" of medium grade and lower grade obligations means the aggregate statutory statement value.

E. "Institution" means a corporation, a joint-stock company, an association, a trust, a business partnership, a business joint venture or similar entity.

Section 5. Provisions

A. A domestic insurer shall not acquire, directly or indirectly, a medium grade or lower grade obligation of an institution if, after giving effect to the acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the domestic insurer would exceed twenty percent (20%) of its admitted assets provided that no more than ten percent (10%) of its admitted assets consists of obligations rated four, five or six by the Securities Valuation Office; and no more than three percent (3%) of its admitted assets consists of obligations rated five or six by the Securities Valuation Office, and no more than one percent (1%) of its admitted assets consists of obligations rated six by the Securities Valuation Office. Attaining or exceeding the limit of any one category shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multi-category limits.

B. A domestic insurer shall not invest more than an aggregate of one percent (1%) of its admitted assets in medium grade obligations issued, guaranteed or insured by any one institution nor may it invest more than one half of one percent (.5%) of its admitted assets in lower grade obligations issued, guaranteed or insured by any one institution. In no event, however, may a domestic insurer invest more than one percent (1%) of its admitted assets in any medium or lower grade obligations issued, guaranteed or insured by any one institution.

C. Nothing contained in this regulation shall prohibit a domestic insurer from acquiring obligations which it has committed to acquire if the insurer would have been permitted to acquire that obligation pursuant to this regulation on the date on which the insurer committed to purchase that obligation.

D. Notwithstanding the foregoing, a domestic insurer may acquire an obligation of an institution in which the insurer already has one or more obligations, if the obligation is acquired in order to protect an investment previously made in the obligations of the institution; provided that all such acquired obligations shall not exceed one-half of one percent (.5%) of the insurer's admitted assets.

E. Nothing contained in this regulation shall prohibit a domestic insurer from acquiring an obligation as a result of a restructuring of a medium or lower grade obligation already held.

F. Nothing contained in this regulation shall require a domestic insurer to sell or otherwise dispose of an obligation legally acquired prior to the effective date of this regulation.

G. The board of directors of a domestic insurance company that acquires or invests, directly or indirectly, more than two percent (2%) of its admitted assets in medium grade and lower grade obligations of an institution, shall adopt a written plan for the making of such investments. The plan, in addition to guidelines with respect to the quality of the issues invested in, shall contain diversification standards including, but not limited to, standards for issuer, industry, duration, liquidity and geographic location.

Section 6. Effective Date

This regulation shall take effect on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1991 Proc. II 25, 57, 327-328, 329-331 (adopted).

INVESTMENTS IN MEDIUM GRADE AND LOWER GRADE OBLIGATIONS MODEL REGULATION

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INVESTMENTS IN MEDIUM GRADE AND LOWER GRADE OBLIGATIONS MODEL REGULATION

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	ALASKA ADMIN. CODE tit. 3 § 21.231 (2001).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-540 (1954/1998).
Arkansas	ARK. CODE ANN. § 23-63-805 (1993/2015).		
California	CAL. INS. CODE § 1196.1 (1991).		
Colorado	COLO. REV. STAT. § 10-3-215.5 (1992).		
Connecticut			CONN. GEN. STAT. §§ 38a-102b to 38a-102c (1991).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. 625.305 (1989/1993).
Georgia	NO CURRENT ACTIVITY		

INVESTMENTS IN MEDIUM GRADE AND LOWER GRADE OBLIGATIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/126.10 (1997).
Indiana			IND. CODE § 27-1-12-2 (1991).
Iowa	IOWA ADMIN. CODE r. § 191-5.32 (1992).		
Kansas	KAN. STAT. ANN. §§ 40-2a27 to 40-2a28 (1992/2005).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 1156 (1987/1993).
Maryland			MD. CODE REGS. §§ 31.05.06.01 to 31.05.06.07 (1990/1994).
Massachusetts	MASS. GEN. LAWS ANN. ch. 175, § 63A (1993).		
Michigan			MICH. COMP. LAWS § 500:922 (1956/1991).
Minnesota			MINN. STAT. § 60A.11 (1991).
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. REV. STAT. § 375.1075 (1991).		
Montana	MONT. CODE ANN. § 33-12-202 (1999/2001).		
Nebraska			NEB. REV. STAT. § 44-5115 (1991); § 44-5152 (1991/1997).

INVESTMENTS IN MEDIUM GRADE AND LOWER GRADE OBLIGATIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 176.1 to 176.4 (1987/1991) (Regulation 130).		
North Carolina			N.C. GEN. STAT. § 58-7-170 (1991/1993).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	OR. ADMIN. R. § 836-033-0120 (1992).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS §§ 58-27-89 to 58-27-111 (1992).
Tennessee			TENN. CODE ANN. § 56-3-303; § 56-3-402 (1985).
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	4-3 VT. CODE R. § 22 (1993) (Regulation 93-3).		

INVESTMENTS IN MEDIUM GRADE AND LOWER GRADE OBLIGATIONS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-1401; § 38.2-1411.2 (1992).		
Washington			WASH. REV. CODE ANN. § 48.13.071 (2011)
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

REDOMESTICATION MODEL BILL

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An Act to provide a means whereby any insurer organized under the laws of any other state may become a domestic insurer; to provide a means for any domestic insurer to transfer its domicile to another state; and to provide a means for the continuation of a certificate of authority and other approvals pertaining to a foreign insurer that transfers its corporate domicile to another state by merger or consolidation or any other lawful method.

Section 1. Approval as a Domestic Insurer

An insurer that is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. The domestic insurer will be entitled to like certificates and licenses to transact business in this state, and shall be subject to the authority and jurisdiction of this state.

Section 2. Conversion to Foreign Insurer

A domestic insurer may, upon the approval of the commissioner of insurance, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon such a transfer shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The commissioner of insurance shall approve the proposed transfer unless he or she determines the transfer is not in the interest of the policyholders of this state.

Section 3. Effects of Redomestication

The certificate of authority, agents appointments and licenses, rates and other items which the commissioner of insurance allows, in his or her discretion, that are in existence at the time an insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation or any other lawful method shall continue in full force and effect upon transfer if the insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of a transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner of insurance. A transferring insurer shall file new policy forms with the commissioner of insurance on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the commissioner of insurance. However, every transferring insurer shall notify the commissioner of insurance of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the commissioner of insurance.

Section 4. Authority of Promulgate Rules and Regulations

The commissioner of insurance of this state may promulgate rules and regulations to carry out the purposes of this Act.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1980 Proc. I 33-34, 37, 211, 229, 230, 231 (adopted).

REDOMESTICATION MODEL BILL

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REDOMESTICATION MODEL BILL

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-3-30 to 27-3-32 (1991).		
Alaska	ALASKA STAT. §§ 21.69.645 to 21.69.648 (1995).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-231 (1979).		
Arkansas	ARK. CODE ANN. § 23-63-218 (1981/1991).		
California	CAL. INS. CODE § 709.5 (1994).		
Colorado	COLO. REV. STAT. § 10-3-125 (1989).		
Connecticut	CONN. GEN. STAT. § 38a-58a (1991).		
Delaware	DEL. CODE ANN. tit. 18, § 4946 (1987).		
District of Columbia	D.C. CODE §§ 31-1701 to 31-1705 (1996/2005).		
Florida	FLA. STAT. §§ 628.520 to 628.535 (1985/1986).		FLA. ADMIN. CODE ANN. r. 69O-143.060 to 69O-143.061 (1990/1994).

REDOMESTICATION MODEL BILL

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. § 33-3-29 (1989).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3-212.5 to 431:3-215 (1991/2004).		HAW. REV. STAT. §§ 431:19-102.3 to 431:19-102.4 (1993/2012) (redomestication of captives).
Idaho	IDAHO CODE ANN. §§ 41-342 to 41-344 (1987/1999).		
Illinois	215 ILL. COMP. STAT. 5/180 to 5/185.2 (1987) (portions of model).		
Indiana	IND. CODE §§ 27-1-6.5-1 to 27-1-6.5-6 (1980/2003).		
Iowa	IOWA CODE § 508.12 (1987/2011).		
Kansas	KAN. STAT. ANN. § 40-2,162 (1997/1998).		
Kentucky	KY. REV. STAT. ANN. § 304.24-500 (1986/2004).		
Louisiana	LA. REV. STAT. ANN. § 22:1461.1 (1988).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 3487 (1999).		
Maryland	MD. CODE ANN., INS. § 3-126 (1985/1997) (portions of model).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 49A (1993).		
Michigan	MICH. COMP. LAWS §§ 500.412 to 500.415 (1989).		
Minnesota	MINN. STAT. § 60A.161 (1990).		

REDOMESTICATION MODEL BILL

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	MISS. CODE ANN. §§ 83-20-1 to 83-20-7 (1989).		
Missouri	MO. REV. STAT. § 375.908 (1991).		MO. CODE REGS. ANN. tit. 20, § 200-17.300 (2001).
Montana	MONT. CODE ANN. §§ 33-2-126 to 33-2-128 (1991).		
Nebraska	NEB. REV. STAT. §§ 44-161 to 44-164 (1989/2004).		
Nevada			NEV. REV. STAT. § 679A.090 (1971); §§ 680A.173 to 680A.177 (1983).
New Hampshire	N.H. REV. STAT. ANN. §§ 405:62 to 405:65 (1992).		
New Jersey	N.J. REV. STAT. § 17:17-20 (1994); § 17B:17-12.1 (1994).		
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAW §§ 7120 to 7121 (1992).
North Carolina	N.C. GEN. STAT. §§ 58-7-60 to 58-7-70 (1987/2001).		
North Dakota	N.D. CENT. CODE §§ 26.1-05-07.1 to 26.1-05-07.3 (1993) (includes tax credit).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. STAT. tit. 36, § 606.1 (1989).		OKLA. ADMIN. R. §§ 365:25-7-10 to 365:25-7-11 (1990).
Oregon	OR. REV. STAT. §§ 731.363 to 731.367 (1995).		

REDOMESTICATION MODEL BILL

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	40 PA. STAT. ANN. § 477e (1992).		
Puerto Rico	26 P.R. LAWS ANN. § 4320 (2004).		
Rhode Island	R.I. GEN. LAWS §§ 27-2.2-1 to 27-2.2-4 (1992).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-5-6.1 (1987).
Tennessee	TENN. CODE ANN. § 56-2-102 (1978) (portions of model).		
Texas	TEX. INS. CODE ANN. §§ 983.001 to 983.102 (2003).		
Utah	NO CURRENT ACTIVITY		
Vermont	VT. STAT. ANN. tit. 8, §§ 3437 to 3440 (1991).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-1019 to 38.2-1023(2006).
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE § 33-5-27 (2003).		
Wisconsin			WIS. STAT. § 611.223 (1988).
Wyoming	WYO. STAT. ANN. §§ 26-41-101 to 26-41-103 (1989).		

.MODEL INDEMNITY CONTRACTS ACT

Editor's Note: These laws are generally referred to as "Reciprocal Insurance" or "Inter-Insurance."

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An Act Authorizing and Regulating Certain Classes of indemnity Contracts Empowering Corporations to Make Such Contracts and Fixing Certain Fees, and the Penalty for Violation Thereof.

Section 1. Authority

Individuals, partnerships and corporations of this state, hereby designated subscribers, are authorized to exchange reciprocal or inter-insurance contracts with each other, or with individuals, partnerships and corporations of other states and countries in which they are authorized or not forbidden to do business, providing indemnity among themselves from any loss which may be insured against under other provisions of the laws, excepting life or accident and health insurance.

Section 2. Execution By Attorney

The contracts may be executed by an attorney, agent or other representative, herein designated "attorney," duly authorized and acting for the subscribers.

Section 3. Filing of Declaration

Subscribers so contracting among themselves shall through their attorney file with the insurance commissioner of this state a declaration verified by the oath of the attorney, setting forth:

A. The name or title of the office at which the subscribers propose to exchange indemnity contracts. The name or title shall not be so similar to any other name or title adopted by a similar organization or by any insurance corporation or association as in the opinion of the insurance commissioner is calculated to result in confusion or deception;

B. The kind or kinds of insurance to be effected or exchanged;

C. A copy of the form of policy contract or agreement under or by which insurance is to be effected or exchanged;

D. A copy of the form of power of attorney or other authority of the attorney under which insurance is to be effected or exchanged. The form shall contain a provision authorizing the attorney for and on behalf of the subscribers to file the written instruments prescribed in Section 4;

E. The location of the office or offices from which the contracts or agreements are to be issued; and

F. That applications have been made for indemnity upon at least 100 separate risks aggregating not less than $1,500,000 as represented by executed contracts or bona fide applications to become concurrently effective, or, in case of liability or compensation insurance, covering a total payroll of not less than $1,500,000.

Section 4. Instrument in Writing for Lawsuits

Concurrently with the filing of the declaration provided for by Section 3, the attorney shall file with the insurance commissioner an instrument in writing executed by the attorney for the subscribers, conditioned that upon the issuance of the certificate of authority provided for in Section 10, in all suits in this state arising out of such policies, contracts or agreements, action may be brought in the county in which the insured property is situated and service of process may be had upon the insurance commissioner. This service shall be valid and binding upon all subscribers exchanging at any time reciprocal or inter-insurance contracts through the attorney. Three (3) copies of the process shall be served and the insurance commissioner shall file one copy, forward one copy to the attorney and return one copy with his admission of service.

Section 5. Maximum Amount of Indemnity

There shall be filed with the insurance commissioner of this state by the attorney a statement under the oath of the attorney showing the maximum amount of indemnity upon any single risk and the attorney shall, whenever and as often as shall be required, file with the insurance commissioner a statement verified by his oath to the effect that he or she has examined the commercial rating of the subscribers as shown by the reference book of a commercial agency having at least 100,000 subscribers, and that from the examination or from other information in the attorney's possession it appears that no subscriber has assumed on any single risk an amount greater than ten percent (10%) of the net worth of the subscriber.

Section 6. Commissioner Examine

Upon the filing of the foregoing papers it shall be the duty of the insurance commissioner to examine and pass upon the same and if found satisfactory to issue a license.

Section 7. Reserves

There shall at all times be maintained as a reserve a sum in cash or convertible securities equal to fifty percent (50%) of the net annual deposits collected and credited to the accounts of the subscribers on policies having one year or less to run and pro rata on those for longer periods. Net annual deposits shall be construed to mean the advance payments of subscribers after deducting the amounts specifically provided in the subscribers' agreements, for expenses. The sum shall at no time be less than $25,000, and if at any time fifty percent (50%) of the deposits so collected and credited shall not equal that amount, then the subscribers, or their attorney for them, shall make up any deficiency.

Section 8. Report by Attorney

The attorney shall make a report to the insurance commissioner for each calendar year on or before [insert date] showing the financial condition of affairs at the office where the contracts are issued and shall furnish any additional information and reports required. The attorney shall not be required to furnish for filing the names and addresses of any subscribers nor the loss ratio. The business affairs and assets of the organizations shall be subject to examination by the insurance commissioner.

Section 9. Exchange Insurance Contracts

A corporation now or hereafter organized under the laws of this state shall, in addition to the rights, powers and franchises specified in its articles of incorporation, have full power and authority to exchange insurance contracts of the kind and character herein mentioned. The right to exchange contracts is hereby declared to be incidental to the purposes for which the corporations are organized and as much granted as the rights and powers expressly conferred.

Section 10. Exchange Indemnity Contracts

An attorney, agent or representative who shall, except for purpose of applying for certificate of authority as herein provided, exchange any contracts of indemnity of the kind and character specified in this Act, or directly or indirectly solicit or negotiate any applications for same without first complying with the foregoing provisions shall be deemed guilty of a misdemeanor, and, upon conviction, shall be subjected to a fine of not less than $100 nor more than $1,000.

Section 11. Certificate of Authority

Each attorney by or through whom is issued any policies of or contracts for indemnity of the character referred to in this Act shall procure from the insurance commissioner annually a certificate of authority stating that all the requirements of this Act have been complied with, and upon such compliance and payment of the fees required by this Act, the insurance commissioner shall issue a certificate. The insurance commissioner may for cause revoke any certificate of authority.

Section 12. Annual License Fee

An attorney, in lieu of all taxes, shall pay to the state with the filing of each annual report, as an annual license fee [insert number] percent of the gross premiums of deposits for the preceding calendar year, deducting all amounts returned to subscribers or credited to their accounts other than for losses; and shall pay a filing fee of $[insert number].

Section 13. Insurance Law Exceptions

Except as herein provided, no insurance law of this state shall apply to the exchange of indemnity contracts unless they are specially mentioned.

Editor's Note: In 1918, the NAIC adopted the following report, which constituted amendments to the 1912 Model Indemnity Contracts Act.

Reciprocal or Inter-Insurance

To the National Convention of Insurance Commissioners:

Your Committee on Laws and Legislation, to which was referred the question of examining the laws of the various States pertaining to the exchange of reciprocal or inter-insurance contracts with a view to making recommendations or changes in the Commissioner's Bill, submits the following report:

Your committee does not deem it advisable at this time to recommend legislation in the form of a new bill, but suggests certain amendments to the Commissioner's Bill which will strengthen that measure.

We recommend that the Commissioner's Bill in the form adopted be amended as follows:

First, so that subscribers exchanging fire insurance contracts in the name of an exchange have assets on hand at all times available for the payment of losses a sum of not less than $50,000.

Second, that the various forms of liability and workmen's compensation insurance exchanges have assets on hand at all times available for the payment of losses the sum of $100,000.

Third, the attorney in fact in the name of the exchange shall have on hand at all times assets in cash or securities authorized by the laws of the state in which the principal office of the exchange is located, for the investment of funds of insurance companies doing the same kind of business, an amount equal to one hundred percent (100%) of the net unearned premiums or deposit collected and credited to the account of the subscribers, or fifty percent (50%) of the net annual advance premium or deposit collected and credited to the account of subscribers on policies having one year or less to run and pro rata on those for a longer period. In addition to the foregoing sum there shall be on hand at all times in cash or such securities, assets equal to all liabilities on account of outstanding losses and other accrued obligations of such exchange.

Fourth, the attorney in fact may purchase reinsurance upon the risk of any subscriber at the exchange. No attorney in fact shall, however, grant reinsurance upon any risk or risks insured by any other insurance carrier. Any exchange may, however, consolidate with or reinsure its entire business in another exchange upon the approval of the insurance commissioners of the States wherein the exchanges are located.

Fifth, all claims for money advanced by the attorney in fact or subscribers shall be deferred to all claims or other obligations arising under the policies and all other obligations imposed by this law.

The following clause is submitted for the last clause of the Commissioner's Bill:

Except as herein provided, no law relating to fire insurance shall apply to reciprocal or inter-insurance contracts or the execution thereof, unless they are therein specifically mentioned.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1912 Proc. 11-12 (adopted).
1918 Proc. 26-27 (amended).

MODEL INDEMNITY CONTRACT ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-31-1 to 27-31-29 (1971).
Alaska			ALASKA STAT. §§ 21.75.010 to 21.75.270 (1966/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-761 to 20-792 (1954/1979).
Arkansas			ARK. CODE ANN. §§ 23-70-101 to 23-70-124 (1958/1985).
California			CAL. INS. CODE §§ 1300 to 1540 (1935/2004).
Colorado	COLO. REV. STAT. §§ 10-13-101 to 10-13-114 (1963/1986).		
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, §§ 5701 to 5726 (1953/1956).
District of Columbia			D.C. MUN. REGS. tit. 26A, §§ 4001 to 4099 (2007).

MODEL INDEMNITY CONTRACT ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 629.011 to 629.520 (1958/1982).
Georgia			GA. CODE ANN. §§ 33-17-1 to 33-17-31 (1960/1982).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431:4-401 to 431:4-424 (1988/2003).
Idaho			IDAHO CODE ANN. §§ 41-2901 to 41-2930 (1961/2005).
Illinois			215 ILL. COMP. STAT. 5/61 to 5/85 (1937/1984).
Indiana	IND. CODE § 27-6-6-1 to 27-6-6-15 (1993).		
Iowa			IOWA CODE §§ 520.1 to 520.23 (1965/1978).
Kansas			KAN. STAT. ANN. §§ 40-1601 to 40-1631 (1927/1984).
Kentucky			KY. REV. STAT. ANN. §§ 304.27-010 to 304.27-280 (1970/1982).
Louisiana			LA. REV. STAT. ANN. §§ 22:161 to 22:185 (1958).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 3851 to 3876 (1970/1978).
Maryland			MD. CODE ANN., INS. §§ 3-201 to 3-222 (1963/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 94A to 94M (1947/1986).
Michigan	MICH. COMP. LAWS §§ 500.7200 to 500.7234 (1957) (portions of model).		

MODEL INDEMNITY CONTRACT ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. §§ 71A.01 to 71A.08 (1967/1986).		
Mississippi	MISS. CODE ANN. §§ 83-33-1 to 83-33-19 (1918/2013).		
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. §§ 33-5-101 to 33-5-503 (1959/2003).
Nebraska	NEB. REV. STAT. §§ 44-1201 to 44-1215 (1917/1986).		
Nevada			NEV. REV. STAT. §§ 694B.010 to 694B.260 (1972).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. REV. STAT. §§ 17:50-1 to 17:50-19 (1945).		
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAWS §§ 6101 to 6116 (1984/2010).
North Carolina			N.C. GEN. STAT. §§ 58-15-1 to 58-15-150 (1990).
North Dakota	N.D. CENT. CODE §§ 26.1-09-01 to 26.1-09-15 (1983).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3931.01 to 3931.99 (1917/1977).		
Oklahoma			OKLA. STAT. tit. 36, §§ 2901 to 2931 (1957/2006).
Oregon			OR. REV. STAT. §§ 731.458 to 731.470 (1967).

MODEL INDEMNITY CONTRACT ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			40 PA. STAT. ANN. §§ 961 to 971 (1921).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 3301 to 3328 (1979).
Rhode Island			R.I. GEN. LAWS §§ 27-17-1 to 27-17-27 (1952/2002).
South Carolina	S.C. CODE ANN. §§ 38-17-10 to 38-17-170 (1988).		
South Dakota			S.D. CODIFIED LAWS §§ 58-34-1 to 58-34-64 (1966).
Tennessee			TENN. CODE ANN. §§ 56-16-101 to 56-16-119 (1990).
Texas			TEX. INS. CODE ANN. §§ 942.001 to 942.203 (2003).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, §§ 4831 to 4856 (1971).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-1200 to 38.2-1231 (1986/2004).
Washington			WASH. REV. CODE ANN. §§ 48.10.010 to 48.10.340 (1947/1985).
West Virginia			W. VA. CODE §§ 33-21-1 to 33-21-26 (1957/1986).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. STAT. ANN. §§ 26-27-101 to 26-27-129 (1967/1983).

CONSUMER CREDIT INSURANCE MODEL ACT

Table of Contents

BE IT ENACTED BY THE STATE OF [insert state].

[adapt caption and formal portions to local requirements and statutes]

Section 1. Purpose

The purpose of this Act is to promote the public welfare by regulating consumer credit insurance. Nothing in this Act is intended to prohibit or discourage reasonable competition. The provisions of this Act shall be liberally construed.

Section 2. Scope and Definitions

A. Citation and Scope

(1) This Act may be cited as the "Consumer Credit Insurance Act."

(2) All consumer credit insurance issued or sold in connection with loans or other credit transactions for personal, family or household purposes shall be subject to the provisions of this Act, except:

(a) Insurance written in connection with a credit transaction that is:

(i) Secured by a first mortgage or deed of trust; and

(ii) Made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose;

(b) Insurance sold as an isolated transaction on the part of the insurer and not related to an agreement or a plan for insuring debtors of the creditor.

(c) Insurance for which no identifiable charge is made to the debtor.

(d) Insurance on accounts receivable.

B. Definitions

For the purpose of this Act:

(1) "Commissioner" means the insurance supervisory authority of the state;

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

(2) "Compensation" means commissions, dividends, retrospective rate credits, service fees, expense allowances or reimbursements, gifts, furnishing of equipment, facilities, goods or services, or any other form of remuneration resulting directly from the sale of consumer credit insurance;

(3) "Consumer credit insurance" is a general term used in this Act to refer to any or all of credit life insurance, credit accident and health insurance, credit unemployment insurance or any other insurance specifically defined in this Act;

(4) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments or debt becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(5) "Credit life insurance" means insurance on a debtor or debtors, pursuant to or in connection with a specific loan or other credit transaction, to provide for satisfaction of a debt, in whole or in part, upon the death of an insured debtor;

(6) "Credit transaction" means any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased, is to be made at a future date or dates;

(7) "Credit unemployment insurance" means insurance on a debtor to provide indemnity for payments or debt becoming due on a specific loan or other credit transaction while the debtor is involuntarily unemployed as defined in the policy;

(8) "Creditor" means the lender of money or vendor or lessor of goods, services or property, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor, or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

(9) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

(10) "Gross debt" means the sum of the remaining payments owed to the creditor by the debtor;

(11) "Identifiable charge" means a charge for a type of consumer credit insurance that is made to debtors having such insurance and not made to debtors not having such insurance; it includes a charge for insurance that is disclosed in the credit or other instrument furnished to the debtor which sets out the financial elements of the credit transaction and any difference in the finance, interest, service or other similar charge made to debtors who are in like circumstances except for the insured or non-insured status of the debtor or of the property used as security for the credit transaction;

(12) "Insurer" means insurer as defined in [insert section of Code];

(13) "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned finance charges;

(14) "Open-end credit" means credit extended by a creditor under an agreement in which:

(a) The creditor reasonably contemplates repeated transactions;

(b) The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

(c) The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

Drafting Note: The definition of open-end credit should be controlled by applicable lending laws in each state and the definition contained in this bill should be consistent with that contained in the applicable lending law. This definition is consistent with that contained in Federal Truth-in-Lending Regulation Z, which applies in most states. In a state having a controlling lending law containing an inconsistent definition, the definition in this bill should be modified to be consistent with the definition in that state's lending law.

Drafting Note: A concern has been raised that the definition of "consumer credit insurance" not be so broad as to exclude coverage of consumer credit insurance under the various state guaranty funds. Specifically, the NAIC's Post-Assessment Property and Liability Insurance Guaranty Model Act specifically excludes coverage for "credit insurance, vendor's single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction." That model further comments that: ""Credit insurance" as used here is intended to mean insurance on accounts receivable." The use of the phrase "consumer credit insurance" in this Consumer Credit Insurance Model Act is intended to differentiate typical forms of insurance made available to consumers from those coverages excluded from the model property and casualty guaranty fund act.

Drafting Note: The definitions in Paragraphs (6), (8), and (9) include terms to allow the writing of Consumer Credit Insurance on leases. States may wish to reword these definitions with the references to leases removed if they feel Consumer Credit Insurance should not be written on leases.

Section 3. Types of Consumer Credit Insurance

The types of consumer credit insurance defined in Section 2 may each be written separately or in combination with other types of consumer credit insurance on an individual policy or group policy basis. The Commissioner may by regulation prohibit or limit any combination.

Drafting Note: States may wish to consider including provisions which call for discounts when policies are sold on a package basis.

Section 4. Amount of Consumer Credit Insurance

A. Credit Life Insurance

(1) The amount of credit life insurance shall at no time exceed the greater of the actual net debt or the scheduled net debt.

(2) If the coverage is written on the actual net debt, then the amount payable at the time of loss may not be less than the actual net debt less any payments more than two (2) months overdue.

(3) If the coverage is written on the scheduled net debt, then the amount payable at the time of loss shall be:

(a) If the actual net debt is less than or equal to the scheduled net debt, then the scheduled net debt;

(b) If the actual net debt is greater than the scheduled net debt but less than or equal to the scheduled net debt plus two (2) months of payments, then the actual net debt; or

(c) If the actual net debt is greater than the scheduled net debt plus two months of payments, then the scheduled net debt plus two months of payments.

Drafting Note: If desired, the following provisions may be added as Paragraphs (4),(5), (6), (7) and (8).

(4) If a premium is assessed to the debtor on a monthly basis and is based on the actual net debt, then the amount payable at the time of loss shall be the actual net debt on the date of death. When such premium is computed on the basis of a balance which does not include accrued past due interest, then the amount payable at the time of loss shall not be less than the actual net debt less any accrued interest more than two (2) months past due.

(5) Notwithstanding the provisions of Paragraph (1) of this subsection, insurance on agricultural loan commitments, not exceeding one year in duration, may be written up to the amount of the loan commitment, on a non-decreasing or level term plan.

(6) Notwithstanding the provisions of Paragraph (1) of this subsection, insurance on educational loan commitments may be written for net unpaid indebtedness plus any unused commitment.

(7) Coverage may be written for less than the net debt by the following methods:

(a) The amount of insurance may be the lesser of a stated level amount and the amount determined by Paragraph (2) of this subsection;

(b) The amount of insurance may be the lesser of a stated level amount and the amount determined by Paragraph (3) of this subsection;

(c) The amount of insurance may be a constant percentage of the amount determined by Paragraph (2) of this subsection;

(d) The amount of insurance may be a constant percentage of the amount determined by Paragraph (3) of this subsection; or

(e) In the absence of any preexisting condition exclusions, the amount of insurance payable in the event of death due to natural causes may be limited to the balance as it existed six (6) months prior to the date of death if:

(i) There has been one or more increase in the outstanding balance during the six-month period, other than those due to the accrual of interest or late charges; and

(ii) Evidence of individual insurability has not been required during the six-month period.

(8) Other patterns of insurance may be used which are not inconsistent with the rest of this subsection.

Drafting Note: States allowing consumer credit insurance on leases may want to consider adding language to this section which specifically defines acceptable amounts of insurance for leases. Some possible variations would include:

1. Coverage providing for the payment in a lump sum of the remaining lease payments;

2. Coverage providing for the payment in a lump sum of the remaining lease payments plus a stated amount for which the leased property may be purchased at the end of the lease;

3. Coverage providing for the payment as they come due of the lease payments; or

4. Coverage providing for the payment as they come due of the lease payments plus payment at the end of the lease of a stated amount which purchases the leased property.

B. Credit Accident and Health Insurance and Consumer Credit Unemployment Insurance

(1) The total amount of periodic indemnity payable by credit accident and health insurance or credit unemployment insurance in the event of disability or unemployment, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the gross debt; and the amount of each periodic indemnity payment shall not exceed the original gross debt divided by the number of periodic installments.

(2) Notwithstanding the provisions of Paragraph (1), for credit accident and health insurance or credit unemployment insurance written in connection with an open-end credit agreement, the amount of insurance shall not exceed the gross debt which would accrue on that amount using the periodic indemnity. Subject to any policy maximums, the periodic indemnity must not be less than the creditor's minimum repayment schedule.

Section 5. Term of Consumer Credit Insurance

A. Effective Date of Coverage

(1) For consumer credit insurance made available to and elected by the debtor before or contemporaneous with a credit transaction to which the insurance relates, the term of the insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor except that when evidence of individual insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the credit insurance may commence on the date on which the insurance company determines the evidence to be satisfactory.

(2) For insurance coverage made available to and elected by the debtor on a date subsequent to the date of the consumer credit transaction to which the insurance relates, the insurance shall, subject to acceptance by the insurer, commence on a date not earlier than the date the election is made by the debtor nor later than thirty (30) days following the date on which the insurance company accepts the risk for coverage, according to an objective method such as one related to a particular date within a billing or repayment cycle or a calendar month.

Drafting Note: A state may wish to review its existing laws to determine if prompt underwriting action is required of insurers when evidence of insurability is submitted. If no other law imposes such a requirement, one may be inserted as a new paragraph in Subsection 5A.

(3) Notwithstanding the provisions of Paragraphs (1) and (2) of this subsection, when a group policy provides coverage with respect to debts existing on the policy effective date, the insurance relating to the debt shall not commence before the effective date of the group policy.

(4) In no event shall a charge for insurance be made to the debtor and retained by the creditor or insurer for any time prior to commencement of the consumer credit insurance to which the charge is related.

B. Termination Date of Coverage

(1) The term of any consumer credit insurance shall not extend beyond the termination date specified in the policy. The termination date of insurance may precede, coincide with or follow the scheduled maturity date of the debt to which it relates, subject to any other requirements and restrictions of this Act.

(2) The term of any consumer credit insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the debt except when extended without additional cost to the debtor or except when extended pursuant to a written agreement, signed by the debtor, in connection with a variable interest rate credit transaction or a deferral, renewal, refinancing or consolidation of debt.

(3) If the debt is discharged due to renewal, refinancing or consolidation prior to the scheduled termination date of the insurance, any insurance in force shall be terminated before any new insurance may be written in connection with the renewed, refinanced or consolidated debt.

(4) In all cases of termination of insurance prior to the scheduled termination of the insurance, an appropriate refund or credit to the debtor shall be made of any unearned insurance charge paid by the debtor for a term of insurance after the date of the termination, except that no refund is required of a charge made for insurance if the insurance is terminated by performance of the insurer's obligation with respect to the insurance.

(5) An insured debtor may terminate consumer credit insurance at any time by providing advance request to the insurer. The individual policy or group certificate may require that the request be in writing or that the debtor surrender the individual policy or group certificate, or both. The debtor's right to terminate coverage may also be subject to the terms of the credit transaction contract.

Section 6. Disclosure to Debtors and Provisions of Policies and Certificates of Insurance

A. Pre-purchase disclosure. Before the debtor elects to purchase consumer credit insurance in connection with a credit transaction, the following shall be disclosed to the debtor in writing;

(1) That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;

(2) If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;

(3) The conditions of eligibility;

(4) That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;

(5) That within the first thirty (30) days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premium paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;

(6) A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package;

(7) That if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

B. The disclosures required in Section 6A shall be provided in the following manner:

(1) In connection with consumer credit insurance offered contemporaneously with the extension of credit or offered through direct mail advertisements, disclosure shall be made in writing and presented to the consumer in a clear and conspicuous manner;

(2) In conjunction with the offer of credit insurance subsequent to the extension of credit by other than direct mail advertisements, disclosure may be provided orally so long as written disclosures are provided to the debtor no later than the earlier of:

(a) Ten (10) days after the offer, or

(b) The date any other written material is provided to the debtor.

C. All consumer credit insurance shall be evidenced by an individual policy or a group certificate of insurance which shall be delivered to the debtor.

D. The individual policy or group certificate shall, in addition to other requirements of law, set forth the following:

(1) The name and home office address of the insurer;

(2) The name or names of the debtor or debtors, or, in the case of a group certificate, the identity by name or otherwise of the debtor or debtors;

(3) The premium or amount of payment by the debtor separately for each kind of coverage or for all coverages in a package, except that for open-end loans, the premium rate and the basis of premium calculation (e.g., average daily balance, prior monthly balance) shall be specified;

(4) A full description of the coverage or coverages including the amount and term thereof, and any exceptions, limitation and exclusions;

(5) A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid debt and, whenever the amount of insurance benefit exceeds the unpaid debt that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor, or to the debtor's estate; and

(6) If the scheduled term of insurance is less than the scheduled term of the credit transaction, a statement to that effect on the face of the individual policy or group certificate in not less than ten-point bold face type.

E. Unless the individual policy or group certificate of insurance is delivered to the debtor at the time the debt is incurred, or at such other time that the debtor elects to purchase coverage, a copy of the application for the policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium rate or amount of payment by the debtor for the insurance and the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time the debt is incurred or the election to purchase coverage is made. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the debt is incurred or the election to purchase coverage is made, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in Section 5.

F. The application, notice of proposed insurance or certificate may be used to fulfill all of the requirements of Subsection A and Subsection D if it contains all of the information required by those subsections.

G. The debtor has thirty (30) days from the date that he or she receives either the individual policy or the group certificate to review the coverage purchased. At any time within the 30-day period, the debtor may contact the creditor or insurer issuing the policy or certificate and request that the coverage be cancelled. The individual policy or group certificate may require the request to be in writing or that the policy or certificate be returned to the insurer or both. The debtor shall, within thirty (30) days of the request, receive a full refund or credit of all premiums or insurance charges paid by the debtor.

H. If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and, if the amount of premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made within thirty (30) days. If no insurer accepts the risk, then all premiums paid shall be refunded or credited within thirty (30) days of application to the person entitled thereto.

I. For the purpose of Subsection E of this section, an individual policy or group certificate delivered in conjunction with an open-end consumer credit agreement or any consumer credit insurance requested by the debtor after the date of the debt shall be deemed to be delivered at the time the debt is incurred or election to purchase coverage is made if the delivery occurs within thirty (30) days of the date the insurance is effective.

J. An individual policy or group certificate delivered in conjunction with an open-end credit agreement shall continue from its effective date through the term of the agreement unless the individual policy or group certificate is terminated in accordance with its terms at an earlier date.

Section 7. Filing, Approval and Withdrawal of Forms

A. All policies, certificates of insurance, notices of proposed insurance, disclosure notices, applications for insurance, endorsements and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Commissioner before being used.

Drafting Note: Some states may want to have advertising filed, but states should consider relying on safe harbor provisions.

B. The Commissioner shall within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, disclosure notices, applications for insurance, endorsements and riders, disapprove any such form if the benefits provided are not reasonable in relation to the premium charged, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of the Insurance Code or of any rule or regulation promulgated thereunder. If the Commissioner does not disapprove a filing within thirty (30) days, it may be deemed approved.

C. If the Commissioner notifies the insurer that the form is disapproved, it is unlawful thereafter for the insurer to issue or use the form. In such notice, the Commissioner shall specify the reason for disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of thirty (30) days after it has been so filed, unless the Commissioner shall give prior written approval.

D. The Commissioner may, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, withdraw approval of any such form on any ground set forth in Subsection B above. The written notice of hearing shall state the reason for the proposed withdrawal.

E. It is not lawful for the insurer to issue forms or use them after the effective date of such withdrawal.

F. If a group policy of consumer credit insurance

(1) Has been delivered in this state before the effective date of this Act; or

(2) Has been or is delivered in another state before or after the effective date of this Act

then the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in Subsections C and E of Section 6 of this Act and such forms shall be approved by the Commissioner if they conform with the requirements specified in these subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the Commissioner; provided, however, the premium rate in effect on existing group policies may be continued until the first

policy anniversary date following the date this Act becomes operative as provided in Section 12. However, all other forms specified in Section 7A shall also be filed as specified in this section unless the group policy has been or is delivered in another state which has adopted statutes, regulations, or other provisions similar to this statute. In that event, the forms should be filed for informational purposes. However, the insurer shall be prohibited from using any form filed for informational purposes if the Commissioner subsequently determines that the form is not in substantive compliance with the requirements of this statute.

G. Any order or final determination of the Commissioner under the provisions of this section shall be subject to judicial review.

Drafting Note: This regulatory format applies only to states with a file and use regulatory system. Appropriate modifications will need to be made in states requiring a prior approval, use and file, or no file system.

Section 8. Premiums and Refunds

A. An insurer may revise its schedules of premium rates from time to time, and shall file the revised schedules with the Commissioner. No insurer shall issue any consumer credit insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the Commissioner. The Commissioner shall have the authority to promulgate regulations to assure that the premium rates are reasonable in relation to the benefits provided, including the authority to regulate the compensation component of the premium rates.

Drafting Note: In the event that a state wishes to develop a regulatory framework allowing for component rating, the following is suggested language:

Alternative Section 8A:

A. An insurer may revise its schedules of premium rates from time to time, and shall file the revised schedules with the Commissioner. No insurer shall issue any consumer credit insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the Commissioner. The Commissioner shall have the authority to promulgate regulations to assure that the premium rates are reasonable in relation to the benefits provided, including the authority to regulate the compensation component of the premium rates. In determining whether the premium rates are reasonable in relation to the benefits provided, the Commissioner shall consider and provide for: actual and expected loss experience, general and administrative expenses, loss settlement and adjustment expenses, reasonable creditor compensation, investment income, the manner in which premiums are charged, and other acquisition costs, reserves, taxes, regulatory license fees and fund assessments, reasonable insurer profit and other relevant data, consistent with generally accepted actuarial standards.

Drafting Note: The NAIC, as a whole, neither endorses nor opposes component rating as the appropriate methodology for developing rates for consumer credit insurance products.

B. Each individual policy or group certificate shall provide for a refund in the event of termination of the insurance prior to the scheduled maturity date of the insurance and upon notice to the insurer. The refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided however, that the Commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. Refund formulas which any insurer desires to use must develop refunds which are at least as favorable to the debtor as refunds equal to the premium cost of scheduled benefits subsequent to the date of cancellation or termination, computed at the schedule of premium rates in effect on the date of issue. The formula to be used in computing such refund shall be filed with and approved by the Commissioner.

Drafting Note: The above refund requirement can be satisfied by a method commonly referred to as either the Rule of Anticipation or the Actuarial Method. The Commissioner may wish to consider other refund methodologies which meet the above requirement.

C. If a creditor requires a debtor to make any payment for consumer credit insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account or issue a refund.

D. The amount charged to a debtor for any consumer credit insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

Drafting Note: Where a state prohibits payments for insurance by the debtor in connection with credit transactions, the following paragraph may be included.

E. Nothing in this Act shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transactions.

Section 9. Issuance of Policies

All policies of consumer credit insurance shall be delivered or issued for delivery in this state only by an insurer authorized to engage in the business of insurance therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.

Section 10. Claims

A. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid either by draft drawn upon the insurer, by electronic funds transfer, or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

C. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts, checks, or electronic transfers in payment of claims due to the group policyholder subject to audit and review by the insurer.

D. All claims for consumer credit insurance shall be subject to Section [insert code section for the Unfair Claims Settlement Practices Act].

Section 11. Existing Insurance—Choice of Insurer

When consumer credit insurance is required as additional security for any debt; the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

Section 12. Duties of an Insurer

Except as otherwise prohibited by law, duties imposed upon an insurer within this Act may be carried out by a creditor if the creditor is acting as a common law or statutory agent on behalf of the insurer.

Section 13. Enforcement

The Commissioner may, after notice and hearing, issue such rules and regulations as the Commissioner deems appropriate for the supervision of this Act. Whenever the Commissioner finds that there has been a violation of this Act or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the Commissioner, he or she shall set forth the details of the findings together with an order for compliance by a specified date. The order shall be binding on the insurer and other person authorized or licensed by the Commissioner on the date specified unless sooner withdrawn by the Commissioner or a stay thereof has been ordered by a court of competent jurisdiction. The provisions of Sections 5 through 11 of this Act shall not be operative until ninety (90) days after the effective date of this Act, and the Commissioner in his or her discretion may extend by not more than an additional ninety (90) days the initial period within which the provisions of the specified sections shall not be operative. The Commissioner may set forth by regulation *prima facie* reasonable premium rates, together with corresponding safe-harbor benefit provisions, which premium rates shall be conclusively presumed reasonable in relation to the benefits provided when used for policies containing such benefit provisions.

Section 14. Judicial Review

Any party to the proceeding affected by an order of the Commissioner shall be entitled to judicial review by following the procedure set forth in [insert applicable section].

Section 15. Penalties

In addition to any other penalty provided by law, any person, firm or corporation which violates an order of the Commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of [insert state] a sum not to exceed $[insert amount] which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed $[insert amount]. The Commissioner, in his discretion, may revoke or suspend the license or certificate of authority of the person, firm or corporation guilty of such violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in Section 13 of this Act.

Section 16. Severability Provision

If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to any person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1958 Proc. I 105, 106-112, 169 (adopted).
1959 Proc. I 119, 126-130 (amended).
1961 Proc. I 294, 300-305, 306 (amended).
1968 Proc. II 499, 508-512, 567 (reprinted and amended) (1961 version reprinted 508-512).
1979 Proc. I 44, 47, 373, 449-450, 451 (amended to limit to 5 years or less)
1988 Proc. I 9, 21-22, 828, 851-853, 854-859 (amended and reprinted).
1988 Proc. II 5, 14, 758, 785-787, 788-791 (technical amendments).
1993 Proc. 4th Quarter 16, 19, 69-78 (amended).
1995 Proc. 4th Quarter 11, 33, 98, 108, 111 (amended).

CONSUMER CREDIT INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CONSUMER CREDIT INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-117 (1999).
Alaska	ALASKA STAT. §§ 21.57.010 to 21.57.160 (1966/1995).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1602 to 20-1616.01 (1961/2002).		
Arkansas	ARK. CODE ANN. §§ 23-87-101 to 23-87-119 (1959/2003).		
California	CAL. INS. CODE §§ 779.1 to 779.27 (1959/1993).		
Colorado	COLO. REV. STAT §§ 10-10-101 to 10-10-119 (1963/2001).		
Connecticut	CONN. GEN. STAT. §§ 38a-645 to 38a-658 (1959).		
Delaware	DEL. CODE ANN. tit. 18, §§ 3701 to 3713 (1953/1996).		
District of Columbia	D.C. CODE §§ 31-5101 to 31-5112 (1981/2004).		

CONSUMER CREDIT INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 627.676 to 627.684 (1982/1989).
Georgia	GA. CODE ANN. §§ 33-31-1 to 33-31-12 (1960/2005).		
Guam			GUAM GOV'T CODE §§ 4101 to 4203 (1981).
Hawaii	HAW. REV. STAT. §§ 431:10B-101 to 431:10B-114 (1988/2003).		
Idaho	IDAHO CODE ANN. §§ 41-2301 to 41-2316 (1961/2005).		
Illinois	215 ILL. COMP. STAT. 5/155.51 to 5/155.65 (1959/1979).		
Indiana	IND. CODE §§ 27-8-4-1 to 27-8-4-14 (1961/1995).		
Iowa			IOWA CODE §§ 509.16 to 509.17 (1973/1990).
Kansas			KAN. STAT. ANN. §§ 16a-4-101 to 16a-4-203 (1973/1988).
Kentucky	KY. REV. STAT. ANN. §§ 304.19-010 to 304.19-140 (1970/1984).		
Louisiana			LA. STAT. ANN. §§ 9:3542 to 9:3550 (1973).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2851 to 2865 (1970/2001).		
Maryland	MD. CODE ANN., INS. §§ 13-101 to 13-117 (1970/1997).		
Massachusetts			MASS. GEN. LAWS ch. 255, § 12G (1989).

CONSUMER CREDIT INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	MICH. COMP. LAWS §§ 550.601 to 550.624 (1958/1987).		
Minnesota	MINN. STAT. §§ 62B.01 to 62B.14 (1967/1999).		
Mississippi	MISS. CODE ANN. §§ 83-53-1 to 83-53-47 (1986/2014).		
Missouri	MO. REV. STAT. §§ 385.010 to 385.080 (1977/1992).		
Montana	MONT. CODE ANN. §§ 33-21-101 to 33-21-207 (1959/1993).		
Nebraska	NEB. REV. STAT. §§ 44-1701 to 44-1713 (1959/1997).		
Nevada	NEV. REV. STAT. §§ 690A.010 to 690A.280 (1971/2008).		
New Hampshire	N.H. REV. STAT. ANN. §§ 408-A:1 to 408-A:15 (1959/1985).		
New Jersey	N.J. REV. STAT. §§ 17B:29-1 to 17B:29-13 (1971/1982).		
New Mexico	N.M. STAT. ANN. §§ 59A-25-1 to 59A-25-14 (1985).		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. §§ 58-57-1 to 58-57-115 (1975/2005).
North Dakota	N.D. CENT. CODE §§ 26.1-37-01 to 26.1-37-16 (1985/2001).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3918.01 to 3918.99 (1959).		

CONSUMER CREDIT INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma			OKLA. STAT. tit. 14A, §§ 4-201 to 4-203 (1969).
Oregon	OR. REV. STAT. §§ 743.371 to 743.380 (1967/1989) (portions of model).		
Pennsylvania	40 PA. STAT. ANN. §§ 1007.1 to 1007.15 (1961).		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1813 to 1823 (1999).
Rhode Island	R.I. GEN. LAWS §§ 27-30-1 to 27-30-16 (1959/2010).		
South Carolina			S.C. CODE ANN. §§ 37-4-101 to 37-4-210 (1976/1999).
South Dakota			S.D. CODIFIED LAWS §§ 58-19-1 to 58-19-35 (1966/2001) (portions of model).
Tennessee			TENN. CODE ANN. §§ 56-7-901 to 56-7-914 (1980/1998).
Texas			TEX. INS. CODE ANN. §§ 1153.001 to 1153.055 (2003).
Utah	UTAH CODE ANN. §§ 31A-22-801 to 31A-22-809 (1986/2004) (portions of model).		
Vermont	VT. STAT. ANN. tit. 8, §§ 4101 to 4115 (1959).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-3717 to 38.2-3738 (1993/2014) (portions of model).		

CONSUMER CREDIT INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	WASH. REV. CODE §§ 48.34.010 to 48.34.120 (1961/1983) (portions of model).		
West Virginia	W. VA. CODE R. §§ 114-6-1 to 114-6-8 (1969/1971) (portions of model).		
Wisconsin			WIS. STAT. §§ 424.101 to 424.209 (1971/1994).
Wyoming	WYO. STAT. ANN. §§ 26-21-101 to 26-21-114 (1961/1983).		

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

Table of Contents

Section 1. Purpose

A. The purposes of this Act are to:

(1) Promote the public welfare by regulating credit personal property insurance;

(2) Create a legal framework within which credit personal property insurance may be written in this state;

(3) Help maintain the separation between creditors and insurers;

(4) Minimize the possibilities of unfair competitive practices in the sale of credit personal property insurance; and

(5) Address the problems arising from reverse competition in credit insurance markets.

B. Nothing in this Act is intended to prohibit or discourage reasonable competition. The provisions of this Act shall be liberally construed.

Section 2. Scope

A. This Act applies to an insurer or producer transacting credit personal property insurance as defined in this Act.

B. All credit personal property insurance written in connection with credit transactions for personal, family or household purposes is subject to the provisions of this Act, except:

Drafting Note: A state may wish to authorize the commissioner to adopt the consumer protections in this model as a regulation. If so, this model can generally be adopted as a regulation with minor editorial changes.

(1) Transactions involving extensions of credit primarily for business or commercial purposes;

(2) Insurance on motor vehicles designed for highway use and mobile homes;

(3) Insurance written in connection with a credit transaction that is secured by a real estate mortgage or deed of trust;

(4) Creditor-placed insurance;

(5) Title insurance;

(6) Non-filing insurance; and

(7) Insurance purchased by a creditor after repossession or a similar event where the creditor gains possession of the property; and

(8) Insurance for which no identifiable charge is made to or collected from the debtor.

Section 3. Definitions

As used in this Act:

A. "Closed-end credit" means a credit transaction that does not meet the definition of open-end credit.

B. "Collateral" means personal property in which a purchase money security interest is retained, or that is pledged as security for the satisfaction of a debt.

C. "Commissioner" means the insurance supervisory authority of the state.

D. "Compensation" means commission, dividends, retrospective rate credits, service fees, expense allowances or reimbursements, gifts, furnishing of equipment, facilities, goods and services or any other form of remuneration that is paid either directly or indirectly as a result of the sale of credit property insurance.

E. "Credit agreement" means the written document that sets forth the terms of the credit transaction and includes the security agreement.

F. "Credit personal property insurance" means a policy, endorsement, rider, binder, certificate or other instrument or evidence of insurance written in connection with a credit transaction that:

(1) Covers perils to the goods purchased through a credit transaction or used as collateral for a credit transaction and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part; or

(2) Covers perils to goods purchased in connection with an open-end credit transaction.

G. "Credit transaction" means a transaction by which the repayment of money loaned or credit commitment made, or payment of goods, services or properties sold or leased, is to be made at a future date or dates.

H. "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of a lender, vendor or lessor and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any person in any way associated with any of them.

I. "Creditor-placed insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, has provided coverage against loss, expense or damage to the collateralized personal property as a result of fire, theft, collision or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral covered by dual interest insurance. It is purchased according to the terms of the credit agreement as a result of the debtor's failure to provide required insurance, with the cost of the coverage being charged to the debtor. It shall be either single interest insurance or dual interest insurance.

J. "Debtor" means the borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

K. "Dual interest insurance" means credit personal property insurance covering the seller's or creditor's interest and at least partially the borrower's interest in the goods purchased through the credit transaction or pledged as collateral for the credit transaction.

L. "Experience" means earned premiums and incurred losses during the experience period.

M. "Experience period" means the most recent period of time for which earned premiums and incurred losses are reported, but not for a period longer than three (3) full years.

N. "Finance charge" means any charge payable directly or indirectly as an incident to or as a condition of the extension of credit, including but not limited to: interest, time price differentials; amount payable under a discount system of additional charges; service, transaction or carrying charges; loan fees; points or similar charges; appraisal fees; or charges incurred for investigating the credit-worthiness of the consumer. The terms shall not include charges as a result of default, taxes, license fees, delinquency charges or filing fees.

O. "Gross debt" means the sum of the remaining payments owed to the creditor by the debtor.

P. "Incurred losses," means total claims and claim adjustment expenses paid during the experience period plus any change in claim and claim adjustment expense reserves.

Q. "Identifiable charge" means a charge for credit personal property insurance that is made to debtors having such insurance and not made to debtors not having such insurance. It includes a charge for insurance that is disclosed in the credit or other instrument furnished to the debtor which sets out the financial elements of the credit transaction and any difference in the finance, interest, service or other similar charge made to debtors who are in like circumstances except for the insured or noninsured status of the debtor.

R. "Insurer" means insurer as identified in [insert section of Code].

S. "Loss ratio" means incurred losses divided by the sum of earned premiums.

T. "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned finance charges.

U. "Non-filing insurance" means insurance that indemnifies the creditor for loss of its interest in the collateral due to the failure to perfect a security interest.

V. "Open-end credit" means credit extended by a creditor under an agreement in which:

(1) The creditor reasonably contemplates repeated transactions;

(2) The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

(3) The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

W. "Producer" means a person or entity that receives compensation for insurance written or that, on behalf of an insurer or creditor, solicits, negotiates, effects, procures, delivers, renews, continues or binds credit personal property insurance to which this Act applies.

X. "Reverse competition" means competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or may control, the placement of the insurance with insurers. Reverse competition tends to increase insurance premiums or prevent the lowering of premiums in order that greater compensation may be paid to persons for such business as a means of obtaining the placement of business. In these situations, the competitive pressure to obtain business by paying higher compensation to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise or remain higher than they would otherwise.

Y. "Single interest insurance" means credit personal property insurance covering only the seller's or creditor's interest in the goods purchased through the credit transaction or pledged as collateral in the credit transaction.

Z. "Title insurance" means insurance that compensates for loss from title defects or encumbrances that were unknown but should have been discovered at the time the policy was issued.

Section 4. Amount, Term, Coverage and Prohibited Practices

A. For credit personal property insurance sold in conjunction with a closed end transaction, an insurer may not issue credit personal property insurance coverage unless the amount financed exceeds $[insert amount].

B. For credit personal property insurance sold in conjunction with a closed end transaction, an insurer may not issue credit personal property insurance in an amount that exceeds the amount of the underlying credit transaction unless otherwise required by [insert state lending law cite].

C. For credit personal property insurance sold in conjunction with a closed end transaction, an insurer may not sell credit personal property insurance with a term that exceeds in duration the scheduled term of the underlying credit transaction.

D. Credit personal property insurance coverage shall, at a minimum, include the coverages in the standard fire policy with coverage attachment, and extended coverage endorsement.

E. Credit personal property insurance shall cover a substantial risk of loss of or damage to the property related to the credit transaction.

F. An insurer may not require the bundling of other credit insurance coverages with the purchase of credit personal property insurance coverage. A debtor shall have the choice to purchase credit personal property insurance separate from other credit insurance coverage.

G. An insurer shall not use gross debt as an exposure base in determining credit personal property insurance premiums.

Section 5. Disclosure to Debtors and Provisions of Policies and Certificates of Insurance

A. Pre-purchase disclosure. The following shall be disclosed to the debtor in writing, and may be combined with other disclosures required by [insert state lending law cite] or by federal laws and regulations;

(1) That the purchase of credit personal property insurance through the creditor is optional and not a condition of obtaining credit approval;

(2) If more than one kind of credit insurance is being made available to the debtor, that the debtor can purchase credit personal property insurance separately;

(3) That if the consumer has other insurance that covers the risk, he or she may not want or need credit personal property insurance;

(4) That within the first thirty (30) days after receiving the individual policy or certificate of insurance, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund or any of the unearned premiums. However, only in those instances where the creditor requires evidence of insurance for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;

(5) A brief description of the coverage, including a description of the major perils and exclusions, any deductible, to whom the benefits would be paid, and the premium or premium rate for the credit personal property coverage; and

(6) If the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

B. The disclosures required in Subsection A shall be provided in the following manner:

(1) In connection with credit personal property insurance offered contemporaneously with the extension of credit or offered through direct mail advertisements, disclosure shall be made in writing and presented to the consumer in a clear and conspicuous manner; and

(2) In conjunction with the offer of credit insurance subsequent to the extension of credit by other than direct mail advertisements, disclosure may be provided orally or electronically so long as written disclosures are provided to the debtor no later than the earlier of:

(a) Ten (10) days after the election, or

(b) The date any other written material is provided to the debtor.

C. An offer to extend coverage for an open-end consumer transaction shall include, at the time of the invitation to contract, the written disclosure below in no smaller than twelve-point type. If the solicitation is made by telephone the disclosure may be summarized and given orally, provided that written disclosure is mailed within ten (10) days of enrollment.

"This coverage might duplicate existing coverage if you have a residential property insurance policy. It applies to any item of covered property on which you owe a debt. This coverage is primary, so it is the first source to be used in the event of a loss on property it covers. You may cancel this coverage at any time by calling the insurer at the telephone number provided to you, or by writing to the insurer. We are charging you a premium that may be based on things for which a claim cannot be made, such as services, meals or other consumables, entertainment, finance or service fees, loan interest, delivery charges or other insurance premiums."

D. All credit personal property insurance shall be evidenced by an individual policy or a certificate of insurance that shall be delivered to the debtor.

E. The individual policy or certificate of insurance shall, in addition to other requirements of law, set forth the following:

(1) The name and home office address of the insurer;

(2) The name or names of the debtor or debtors, or, in the case of a certificate of insurance, the identity by name or otherwise of the debtor or debtors;

(3) The premium or amount of payment by the debtor, except that for open-end loans, the premium rate and balance to which the rate applies shall be specified;

(4) A full description of the coverage or coverages including the amount and term thereof, and any exceptions, limitations, and exclusions;

(5) A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid debt or to repair or replace the property and, whenever the amount of loss payment exceeds the unpaid debt, that any excess payment shall be payable to the debtor;

(6) If the scheduled term of the insurance is less than the scheduled term of the credit transaction, a statement to that effect on the face of the individual policy or certificate of insurance in not less than twelve-point bold face type.

(7) Policies issued to cover open-end consumer transactions shall provide that the policyholder or certificate holder will be furnished the following disclosure notice with the account statement at least annually in no smaller than twelve-point type:

"You are paying credit property insurance premium based on the outstanding balance of this account. You may cancel this coverage at any time by calling the insurer at the telephone number the insurer has provided to you, or by writing to the insurer. Your premium may be based on things for which a claim cannot be made, such as services, meals or other consumables, entertainment, finance or service fees, loan interest, delivery charges, or other insurance premiums."

F. (1) Except as provided in Paragraph (2), the individual policy or group certificate shall be delivered to the debtor upon acceptance of the insurance by the insurer.

(2) An individual policy or group certificate delivered in conjunction with an open-end credit agreement or any credit personal property insurance requested by the debtor after the date the indebtedness is incurred shall be deemed to be delivered or the election to purchase insurance is made if the delivery occurs within thirty (30) days of the date the insurance is requested by the debtor.

Section 6. Filing, Approval and Withdrawal of Forms

A. All policies, certificates of insurance, group and individual applications for insurance and enrollment forms, endorsements and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner before being used. No policy, certificate of insurance, nor any application, endorsement or rider, shall be issued until the expiration of thirty (30) days after it has been filed, unless the commissioner shall have given prior written approval.

B. The commissioner shall within thirty (30) days after the filing of a form or rate disapprove a form or rate if the benefits provided are not reasonable in relation to the premium charged, or if it contains provisions that are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of the Insurance Code or of any regulation promulgated thereunder. If the commissioner does not disapprove a filing within thirty (30) days, it shall be deemed approved.

C. If the commissioner notifies the insurer that the form is disapproved, it is unlawful for the insurer to issue or use the form. The commissioner shall specify the reason for disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued until the expiration of thirty (30) days after it has been filed, unless the commissioner shall have given prior written approval.

D. The commissioner may, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, withdraw approval of any form or rate on any ground set forth in Subsection B. The written notice of hearing shall state the reason for the proposed withdrawal.

E. An insurer shall not issue forms or use them after the effective date of withdrawal.

Section 7. Reasonableness of Benefits in Relation to Premium Charge

A. An insurer may revise its schedule of premium rates from time to time and, shall file the revised schedules with the commissioner pursuant to the filing requirements in Section 6. An insurer shall not issue a credit personal property insurance policy for which the premium rates exceed that determined by the approved schedules of the insurer as then on file with the commissioner.

B. Benefits provided by credit personal property insurance policies shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than sixty percent (60%) or such higher loss ratio as designated by the commissioner to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium taxes, licenses, fees, assessments, and reasonable insurer profit.

C. For open-end credit transactions, an insurer's rating plan shall address, by grouping of like accounts, the expected variance in the mix of goods purchased that are covered under the credit personal property coverage versus items purchased that are not covered under the credit personal property coverage. Accounts shall be separated into groupings that possess or are expected to possess a similar mix of covered goods purchased versus not covered goods purchased.

Section 8. Limitation on Creditor Compensation [Optional]

An insurer shall not pay compensation in excess of [insert amount] percent of premium to a creditor. A reasonable level of creditor compensation may be lower than this limitation and this reasonable level shall be justified in determining the reasonableness of benefits pursuant to Section 7.

Section 9. Experience Reports and Triennial Filing Requirements

A. An insurer doing insurance business in this state shall annually file with the commissioner and the National Association of Insurance Commissioners (NAIC) a report of credit personal property insurance written on a calendar year basis. The report shall utilize the Credit Insurance Supplement–Annual Statement Blank approved by the NAIC, and shall contain data separately for each state, rather than an allocation of the company's countrywide experience. The filing shall be made in accordance with and no later than the due date in the Instructions to the Annual Statement.

B. Rates that have been filed and approved pursuant to Section 6 are effective for a period not to exceed three (3) years. An insurer shall file a new rate or support the previously approved rate before the three-year period expires. An insurer may file for a new rate before the end of the three-year period.

Section 10. Cancellation and Refund of Unearned Premium

Upon cancellation for any reason, the debtor is entitled to a refund of unearned premiums calculated on a daily pro rata basis. No refunds of less than $[insert amount] are required.

Section 11. Claims

A. All claims shall be promptly reported by the creditor to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid either by draft drawn upon the insurer, by electronic funds transfer, or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of the claimant to the party specified by the claimant.

C. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that once the amount is determined a group policyholder may, by arrangement with the group insurer, draw drafts, checks or electronic transfers in payment of claims due to the group policyholder subject to audit and review by the insurer.

D. No claim may be denied because the debtor was ineligible for coverage later than ninety (90) days after the initiation of coverage unless the debtor misrepresented a material fact. If a claim is denied because the debtor was ineligible for coverage within ninety (90) days of initiation of coverage or because the debtor misrepresented a material fact for coverage, the insurer shall refund to the debtor all premium paid and the creditor shall refund any finance charge paid on the premium.

E. All claims for credit personal property insurance shall be subject to Section [insert reference to the Unfair Claims Settlement Practices Act].

Drafting Note: In the event enforcement is addressed on a global basis in other statutes, the following section should be omitted.

Section 12. Enforcement

A. The commissioner may conduct investigations or examinations of insurers and producers to ensure compliance with and enforcement of the provisions of this Act.

B. The commissioner may take any of the following actions when necessary or appropriate to enforce the provisions of this Act and any regulations promulgated under this Act:

(1) Upon finding that an insurer or producer has violated a provision of this Act or a regulation promulgated under this Act, the commissioner may issue an order directing that the insurer or producer cease and desist from committing the violations, impose a civil penalty for the violations, provide an equitable remedy for past violations, or any combination of these.

(2) Upon the issuance of an order pursuant to Paragraph (1) of this subsection, the insurer or producer shall have the right to request a hearing. At the hearing, the burden shall be on the insurer or producer to show cause why an order pursuant to this subsection should be annulled, modified or confirmed. The provisions of [insert citation of statute concerning the conduct of hearing before the commissioner] shall apply to all hearings.

(3) Pending the hearing and the decision by the commissioner, the commissioner shall suspend the effective date of the order.

(4) Not more than sixty (60) days following completion of the hearing, the commissioner shall enter an order of final determination which shall specify all relevant findings of fact, conclusions of law and orders.

(5) With the agreement of each affected insurer or producer, and in lieu of a hearing, the commissioner may enter into a consent agreement disposing of the matters that would be the subject of the hearing and order.

(6) The commissioner may bring an action in [insert court] Court for an injunction or other appropriate relief to enjoin threatened or existing violations of this Act, the commissioner's orders or regulations. An action filed under this paragraph may also seek restitution on behalf of persons aggrieved by a violation of this Act or orders or regulations of the commissioner.

Section 13. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations and orders to carry out and effectuate the provisions of this Act.

Section 14. Judicial Review

A. A person subject to an order or final determination of the commissioner under Section 6 or Section 12 may obtain a review of the order or final determination by filing in the [insert date] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order or final determination of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the questions determined, shall determine whether the filing of the petition shall operate as a stay of the order or final determination of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order or final determination of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

B. To the extent that the order or final determination of the commissioner is affirmed, the court shall issue its own order commanding obedience to the terms of the order or final determination of the commissioner. If either party applies to the court for leave to adduce additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and to be adduced upon the hearing in the manner and upon the terms and conditions the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file such modified or new findings that are supported by [insert type] evidence with a recommendation, if any, for the modification or setting aside of the original order or final determination, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgement, order or final determination or decree would not be subject to review by an appellate court, provision therefor should be inserted here.

C. An order issued by the commissioner under Section 12 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no petition had been duly filed within that time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 12; or

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for the review dismissed.

D. No order of the commissioner under this Act or order of a court to enforce the same shall relieve or absolve any person affected by the order from liability under any other laws of this state.

Drafting Note: In the event penalties are addressed on a global basis in other statutes, the following section should be omitted.

Section 15. Penalties

An insurer that violates an order of the commissioner while the order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to either or both of the following:

A. Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation not to exceed an aggregate penalty of $250,000; or

B. Suspension or revocation of the insurer's license.

Section 16. Severability

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of this Act, and the application of the provision to any person or circumstance other than those as to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall take effect [insert effective date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2001 Proc. 1st Quarter 16-17, 279, 300, 302-309 (adopted).
2002 Proc. 4th Quarter 32-33, 524, 768 (amended).

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-093 (1992/2002).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1621 to 20-1621.11 (2002).		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado			3 COLO. CODE REGS. § 702-4:4-9-2 (1974/2009).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. ADMIN. CODE ANN. r. 69O-184.006 (1992).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. § 16a-4-301 (1973/1999).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. §§ 385.010 to 385.080 (1977/1992); MO. CODE REGS. ANN. tit. 20, § 1140-3.041 (1978/2006).
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NEV. REV. STAT. §§ 691C.010 to 691C.440 (2017).		BULLETIN 2007-003 (2007).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York			N.Y. INS. LAW § 2340 (1984/1996) (superintendent may promulgate rules); N.Y. BANKING LAW § 357 (1996); N.Y. COMP. CODES R. & REGS. tit. 11, § 186.9 (Regulation 27-B) (1973/2002).
North Carolina			N.C. GEN. STAT. § 58-57-90 (1981/1994).
North Dakota			N.D. CENT. CODE §§ 26.1-37-01 to 26.1-37-16 (1985/2001).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 14A, § 4-301 (1969/1988).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania			31 PA. CODE §§ 112.1 to 112.12 (1974/1975).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-233 (1993/2009).

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE R. §§ 114-61-1 to 114-61-9 (2003).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2002

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT (#365)

1. Project Description

The National Council of Insurance Legislatures (NCOIL) issued a resolution opposing the inclusion of the 60% loss ratio in the Credit Personal Property Insurance Model Act. The Credit Insurance (D) Working Group reviewed the concerns and determined a drafting note should be added to the model.

2. Group Responsible for Drafting Model and States Participating

The Credit Insurance (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee assumed responsibility for reviewing the NCOIL resolution. Commissioner David Parsons of Alabama and Commissioner Mike Kreidler of Washington co-chaired the working group. The following states are members of the working group: Colorado, District of Columbia, Florida, Illinois, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, North Carolina, Oklahoma, Oregon and Utah.

3. Charge Authorizing Project

The 2002 charge to the working group reads, "Appoint a working group to 1) finalize a bulletin to encourage states to revise prima facie rates and take other steps available under the NAIC credit insurance model acts and regulations and state laws to bring credit insurance rates in line with benchmark loss ratios and to correct other problem areas of credit insurance, 2) coordinate with the Blanks Task Force to revise the credit insurance experience exhibit to better capture information on credit property and new coverages and 3) work with attorneys general and other state and federal regulators to investigate marketing practices in the sale and distribution of credit insurance products and determine whether further action is necessary to address any identified consumer issues. Report by the NAIC 2002 Winter National Meeting." The Market Regulation and Consumer Affairs (D) Committee asked the Credit Insurance Working Group to review the NCOIL resolution to determine if additional action should be taken regarding the model.

4. General Description of Drafting Process

The drafting process was very open as the Credit Insurance Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group also solicited key concerns from interested parties and funded consumer representatives. All of the meetings of the working group were open to all interested parties. All revised language of the drafting note were posted on the NAIC Website and circulated for public comment. The working group received and reviewed numerous comments from interested parties.

5. Significant Issues Raised

The significant issues introduced about the resolution and drafting note revolved around whether a loss ratio requirement should be included in a model act rather than a model regulation. In addition, there was discussion about whether the entire provisions of the model act could be modified for adoption as a regulation versus an act.

6. Other Pertinent Information

NCOIL representatives participated in the review and drafting discussions and did not voice opposition to the inclusion of this new drafting note.

PROJECT HISTORY – 2001

CREDIT PERSONAL PROPERTY INSURANCE MODEL ACT (#365)

1. Project Description

The Credit Personal Property Insurance Model Act provides a recommended statute specifically for the regulation of credit property insurance. This model is designed to complement other credit insurance related models such as the Consumer Credit Insurance Model Act, the Consumer Credit Insurance Model Regulation and the Creditor-Placed Insurance Model Act.

2. Group Responsible for Drafting Model and States Participating

The Credit Property Working Group of the Market Conduct and Consumer Affairs (D) Committee was responsible for drafting the model. Commissioner David Parsons of Alabama chaired the working group. The following states were members of the working group: Colorado, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, North Carolina, and South Dakota.

3. Charge Authorizing Project

The 2001 charge of the working group is, "Appoint a working group to finalize the credit property model act." This charge resulted from a previous charge of the Market Conduct and Consumer Affairs (D) Committee in 1999: "Appoint a working group to review existing and proposed state laws and regulations and current regulatory efforts by states addressing credit insurance products offered by insurers in order to assess the overall effectiveness of the existing regulatory framework and to make recommendations for areas needing change or improvement. After completing a study of credit insurance, the D Committee recommended that a model addressing credit property insurance be developed.

4. General Description of Drafting Process

The drafting process was very open as the Credit Property Insurance Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group also solicited key concerns from interested parties and funded consumer representatives. All of the meetings of the working group and of the Market Conduct and Consumer Affairs (D) Committee were open to all interested parties. All revised drafts of the paper were posted on the NAIC Website and circulated for public comment. The working group received and reviewed numerous comments from interested parties.

5. Significant Issues Raised

The most significant issues raised and discussed by the working group and interested parties include (1) the definition of credit personal property insurance; and (2); the method of rate supervision that should be in place for credit property insurance. The positions of industry representatives, consumer representatives and regulators were considered while developing the model act.

The controversy surrounding the definition of credit personal property insurance involves the inadvertent inclusion of products not intended to be considered as credit property insurance. After several iterations of the definition, the last debate involved whether the definition should include a reference to security interest. The final definition adopted by the working group reads, "Credit personal property insurance" means a policy, endorsement, rider, binder, certificate or other instrument or evidence of insurance written in connection with a credit transaction that:

(1) covers perils to the goods purchased through a credit transaction or used as collateral for a credit transaction and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part; or

(2) covers perils to goods purchased in connection with an open-end credit transaction.

The second major issue surrounded the best method for regulating credit property insurance rates. The working group decided to use a loss ratio requirement in conjunction with a component rating feature. Once the determination to include a loss ratio requirement was determined, there was extended debate on the language to use with the percentage (e.g. % or such "higher" loss ratio, % or such "other" loss ratio, etc.) The working group determined they would include a 60% loss ratio

requirement, or such "higher" loss ratio as designated by the Commissioner. This issue remained controversial through the adoption of the model act.

Other issues addressed by the working group included phantom coverage (insurance coverage for non-durable goods for which no claim can be made), reverse competition, and creditor compensation limitations. Each of these topics were considered and discussed before reaching agreement on how to incorporate provisions in the model addressing these issues.

6. Other Pertinent Information

The NAIC previously considered development of a credit property insurance model in 1995. A determination was made not to develop a model at that time.

CONSUMER CREDIT INSURANCE MODEL REGULATION

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Section 1. Purpose and Authority

The purpose of this regulation is to protect the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life, credit accident and health, and credit unemployment insurance. This rule interprets and implements the [insert state] Statutes, including but not limited to the following sections: [insert sections].

Section 2. Definitions

As used in this regulation:

A. "Affiliate" has the same meaning as defined in Section [insert reference to state's insurance holding company registration act].

B. "Closed-end credit" means a credit transaction that does not meet the definition of open-end credit.

C. "Control" has the same meaning as defined in Section [insert reference to state's insurance holding company registration act].

D. "Evidence of individual insurability" means a statement furnished by the debtor, as a condition of insurance becoming effective, that relates specifically to the health status or to the health or medical history of the debtor.

E. "Loss ratio" means incurred claims divided by the sum of earned premiums and imputed interest earned on unearned premiums.

Drafting Note: Although this definition of loss ratio represents a change from the prior method, the (EX) Committee on Credit Insurance has determined that this definition represents the most appropriate option. While the crediting of imputed interest means that single premium rates will be slightly lower (for a specified loss ratio) under this definition than under the prior methodology, for most states the reduction in single premium rates will be approximately five percent (5%) due to the implementation of this definition.

F. "Open-end credit" means credit extended by a creditor under an agreement in which:

(1) The creditor reasonably contemplates repeated transactions;

(2) The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

(3) The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

Drafting Note: The definition of open-end credit here is identical to the definition in the Consumer Credit Insurance Model Act. There is generally no need to restate a definition from the Act in this regulation; however, since the definition here of closed-end credit is dependent on the definition of open-end credit, it seems appropriate to include it here as well. States should consider their own drafting procedures to determine where the definitions should be located.

G. "Person" has the same meaning as defined in Section [insert reference to state's insurance holding company registration act].

H. "Preexisting condition" means any condition for which the insured debtor received medical advice, consultation or treatment within six (6) months before the effective date of the coverage and from which the insured debtor becomes disabled within six (6) months after the effective date of this coverage.

Section 3. Rights and Treatment of Debtors

A. Multiple Plans of Insurance. If a creditor makes available to the debtors more than one plan of consumer credit insurance, every debtor must be informed of each plan for which the debtor is eligible and of the premium or insurance charge for each.

B. Substitution. When a creditor requires insurance as additional security for a debt, the debtor shall be given the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact insurance business in this state. If this subsection is applicable, the debtor shall be informed by the creditor of the right to provide alternative coverage before the transaction is completed.

C. Termination of Group Consumer Credit Insurance Policy.

(1) If a debtor is covered by a group consumer credit insurance policy providing for the payment of single premiums to the insurer, or any other premium payment method which prepays coverage beyond one month, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under the policy shall be continued for the entire period for which the premium has been paid.

(2) If a debtor is covered by a group consumer credit insurance policy providing for the payment of premiums to the insurer on a monthly basis, then the policy shall provide that, in the event of termination of the policy, termination notice shall be given to the insured debtor at least thirty (30) days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The insurer shall provide or cause to be provided this required information to the debtor.

D. Remittance of Premiums. If the creditor adds identifiable insurance charges or premiums for consumer credit insurance to the debt, and any direct or indirect finance, carrying, credit or service charge is made to the debtor on the insurance charges or premiums, the creditor must remit and the insurer shall collect the premium within sixty (60) days after it is added to the debt.

E. Refinancing of the Debt. If the debt is discharged due to refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the refinanced debt. In all cases of termination prior to scheduled maturity, a refund of all unearned premium or unearned insurance charges paid by the debtor shall be paid or credited to the debtor as provided in Section 9. In any refinancing of the debt, the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy with respect to the debt which was refinanced, at least to the extent of the amount and term of the debt outstanding at the time of refinancing of the debt.

F. Maximum Aggregate Provisions. A provision in an individual policy or group certificate that sets a maximum limit on total claim payments must apply only to that individual policy or group certificate.

Drafting Note: It should be noted that the maximum amount which can be paid for coverage for a single consumer credit transaction may be subject to statutory limitations.

G. Prepayment of Debt. If a debtor prepays the debt in full, then any consumer credit insurance covering the debt shall be terminated and an appropriate refund of the consumer credit insurance premium shall be paid or credited to the debtor in accordance with Section 9. However, if the prepayment is a result of death or any other lump sum consumer credit insurance payment, no refund shall be required for the coverage under which the lump sum was paid. If a claim under credit accident and health coverage or credit unemployment coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and health benefits are payable or during any period of unemployment for which credit unemployment benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period or at the end of the unemployment period.

H. If a creditor has opened a line of credit for a debtor and, under Section 4A(5) or 4A(6) of the Consumer Credit Insurance Model Act, is charging for this line of credit rather than the amount of debt in the event of the death of the debtor, the insured amount due is the amount of the established amount of credit against which premium was last charged.

Section 4. Determination of Reasonableness of Benefits in Relation to Premium Charge

A. Benefits provided by consumer credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium ratecharged develops or may reasonably be expected to develop a loss ratio of not less than sixty percent (60%). With the exception of deviations approved under Section 11, the rates shown in Sections 6 and 7, as adjusted pursuant to Section 10, shall be presumed to satisfy this standard. Anticipated losses that develop or are expected to develop a loss ratio of not less than sixty percent (60%) shall be presumed reasonable. Any insurer filing a deviation in accordance with Section 11 must satisfy the sixty percent (60%) loss ratio standard on their total consumer credit insurance business, including that of affiliated insurers, for each type of insurance defined in Section [insert section referring to definitions in state Consumer Credit Insurance Model Act] of the [insert state] Statutes for which the deviation is being filed.

Drafting Note: In the event that a state wishes to develop a regulatory framework allowing for component rating, the following is suggested language which should be used in conjunction with suggested language for Section 10B:

Alternative Section 4A:

A. Benefits provided by consumer credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than sixty percent (60%) or such lower loss ratio as designated by the Commissioner to afford a reasonable allowance for actual and expected loss experience, general and administrative expenses, reasonable creditor compensation, investment income, the manner in which premiums are charged and other acquisition costs, reserves, taxes, regulatory license fees and fund assessments, reasonable insurer profit and other relevant actuarial data. With the exception of deviations approved under Section 11, the rates shown in Sections 6 and 7, as adjusted pursuant to Section 10, shall be conclusively presumed to satisfy the loss ratio standard. Any insurer filing a deviation in accordance with Section 11 must satisfy the loss ratio standard designated by the Commissioner pursuant to Section 10 on their total consumer credit insurance business, including that of affiliated insurers, for each type of insurance defined in Section [insert section referring to definitions in state Consumer Credit Insurance Model Act] of the [insert state] Statutes for which the deviation is being filed.

Drafting Note: The NAIC, as a whole, neither endorses nor opposes component rating as the appropriate methodology for developing rates for consumer credit insurance products.

B. Nonstandard Coverage. If any insurer files for approval of any form providing coverage different than that described in Sections 6 through 8, the insurer shall demonstrate to the satisfaction of the commissioner that the premium rates to be charged for such coverage are: (a) reasonably expected to develop a loss ratio of not less than sixty percent (60%), or (b) actuarially consistent with the rates used for standard coverages.

Section 5. Limitation on Compensation [Optional]

A. An insurer shall not pay compensation in excess of thirty percent (30%) of the net written *prima facie* premium of which not more than twenty-five percent (25%) of net written *prima facie* premium may be paid to a creditor.

B. For the purpose of Subsection A, *prima facie* premium means premium using the premium rates set out in Sections 6 and 7, or actuarially consistent premium rates for plans not described in Sections 6 and 7, without any adjustment pursuant to Section 10.

Drafting Note: This is an optional provision subject to the statutory provisions of the state or jurisdiction. Once a state has established a *prima facie* rate based upon a sixty percent (60%) loss ratio, a state may wish to consider that this provision be deleted.

Section 6. Credit Life Insurance Rates

A. Premium Rate. Subject to the conditions and requirements in Section 6B and Section 11, the *prima facie* rates shown below are considered to meet the requirements of Section 4, and may be used without filing additional actuarial support.

(1) Monthly outstanding balance basis: _____ per month per $1,000 of outstanding insured debt on single life and _____ per month per $1,000 of outstanding insured debt on joint life if premiums are payable on a monthly outstanding balance basis.

(2) Single premium basis: If the premium is charged on a single premium basis, the rate shall be computed according to the following formula or according to a formula approved by the commissioner which produces rates substantially the same as those produced by the following formula:

$$Sp = \sum_{t=1}^{n} \left(\frac{O_p}{10} \times \frac{I_t}{I_i} \times (v^{t-1}) \right)$$

$$v = \frac{1}{1 + (dis)}$$

S_p = Single Premium per $100 of initial consumer credit life insurance coverage.

O_p = _____, the *prima faci*e consumer credit life insurance premium rate for monthly outstanding balance coverage from Paragraph 1.

I_t = The scheduled amount of insurance for month t.

I_i = Initial amount of insurance. For a net insurance policy, I_i equals the initial principal balance of the loan.

dis = .0036, representing an annual discount rate of 4 percent for interest plus 0.4 percent for mortality.

Drafting Note: The 4 percent discount for interest reflected current rates at the time this model was drafted. States should set the discount rate in their regulation to equal the average of the rates being paid on 3 year United States Treasury Notes as reported in the Wall Street Journal on the last day of sale in the most recent 3 calendar years.

n = The number of months in the term of the insurance.

(3) If the benefits provided are other than those described in the introduction to this subsection, premium rates for such benefits shall be actuarially consistent with the rates provided in Paragraphs (1) and (2).

Drafting Note: Credit life insurance premium rates have not been included in the model regulation. Each state should adopt rates which reflect the experience developed within that state or regionally if a state lacks sufficient credible data. A state may also establish rates by creditor class of business wherever warranted. For those states addressing the issue of delinquencies, the prima facie rates included in Sections 6 and 7 and any other rates approved for use, restricted to premium rates that are computed by formulae such as that contained in Paragraph 6A(2), are presumed sufficient to provide for up to two months of delinquencies. Therefore, the amount of insurance shall not be increased to accommodate such delinquencies.

B. The premium rates in Subsection A shall apply to contracts providing credit life insurance that are offered to all eligible debtors, that do not require evidence of individual insurability from any eligible debtor electing to purchase coverage within thirty (30) days of the date the debtor becomes eligible and that contain the provisions below:

(1) Coverage for death by whatever means caused, except that coverage may exclude death resulting from:

(a) War or any act of war;

(b) Suicide within six (6) months after the effective date of the coverage; or,

(c) Subject to the provisions of Section 6B(2), a preexisting condition or conditions.

(2) For the purpose of Section 6B(1)(c),

(a) Preexisting condition means any condition for which the debtor received medical advice or treatment within six (6) months preceding the effective date of coverage;

(b) No preexisting condition exclusion shall apply unless death is caused by or substantially contributed to by the preexisting condition and unless death occurs within six (6) months following the effective date of coverage; and,

(c) A preexisting condition exclusion shall apply only if and to the extent that the amount of coverage to which it would otherwise apply (in the absence of this limitation) exceeds $1,000.

(3) For the exclusions listed in Section 6B(1) and (2) above, the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account is the date on which the advance or charge occurs.

(4) At the option of the insurer and in lieu of a preexisting condition exclusion on insurance written in connection with open-ended consumer credit, a provision may be included to limit the amount of insurance payable on death due to natural causes to the balance as it existed six (6) months prior to the date of death if there has been one or more increases in the outstanding balance during the six-month period and if evidence of individual insurability has not been required in the six-month period prior to the date of death. This provision applies only if and to the extent that the amount of coverage to which it would otherwise apply (in the absence of this limitation) exceeds $1,000.

(5) An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six (66) and that all insurance will terminate upon attainment by the debtor of age sixty-six (66).

Drafting Note: These provisions are intended only to be provisions that correspond to the use of the rates provided for in Subsection 7A. Consistent with the commissioner's authority in the Model Bill, they are neither required provisions nor minimum standards. They are no more than safe harbor provisions. All other policy provisions must be judged based solely on the standard in the Model Bill that prohibits provisions that are unfair, unjust, inequitable, misleading, deceptive or encourage misrepresentation of the coverage or that are contrary to statute or administrative rule.

The suicide provision exemplifies this. Subsection 7B provides for use of a six-month exclusionary period for suicide in contracts to which the *prima facie* rate is applied. However, a suicide exclusionary period of one or two years is consistent with statutes enacted in several states. Thus, the use of a suicide exclusionary period exceeding six (6) months is not prohibited by the mere fact that a six-month period is set out as a provision corresponding to the use of *prima facie* rates. The use of a longer exclusionary period may, however, require the use of reduced premium rates.

C. Application of Rates:

(1) If the insurer, its agent, or the application form for credit life insurance does not request or require that the debtor provide evidence of insurability, then the premium rates deemed reasonable will be the prima facie rates in Section 6A.

(2) Except as provided in Section 6C(3), if the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is $15,000 or less, then the premium rates deemed reasonable will be the rates in Section 6A multiplied by 90 percent (.90).

(3) If the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is above $15,000 or the applicant elects to purchase coverage more than thirty (30) days after the date the debtor became eligible under a group plan of insurance, then the premium rates deemed reasonable will be the *prima facie* rates in Section 6A. For policies insuring open lines of credit, the insurer may require evidence of insurability for advances which increase the outstanding debt above $15,000.

D. Insurers may use the same application forms for credit life insurance whether or not underwriting questions are asked pursuant to Section 6C. The commissioner will presume that any application form for which all relevant underwriting questions have been left unanswered represents a policy which has not been underwritten and for which *prima facie* rates are permissible. A form for which any relevant underwriting questions have been answered or filled in represents a policy for which premium decreases pursuant to Section 6C are required. Insurers should maintain in their files their rules for those circumstances where underwriting questions shall be asked. Those rules shall be communicated to and followed by the insurer's agents or other producers.

Section 7. Credit Accident and Health Insurance Rates

A. Premium Rate. Subject to the conditions and requirements in Section 6B and Section 11, the *prima facie* rates shown below are considered to meet the requirements of Section 4, and may be used without filing additional actuarial support.

(1) If premiums are payable on a single-premium basis for the duration of the coverage, the *prima facie* rate per $100 of initial insured debt for single accident and health is as set forth in the table below (rates for monthly periods other than those listed shall be interpolated or extrapolated):

Original Number of Equal Monthly Installments	14 Day retroactive policies	14 Day non-retroactive policies	30 Day retroactive policies	30 Day non-retroactive policies
6				
12				
24				
36				
48				
60				
72				
84				
96				
108				
120				

Drafting Note: Consistent with Subsection 6A(2), pursuant to which credit life single premiums are discounted for interest and mortality, credit disability single premiums in the table above should incorporate similar discount for interest (but not for mortality, since on death a refund of the unearned credit disability premium is required to be made).

(2) If premiums are paid on the basis of a premium rate per month per thousand of outstanding insured gross debt, these premiums shall be computed according to the following formula or according to a formula approved by the commissioner which produces rates actuarially consistent with the single premium rates in Subsection 7A(1):

$$OP_n = \frac{10\ SP_n}{\{\sum_{t=1}^{n} (v^{t-1} \times (n-t+1))\}}$$

$$\text{where } v = \frac{1}{1 + (dis)}$$

Where SP_n = Single Premium Rate per $100 of initial insured debt repayable in n equal monthly installments as shown in Subsection 7A(1).

OP_n = Monthly Outstanding Balance Premium Rate per $1,000.

n = The number of months in the term of the insurance.

dis = .0033, representing an annual discount rate of 4 percent for interest.

Drafting Note: The 4 percent discount for interest reflected current rates at the time this model was drafted. States should set the discount rate in their regulation to equal the average of the rates being paid on 3-year United States Treasury Notes as reported in the Wall Street Journal on the last day of sale in the most recent 3 calendar years.

(3) If the coverage provided is a constant maximum indemnity for a given period of time, the actuarial equivalent of Section 7A(1) and 7A(2) shall be used.

(4) If the coverage provided is a combination of a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month, an appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month shall be used.

(5) The outstanding balance rate for credit accident and health insurance may be either a term-specified rate or may be a single composite term outstanding balance rate.

B. Subject to the conditions and requirements in Section 7C and Section 11, the *prima facie* rates for credit accident and health insurance shown below are considered to meet the requirements of Section 4 in the situation where the insurance is written on an open-end loan. These *prima facie* rates and the formulae used to calculate them may be used without filing additional actuarial support. Other formulae to convert from a closed-end credit rate to an open-end credit rate may be used if approved by the commissioner.

(1) If the maximum benefit of the insurance equals the net debt on the date of disability, the term of the loan is calculated according to the formula: 1/(minimum payment percent). The *prima facie* rate is determined by applying the calculated term to the rates shown in Section 7A. A composite minimum payment percentage may be used in place of the minimum payment percentage for a specific credit transaction.

(2) If the maximum benefit of the insurance equals the outstanding balance of the loan on the date of disability plus any interest accruing on that amount during disability, the term of the insurance (n) is estimated by using the following formula:

$$n = \ln\{1-(1000i/x)\}/\ln(v)$$

where:

i = interest rate on the account or a composite interest rate used for the type of policy;
x = monthly payment per $1000 of coverage consistent with the term calculated above; and,
$v = 1/(1 + i)$.

The calculated value of the term is used to look up an initial rate in Section 7A. The final *prima facie* rate is calculated by multiplying the initial rate by:

the adjustment $n/a_{\overline{n}|}$

where:

n is the term calculated above; and

$a_{\overline{n}|} = (1 - v^n)/i$.

C. If the accident and health coverage is sold on a joint basis (involving two people), the rate for the joint coverage shall be filed with the commissioner prior to use.

D. If the benefits provided are other than those described in Section 7A or 7B above, rates for those benefits shall be actuarially consistent with rates provided in Section 7A and 7B.

E. The premium rates in Subsection A shall apply to contracts providing credit accident and health insurance that are offered to all eligible debtors, that do not require evidence of individual insurability from any eligible debtor electing to purchase coverage within thirty (30) days of the date the debtor becomes eligible and that contain the provisions below:

(1) Coverage for disability by whatever means caused, except that coverage may be excluded for disabilities resulting from: (a) normal pregnancy; (b) war or any act of war; (c) elective surgery; (d) intentionally self-inflicted injury; (e) sickness or injury caused by or resulting from the use of alcoholic beverages or narcotics (including hallucinogens) unless they are administered on the advice of and taken as directed, by a licensed physician other than the insured; (f) flight in any aircraft other than a commercial scheduled aircraft; (g) a preexisting condition.

(2) For the exclusion listed in Section 7B(1)(g) above, the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account is the date on which the advance or charge occurs.

(3) A definition of disability providing that for the first twelve (12) months of disability, total disability shall be defined as the inability to perform the essential functions of the insured's own occupation. Thereafter, it shall mean the inability of the insured to perform the essential functions of any occupation for which he or she is reasonably suited by virtue of education, training or experience.

(4) No employment requirement more restrictive than one requiring that the debtor be employed full-time on the effective date of coverage and for at least twelve (12) consecutive months prior to the effective date of coverage. "Full time" means a regular work week of not less than thirty (30) hours.

(5) An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six (66) and that all insurance will terminate upon attainment by the debtor of age sixty-six (66).

(6) A daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

Drafting Note: These provisions are intended only to be provisions that correspond to the use of the rates provided for in Subsection 7A. Consistent with the commissioner's authority in the Model Bill, they are neither required provisions nor minimum standards. They are no more than safe harbor provisions. All other policy provisions must be judged based solely on the standard in the Model Bill that prohibits provisions that are unfair, unjust, inequitable, misleading, deceptive or encourage misrepresentation of the coverage or that are contrary to statute or administrative rule.

The preexisting condition exemplifies this. Subsection 7B contemplates that a six (6) month exclusionary period for preexisting conditions will be used in contracts to which the *prima facie* rates are applied. This alone does not, however, prohibit the use of a longer exclusionary period for preexisting conditions. A longer exclusionary period could be prohibited only if it is reasonably determined to be unjust or unfair, etc. Use of a longer exclusionary period would, however, remove the presumption that the *prima facie* rates are acceptable for use in connection with that form and use of lower rates may be required to reflect the difference in expected claims.

F. Application of Rates:

(1) If the insurer, its agent, or the application form for credit life insurance does not request or require that the debtor provide evidence of insurability, then the premium rates deemed reasonable will be the prima facie rates in Section 7A.

(2) Except as provided in Section 7F(3), if the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is $15,000 or less, then the premium rates deemed reasonable will be the rates in Section 7A multiplied by 90 percent (.90).

(3) If the insurer, its agent, or the application form for credit life insurance requests or requires that the debtor provide evidence of insurability and the initial amount of insurance is above $15,000 or the applicant is a elects to purchase coverage more than thirty (30) days after the date the debtor became eligible under a group plan of insurance, then the premium rates deemed reasonable will be the prima facie rates in Section 7A. For policies insuring open lines of credit, the insurer may require evidence of insurability for advances which increase the outstanding debt above $15,000.

G. Insurers may use the same application forms for credit accident and health insurance whether or not underwriting questions are asked pursuant to Section 7F. The commissioner will presume that any application form for which all relevant underwriting questions have been left unanswered represents a policy which has not been underwritten and for which *prima facie* rates are permissible. A form for which any relevant underwriting questions have been answered or filled in represents a policy for which premium decreases pursuant to Section 7F are required. Insurers should maintain in their files their rules for those circumstances where underwriting questions shall be asked. Those rules shall be communicated to and followed by the insurer's agents or other producers.

Section 8. Credit Unemployment Insurance Rates

A. Each insurer filing rates for credit unemployment insurance shall include in its rate filing with the commissioner the appropriate rate formula upon which its rates are based, including a provision for anticipated losses. Anticipated losses that develop or are expected to develop a loss ratio of not less than sixty percent (60%) shall be presumed reasonable. Anticipated losses may include an amount for fluctuation in loss due to catastrophe based on the experience of at least the latest nine (9) policy years or as long as the company has been writing this line of business.

B. Credit unemployment insurance policies must contain benefits at least as favorable to insureds as the provisions below:

(1) Coverage for unemployment for any reason, except that coverage may be excluded for: (a) voluntary forfeiture of salary, wage or other employment income; (b) resignation; (c) retirement; (d) general strike; (e) illegal walk out; (f) war; (g) separation from the military; (h) willful misconduct or criminal misconduct or unlawful behavior; and (i) disability caused by injury, sickness or pregnancy.

Drafting Note: State laws may vary on whether strikes or labor disputes may qualify an individual for unemployment insurance benefits.

(2) For credit unemployment insurance which provides for a monthly benefit in the event of unemployment, benefits must start after a waiting period of not longer than thirty (30) days but need not be retroactive to the first day of unemployment and must have a maximum benefit period that is no shorter than six (6) months.

C. Credit unemployment insurance policies may not contain eligibility requirements more restrictive than the restrictions below:

(1) Exclusion from qualification for coverage: (a) self employed individuals; (b) workers in seasonal or temporary jobs, defined as jobs designed to last six (6) consecutive months or less; and, (c) debtors who have been notified either orally or in writing of any layoff or of employment termination either now or within the next sixty (60) days. This exclusion must be disclosed to all prospective insureds.

Drafting Note: States may wish to adjust the time period that defines temporary and seasonal workers to be appropriate for the types of businesses in their state.

(2) No employment requirement more restrictive than one requiring that the debtor be employed full-time on the effective date of coverage for at least twelve (12) consecutive months prior to the effective date of coverage. "Full time" means a regular work week of not less than thirty (30) hours.

(3) An age restriction providing that no insurance will become effective on debtors on or after the attainment of age sixty-six (66) and that all insurance will terminate upon attainment by the debtor of age sixty-six (66).

Section 9. Refund Formulas

A. In the event of termination, no charge for consumer credit insurance may be made for the first fifteen (15) days of a month and a full month may be charged for sixteen (16) days or more of a month.

Drafting Note: States should verify that the use of 15 days in the above section does not conflict with their banking laws.

B. The requirements of the consumer credit insurance law that refund formulas be filed with the commissioner shall be considered fulfilled if the refund formulas are set forth in the individual policy or group certificate filed with the commissioner.

C. No refund of $5 or less need be made.

Section 10. Experience Reports and Adjustment of *Prima Facie* Rates

A. Each insurer doing insurance business in this state shall annually file with the commissioner and the National Association of Insurance Commissioners (NAIC) Support and Services Office a report of consumer credit insurance written on a calendar year basis. The report shall utilize the Credit Insurance Supplement—Annual Statement Blank as approved by the NAIC, and shall contain data separately for each state, rather than an allocation of the company's countrywide experience. The filing shall be made in accordance with and no later than the due date in the Instructions to the Annual Statement.

B. The commissioner will, on a triennial basis, review the loss ratio standards set forth in Section 4 and the *prima facie* rates set forth in Sections 6 and 7 and determine therefrom the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three (3) years determined from the incurred claims and earned premiums at *prima facie* rates reported in the Annual Statement Supplement or other available source, and publish the adjusted actual statewide *prima facie* rates to be used by insurers during the next triennium. The rates will reflect the difference between (a) actual claims based on experience; and (b) expected claims based on the loss ratio standards set forth in Section 4 applied to the *prima facie* rates set forth in Sections 6 and 7.

C. The commissioner will, on a triennial basis, review the discount rates for interest included in the formulae in Sections 6A and 7A, and adjust those discount rates to equal the average of the rates being paid at that time on three-year United States Treasury Notes as reported in the Wall Street Journal on the last day of sale in the most recent three (3) calendar years.

Drafting Note: This contemplates automatic adjustment of premium and discount rates every three years, based on state-wide experience. The need for notice and public hearing will be dictated by the provisions of the Administrative Procedures Acts in the various states. It is contemplated that the rate adjustments, as a purely administrative procedure, should generally require only notice, without formal hearings.

Drafting Note: States should verify that the wording in Section 10C is specific enough to allow the commissioner to change the interest rate in an administrative action, rather than by having to readopt the regulation.

Section 11. Use of Rates - Direct Business Only

A. Use of *Prima Facie* Rates.

An insurer that files rates or has rates on file that are equivalent to the *prima facie* rates shown in Sections 6 and 7, to the extent adjusted pursuant to Section 10, may use those rates without further proof of their reasonableness.

B. Use of Rates Higher Than *Prima Facie* Rates.

An insurer may file for approval of and use rates that are higher than the *prima facie* rates shown in Sections 6 and 7, to the extent adjusted pursuant to Section 10, as long as the filed rates are consistent with the provisions of Section 4 of this regulation.

If rates higher than the *prima facie* rates shown in Sections 6 and 7, to the extent adjusted pursuant to Section 10, are filed for approval, the filing shall specify the account or accounts to which the rates apply. The rates may be:

(1) Applied uniformly to all accounts of the insurer; or

(2) Applied on an equitable basis approved by the commissioner to only one or more accounts of the insurer for which the experience has been less favorable than expected; or

(3) Applied according to a case-rating procedure on file with the commissioner.

C. Approval Period of Deviated Rates.

(1) A deviated rate will be in effect for a period of time not longer than the experience period used to establish the rate (i.e. one year, two years or three years). An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve-month period.

(2) Notwithstanding the provision of Subsection A of this section, if an account changes insurers, the rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on the account, if sooner.

D. Use of Rates Lower than Filed Rates.

An insurer may at any time use a rate for an account that is lower than its filed rate without notice to the commissioner.

E. Glossary of Terms and Definitions as Used in Section 11.

(1) "Experience" means "earned premiums" and "incurred losses during the experience period.

(2) "Experience period" means the most recent period of time for which earned premiums and incurred losses are reported, but not for a period longer than three (3) full years.

(3) "Incurred losses means total claims paid during the experience period, adjusted for the change in claim reserve.

Section 12. Supervision of Consumer Credit Insurance Operations

A. Each insurer transacting credit insurance in this state shall be responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business with such creditors, to assure compliance with the insurance laws of this state and the regulation promulgated by the commissioner.

B. Written records of such reviews shall be maintained by the insurer for review by the Insurance Commissioner.

Note: The states may wish to specify the minimum time in accordance with their respective statutes.

Section 13. Prohibited Transactions

The following practices, when engaged in by insurers in connection with the sale or placement of credit insurance, or as an inducement thereto, shall constitute unfair methods of competition and shall be subject to the Unfair Trade Practices Act of this State.

A. The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than the payment of agent's commissions;

B. Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that the same shall affect or take the place of a deposit of money or securities which otherwise would be required of the creditor by the bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement; and

C. Deposit by an insurer of money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank or financial institution to other depositors of like amounts for similar durations. This subsection shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of the insurer's business.

Section 14. Readability [Optional]

The commissioner shall not approve any form unless the policy or certificate is written in non-technical, readily understandable language, using words of common everyday usage:

A. Each insurer is required to test the readability of its policies or certificates by use of the Flesch Readability Formula, as set forth in Rudolf Flesch, *The Art of Readable Writing,* (1949, as revised 1974);

B. A total readability score of forty (40) or more on the Flesch scale is required;

C. All policies or certificates within the scope of this section shall be filed with the commissioner, accompanied by a certification setting forth the Flesch score and certifying the compliance with the guidelines set forth in this Section.

Drafting Note: This optional section should be included only in those states which have not enacted a policy language simplification act.

Section 15. Severability

If any provision or clause of this regulation or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the regulation which can be given effect without the invalid provision or application, and to this end the provisions of this regulation are declared severable.

Section 16. Effective Date

A. This regulation shall take effect [insert date] as to premium rates.

B. Approval of all forms not in compliance with this regulation is hereby withdrawn as of [insert date]. No such form may be issued after said date unless it has been submitted to and approved by the commissioner subsequent to [30 days prior to effective date], or unless a rider approved subsequent to such date has been attached bringing the form into compliance with this regulation.

C. Any deviations thought to be appropriate by an insurer as a result of promulgation of this regulation shall be filed in accordance with the provisions of Section 11 no later than [insert date].

D. Certificates, notices of proposed insurance and premium rates in connection with existing group policies shall conform to the requirements of this regulation not later than the anniversary date of the group policy next following the effective date of this regulation.

E. Any group policy issued to replace an existing group policy of consumer credit insurance or an amendment to an existing group policy of consumer credit insurance shall be ignored for the purposes of determining the anniversary date if the change is made on or after [insert the date of publication of notice].

Drafting Note: This section should be drafted in accordance with the state statutes regarding approval and disapproval of forms.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1960 Proc. I 176 (implementation recommendations for model bill: 50% loss ratio benchmark recommended).
1966 Proc. II 402-403 (Richmond resolution expanding on 50% loss ratio benchmark).
1968 Proc. II 575 (interpretation of Richmond resolution) (Las Vegas resolution).
1969 Proc. II 770-772 (Richmond resolution amended) (Neff amendment).
1971 Proc. I 295-296 (Richmond resolution amended) (O'Hare resolution).
1971 Proc. I 288-293 (Richmond resolution amended to eliminate accident and health insurance, with deviation and credibility methods).
1971 Proc. II 478-487 (New York resolution with deviation and credibility methods).
1972 Proc. I 582 (amended New York resolution).
1973 Proc. II 18, 21, 471, 481, 485-531 (model adopted).
1974 Proc. II 501 (corrected).
1979 Proc. II 31, 10, 326, 409 (established 60% loss ratio for credit accident and health).
1980 Proc. I 34, 38, 406, 473, 475-484 (amended and reprinted).
1981 Proc. I 47, 51, 421, 488-489, 490-498 (amended).
1988 Proc. I 9, 21-22, 828, 851-853, 859-871 (amended and reprinted).
1988 Proc. II 5, 14, 758, 785-787, 788-791 (adopted technical amendments).
1994 Proc. 2nd Quarter 13, 39, 44, 73-91 (amended and reprinted).
1995 Proc. 4th Quarter 11, 33, 98, 108, 111-112 (amended).

CONSUMER CREDIT INSURANCE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CONSUMER CREDIT INSURANCE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-117 (1999).
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 28.310 to 28.405 (1981/2007).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE § 20-6-604 (1983).		
Arkansas			CODE ARK. R. 054.00.12 (1968/1986).
California			CAL. CODE REGS. tit. 10, §§ 2248 to 2248.14 (1978/2013); §§ 2249.1 to 2249.16 (1978/2006).
Colorado			3 COLO. CODE REGS. § 702-4:4-9-2 (1992/2010).
Connecticut			CREDIT, LIFE AND HEALTH BULLETIN C-3 (1967); CREDIT, LIFE AND HEALTH BULLETIN C-4 (1983).
Delaware			18 DEL. CODE REGS. § 1701 (1970/2003).
District of Columbia	NO CURRENT ACTIVITY		

CONSUMER CREDIT INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. ADMIN. CODE ANN. r. 69O-163 (2003).
Georgia			GA. COMP. R. & REGS. 120-2-27 (1977/1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-6-1 to 16-6-16 (1981/1988).		
Idaho	IDAHO ADMIN. CODE r. 18.03.05.000 to 18.03.05.023 (1992/2019).		
Illinois			ILL. ADMIN. CODE. tit. 50, §§ 1051.10 to 1051.80 (1959/1996).
Indiana	760 IND. ADMIN. CODE 1-5.1-1 to 1-5.1-12 (2003/2009).		
Iowa	IOWA ADMIN. CODE r. 191-28.1 to 191-28.17 (1991).		
Kansas			KAN. ADMIN. REGS. §§ 40-5-102 to 40-5-110 (1966/2012); § 40-5-12 (1993).
Kentucky			806 KY. ADMIN. REGS. 19:010 to 19:060; BULLETIN 81-DM-009 (1981).
Louisiana	NO CURRENT ACTIVITY		
Maine			CODE ME. R. tit. 02-031 Ch. 220 §§ 1 to 16 (1979/2006).
Maryland			MD. CODE REGS. 31.13.01.01 to 31.13.01.27 (1978/2001).
Massachusetts	MASS. GEN. LAWS ch. 175 § 117C (1989) (portions of model).		
Michigan	MICH. ADMIN. CODE r. 550.201 to 550.221 (1987/1995).		

CONSUMER CREDIT INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. R. §§ 2760.0010 to 2760.0090 (1968/2008); §§ 2761.0100 to 2761.1200 (1995) (credit unemployment insurance).
Mississippi	19 CODE MISS. R. Pt. 3, R. 6.01 to 6.06 (86-102) (1986); Pt. 2, R. 11.01 to 11.07 (89-103) (1989); Pt. 2, R. 10 (89-102) (1989); Pt. 2, R. 12 (94-103) (1995).		
Missouri			MO. CODE REGS. ANN. tit. 20, § 600-2.110 (1975/1992).
Montana			MONT. ADMIN. R. 6.6.1101 to 6.6.1111 (1975/1996).
Nebraska			210 NEB. ADMIN. CODE ch. 22 (1976/1994).
Nevada	NEV. ADMIN. CODE §§ 690A.002 to 690A.185 (2007).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 1201.01 to 1201.19 (1982/2002).		
New Jersey			N.J. ADMIN. CODE §§ 11:2-3.1 to 11:2-3.26 (1959/2001).
New Mexico			N.M. CODE R. §§ 13.18.2.1 to 13.18.2.43 (1997/1998); BULLETIN 2005-002 (2005).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 185.0 to 185.16 (Regulation 27-A) (1980/2003).
North Carolina			11 N.C. ADMIN. CODE §§ 12.0701 to 12.0714 (1989/2002).

CONSUMER CREDIT INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota			N.D. ADMIN. CODE §§ 45-07-01.1-01 to 45-07-01.1-13 (2003).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO ADMIN. CODE § 3901-1-14 (1983/2014).
Oklahoma			OKLA. ADMIN. CODE §§ 365:10-5-60 to 365:10-5-74 (1982/1997).
Oregon			OR. ADMIN. R. 836-60-0000 to 836-60-0060 (1983/2001).
Pennsylvania			31 PA. CODE §§ 73.101 to 73.143 (1998/2006).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-60-1.1 to 20-60-1.16 (2010).		
South Carolina			S.C. CODE ANN. REGS. 69-11.1 (1977).
South Dakota			S.D. ADMIN. R. 20:06:06:01 to 20:06:06:08 (1977/1990).
Tennessee			TENN. COMP. R. & REGS. 0780-1-4-.01 to 0780-1-4-.15 (1974/1995).
Texas			28 TEX. ADMIN. CODE § 3.5001 to 3.6011 (1980/2003).
Utah	UTAH ADMIN. CODE r. 590-91 (1983/2007).		
Vermont	4-3 VT. CODE R. § 9 (Regulation I-84-1) (1967/1988).		
Virgin Islands	NO CURRENT ACTIVITY		

CONSUMER CREDIT INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-3726 to 38.2-3738 (1993) (portions of model).		
Washington			WASH. ADMIN. CODE 284-34-100 to 284-34-260 (2005).
West Virginia			W. VA. CODE R. §§ 114-6-1 to 114-6-8 (1969/1995).
Wisconsin			WIS. ADMIN. CODE INS. § 3.25 (1979/1996).
Wyoming			WYO. CODE R. § 52 (1967/1997).

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

Table of Contents

Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to Section [insert reference to section authorizing the commissioner to adopt regulations and a reference to the state equivalent of the NAIC Insurer's Rehabilitation and Liquidation Model Act and any other section where the term hazardous financial condition or a similar term is used] of the [insert state] Insurance Code.

Section 2. Purpose

The purpose of this regulation is to set forth the standards which the commissioner may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to their policyholders, creditors or the general public.

This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supercede any laws or parts of laws of this state.

Section 3. Standards

The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to its policyholders, creditors or the general public. The commissioner may consider:

A. Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries;

B. The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports;

C. Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;

D. The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taksing into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

E. Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

F. Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

G. Whether a reinsurer, obligor or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations, and which in the opinion of the commissioner may affect the solvency of the insurer;

H. Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer;

I. Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;

J. The age and collectibility of receivables;

K. Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

L. Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

M. Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner;

N. Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

O. Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

P. Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

Q. Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice;

R. Whether management persistently engages in material under reserving that results in adverse development;

S. Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;

T. Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

Section 4. Commissioner's Authority

A. For the purposes of making a determination of an insurer's financial condition under this regulation, the commissioner may:

(1) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(2) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates consistent with the NAIC Accounting Practices And Procedures Manual, state laws and regulations;

(3) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor;

(4) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

B. If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to its policyholders, creditors or the general public, then the commissioner may, upon a determination, issue an order requiring the insurer to:

(1) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(2) Reduce, suspend or limit the volume of business being accepted or renewed;

(3) Reduce general insurance and commission expenses by specified methods;

(4) Increase the insurer's capital and surplus;

(5) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(6) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(7) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(8) Document the adequacy of premium rates in relation to the risks insured;

(9) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the commissioner.

(10) Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner.

(11) Provide a business plan to the commissioner in order to continue to transact business in the state.

(12) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer the commissioner's order may be limited to the extent provided by statute.

C. An insurer subject to an order under Subsection B may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant to [cite the applicable rules of civil or administrative procedure]. The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the commissioner based the order. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days after notice is served and shall be either in [insert proper county] county or in some other place convenient to the parties designated by the commissioner. The commissioner shall hold all hearings under this subsection privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

Section 5. Judicial Review

Any order or decision of the commissioner shall be subject to review in accordance with [cite applicable provision of the state administrative code] at the instance of any party to the proceedings whose interests are substantially affected.

Note: Consideration should be given to the practice and procedure in each state.

Section 6. Separability

If any provisions of this regulation be held invalid, the remainder shall not be affected.

Section 7. Effective Date

This regulation shall become effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1985 Proc. II 11, 23, 243, 244-247 (adopted).
2008 Proc. 2nd Quarter10-86 to 10-91 (adopted).

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-101-.01 to 482-1-101-.07 (1994/2009).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.500 to 21.520 (1993/2011).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-220.01 (2013).		
Arkansas	CODE ARK. R. 054.00.53-1 to 054.00.53-7 (1991/2014).		
California	CAL. CODE REGS. tit 10 §§ 2598.1 to 2598.6 (2013).		
Colorado	3 COLO. CODE REGS. § 702-3:3-1-7 (1991/2013).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-8-101 to 38a-8-104 (1992/2010).		
Delaware	18 DEL. CODE REGS. § 304-1.0 to 304-7.0 (2017).		
District of Columbia	D.C. CODE §§ 31-2101 to 31-2103 (1993/2015).		

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. AMIN. CODE ANN. r. 69O-141.001 to 69O-141.006 (1991/1992).
Georgia	GA. COMP. R. & REGS. 120-2-54 (1993/2013).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:15-103.5 (1993/2013) (portions of model).		
Idaho	IDAHO ADMIN. CODE r. 18.07.05 (1993/2011).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1250.10 to 1250.40 (1994/2015).		
Indiana	760 IND. ADMIN. CODE 1-53-1.1 to 1-53-7 (2007/2013).		
Iowa	IOWA ADMIN. CODE r. 191-110.1 to 191-110.8 (2010).		
Kansas	KAN. ADMIN. REGS. § 40-1-38 (1992/2009) (portions of model).		
Kentucky	806 KY. ADMIN. REGS. § 3:150 (1991/2009).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.1301 to XIII.1315 (Regulation 43) (1992/2013).		
Maine	CODE ME. R. tit. 02-031 Ch. 710 §§ 1 to 7 (1993/2014) (portions of model).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	MASS. GEN. LAWS ch. 175J, §§ 1 to 10 (1993/2012); 211 MASS. CODE REGS. 150.00 to 150.06 (2011).		

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS § 500.436a (1992).	
Minnesota		MINN. STAT. §§ 60G.20 to 60G.22 (1991/2011).	
Mississippi	19 CODE MISS. R. Pt. 1, R. 39.01 to 39.08 (2009).		
Missouri	MO. REV. STAT. § 375.539 (2010).		
Montana		MONT. ADMIN. R. 6.6.3401 to 6.6.3405 (1993).	
Nebraska	210 NEB. ADMIN. CODE § 55 (1991/2010).		
Nevada	NEV. ADMIN. CODE §§ 680A.220 to 680A.228 (1996/2012).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. §§ 2901.01 to 2901.05 (1992/2011).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-27.1 to 11:2-27.5 (1992/2014).		
New Mexico	N.M. STAT. ANN. §§ 59A-41-24 to 59A-41-25 (1993/2014).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. § 58-30-60 (1989/2013).		
North Dakota	N.D. ADMIN. CODE § 45-03-13 (1992/2010).		
Northern Marianas	NO CURRENT ACTIVITY		

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio			OHIO ADMIN. CODE § 3901-3-04 (1991/2010); OHIO REV. CODE ANN. § 3903.09 (1982).
Oklahoma	OKLA. ADMIN. CODE §§ 365:25-7-40 to 365:25-7-45 (1992/2009).		
Oregon		OR. ADMIN. R. 836-013-0100 to 836-013-0120 (1993/2010).	
Pennsylvania	31 PA. CODE §§ 160.1 to 160.6 (1993/2012).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-14.2-1 to 27-14.2-4 (1992/2010).		
South Carolina	S.C. CODE ANN. § 38-5-120 (1991/2013) (portions of model).		
South Dakota		S.D. CODIFIED LAWS §§ 58-4-39 to 58-4-43 (1992/2013); S.D. ADMIN. R. 20:06:23 (1992).	
Tennessee	TENN. COMP. R. & REGS. 0780-1-66 (1994/2014).		
Texas	28 TEX. ADMIN. CODE §§ 8.1 to 8.3 (1990/2012).		BULLETIN B-0040-10 (2010).
Utah	UTAH ADMIN. CODE r. 590-265 (2012).		
Vermont	4-3 VT. CODE R. § 21 (Regulation 93-2) (2014).		
Virgin Islands	22 V.I. CODE ANN. §§ 519 to 521 (2016).		
Virginia	14 VA. ADMIN. CODE §§ 5-290-10 to 5-290-50 (1992/2013).		VA. CODE ANN. § 38.2-1038 (1986/1991).

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	WASH. ADMIN. CODE 284-16-310 to 284-16-320 (1992/2009).		
West Virginia	W. VA. CODE § 33-34-3a (2010).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	WYO. STAT. ANN. §§ 26-3-116 (1992/2012); § 26-3-132 (1992/2012); § 26-3-133 (2012).		

PROJECT HISTORY - 2008

MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION (#385)

1. Project Description

In June 2004, the Examination Oversight (E) Task Force received a referral from the Financial Condition (E) Committee to review Model Law #385: Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition. The Task Force was asked to work with the Receivership and Insolvency (E) Task Force in reviewing the model as it represented an accreditation standard that had not been revised since its adoption in 1985. Based on the initial review performed in 2005, the Task Force recommended that the model be revised and updated. A charge was adopted for 2006 instructing the Task Force to produce revisions to the model in coordination with the Receivership and Insolvency (E) Task Force. Preliminary work was completed on the charge in 2006 but in 2007, in accordance with the NAIC's adoption of a revised Model Law Development Framework, the project to revise the model was put on hold until the approval of an Appendix A by the Executive Committee. The Appendix A was approved by the Executive Committee at the 2007 Winter National Meeting and the task forces resumed their work to revise the model at this time.

2. Group Responsible for Drafting the Regulation

The project to review and produce revisions to Model #385 was given to the Examination Oversight (E) Task Force and the Receivership and Insolvency (E) Task Force. The two task forces formed a joint subgroup, entitled the Hazardous Financial Condition Model Revisions Subgroup, to draft revisions to the model regulation. The following states participated in the subgroup:

Iowa, Chair	Pennsylvania
Arkansas	Tennessee
Florida	Utah
New York	Virginia
Ohio	

3. Charge Authorizing the Project

The Examination Oversight (E) Task Force and the Receivership and Insolvency (E) Task Force have been working on this project in accordance with related charges since 2004. In 2007, in accordance with the revised Model Law Development Framework, the task forces prepared an Appendix A-Request for Model Law Development, for the approval of the Financial Condition (E) Committee and the Executive (EX) Committee. The Appendix A received final approval of the Executive Committee at the 2007 NAIC Winter National Meeting and the Examination Oversight (E) Task Force was asked to proceed with the following charge:

Produce in coordination with the Receivership and Insolvency Task Force, revisions to Model 385 – Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition.

4. General Description of the Drafting Process and Due Process

In November 2004, the Examination Oversight (E) Task Force conducted a survey of state insurance departments to determine state satisfaction with the current version of Model #385. As a result of the survey, a number of suggested revisions were proposed by various state insurance departments. When the approval to proceed with the project was received in December 2007, the Hazardous Financial Condition Subgroup utilized the suggested revisions from the survey results as a starting point to draft revisions to the Model. These suggested revisions were discussed on a call of the Subgroup on February 20, 2008. During this call, draft revisions to the model were finalized and the Subgroup voted to expose the proposed revisions for a 45-day comment period. The exposure period was subsequently extended to 60-days at the request of the Examination Oversight (E) Task Force. After the exposure period concluded, the Subgroup held a conference call on May 22, 2008, to discuss the three comment letters received during the exposure period. During this conference call, the group discussed the comments received and agreed to add explanatory language to amend several of the proposed revisions. The proposed revisions to Model #385 were then adopted as amended. The revisions to the model were then unanimously adopted by both the Examination Oversight and Receivership & Insolvency (E) Task Forces and the Financial Condition (E) Committee at their June 2008 meetings.

5. Discussion of Key Issues

Section 3. Standards

The following additions were made to the standards that may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public:

- Findings from audit reports and actuarial opinions, reports or summaries;
- Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;
- Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;
- Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner;
- Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice;
- Whether management persistently engages in material under reserving that results in adverse development;
- Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;
- Any other finding determined by the commissioner to be hazardous to the policyholders, creditors or general public.

These standards have been added to give the commissioner additional items to consider in determining whether an insurer is in a hazardous financial condition.

Section 4. Commissioner's Authority

The following additions were made to the commissioner's authority to issue an order requiring the insurer to:

- Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner.
- Provide a business plan to the commissioner in order to continue to transact business in the state.
- Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

These additional requirements have been included in the revised model to allow the commissioner additional authority in preventing the situation at insurers in hazardous financial condition from worsening.

6. Any Other Important Information

No other items identified at this time.

Exhibit A: Illustrative Timeline on Due Process and Drafting Process– Model 385

June 2004	(Summer National Meeting) Examination Oversight Task Force receives the referral of the Financial Condition (E) Committee to review Model #385 in conjunction with the Receivership and Insolvency (E) Task Force.
September 2004	(Fall National Meeting) Subgroup of Examination Oversight Task Force formed to begin review of the model.
October 2004	Subgroup holds a conference call to review the model and develops a survey to be conducted among all states regarding the current effectiveness of the model and whether revisions may be necessary.
November 2004	Survey of states conducted.
December 2004	(Winter National Meeting) Survey responses are briefly discussed. Receivership and Insolvency (E) Task Force indicates that it is actively working on revisions to Model #555 (Insurer Receivership Model Act) and has limited availability to participate in the review of Model #385 at this time.
March 2005	Due to the involvement of the Receivership and Insolvency (E) Task Force in developing revisions to Model #555, the project to review Model #385 is postponed.
December 2005	Financial Condition (E) Committee adopts a charge for the task forces to move forward by drafting revisions to update the model.
2006	Limited work performed on the project due to the Receivership and Insolvency Task Force's work on Model #555.
March 2007	(Spring National Meeting) A joint subgroup of the Examination Oversight (E) Task Force and the Receivership and Insolvency (E) Task Force titled the Hazardous Financial Condition Model Revisions Subgroup is formed to work on the project.
May 2007	The NAIC adopts a new Model Law Development Framework requiring an additional approval process before work to revise the model is begun.
June-August 2007	The Hazardous Financial Condition Model Revisions Subgroup surveys Chief Financial Regulators regarding their support for formally revising Model #385 to comply with the Model Law Development Framework. The results of the survey indicate sufficient support for the project and an Appendix A is created to request approval to proceed with formally revising the model.
September 2007	(Fall National Meeting) The Appendix A to proceed with formally revising Model #385 is approved by both the Examination Oversight and the Receivership and Insolvency (E) Task Forces and the Financial Condition (E) Committee.
December 2007	(Winter National Meeting) The Appendix A is approved by the Executive Committee.
February 20, 2008	In a conference call of the Hazardous Financial Condition Model Revisions Subgroup, proposed revisions to the model are discussed and voted to be exposed for public comment.
May 22, 2008	A conference call of the Hazardous Financial Condition Model Revisions Subgroup is held to discuss comments received during the exposure period. An amended version of the revisions to the model is adopted for presentation to the Examination Oversight and the Receivership and Insolvency (E) Task Forces.
June 1, 2008	The revised model is adopted by both the Examination Oversight and the Receivership & Insolvency (E) Task Forces.
June 2, 2008	The revised model is adopted by the Financial Condition (E) Committee.

MODEL LAW ON EXAMINATIONS

Table of Contents

Prefatory Drafting Comment

This model act reflects a conceptual change with respect to the frequency and scope of on-site financial examinations of insurers. The Act authorizes the commissioner to conduct examinations whenever it is deemed necessary and the commissioner is given the flexibility to decide the scope of the examination. Since criteria for determining when a company should be examined and the scope of that examination and procedures to be employed is a complex matter, the Act requires the commissioner to observe the direction set forth in the *NAIC Examiner's Handbook* with respect to these matters.

The objective of the model act is to direct department resources to companies having or likely to have financial difficulty; however, all companies are required to be examined once every five years, although the scope and extent of that exam will be based on the particular attributes of the company to be examined.

The conceptual change reflected by this model law can be accomplished because over the last several years a variety of additional financial regulatory tools have been developed and implemented including annual independent CPA audits, opinions on insurance reserves by qualified actuaries, annual financial statement analyses and others which alleviate the necessity for comprehensive periodic examinations.

This model act will not diminish the commissioner's authority to conduct examinations but rather will see that examinations are a more effective part of the department financial regulation and surveillance program.

Section 1. Purpose

The purpose of this Act is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. The provisions of the Act are intended to enable the commissioner to adopt a flexible system of examinations that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this state.

Section 2. Definitions

The following terms as used in this Act shall have the respective meanings hereinafter set forth:

A. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: The title of the chief insurance regulatory official should be used here and throughout the law.

B. "Company" means a person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the commissioner.

C. "Department" means the department of insurance of this state.

D. "Examiner" means an individual or firm having been authorized by the commissioner to conduct an examination under this Act.

E. "Insurer" means [refer to appropriate definition in state insurance code].

F. "Person" means an individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

Section 3. Authority, Scope and Scheduling of Examinations

A. The commissioner or any of the commissioner's examiners may conduct an examination under this Act of any company as often as the commissioner in his or her sole discretion deems appropriate but shall at a minimum, conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent Certified Public Accountants and other criteria as set forth in the *Examiners' Handbook* adopted by the National Association of Insurance commissioners and in effect when the commissioner exercises discretion under this section.

B. For purposes of completing an examination of a company under this Act, the commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

Drafting Note: In order to force a person outside the state to cooperate with any examination, it may be necessary to obtain judicial enforcement of a subpoena.

C. In lieu of an examination under this Act of a foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if (1), the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

Section 4. Conduct of Examinations

A. Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the *Examiners' Handbook* adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

B. Every company or person from whom information is sought, its officers, directors and agents shall provide to the examiners appointed under Subsection A timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of a license or authority shall be conducted pursuant to Section [insert reference to cease and desist statute or other law having a post-order hearing mechanism].

C. The commissioner or any of the commissioner's examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. [or "Such subpoenas may be enforced pursuant to the provisions of Section _____ of this Code."]

D. When making an examination under this Act, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company that is the subject of the examination.

E. Nothing contained in this Act shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to an examination shall be prima facie evidence in any legal or regulatory action.

F. Nothing contained in this Act shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner may, in his or her sole discretion, deem appropriate.

Section 5. Examination Reports

A. General Description

An examination report shall be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

B. Filing of Examination Report

No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice that shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

C. Adoption of Report on Examination

Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(1) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation; or

(2) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to Subsection A above; or

(3) Calling for an investigatory hearing with no less than twenty (20) days notice to the company for purposes of obtaining additional documentation, data, information and testimony.

D. Orders and Procedures

(1) Orders entered pursuant to Subsection C(1) above shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. An order shall be considered a final administrative decision and may be appealed pursuant to the [insert name of State Administrative Review Law], and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) A hearing conducted under Subsection C(3) above by the commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of any such hearing, the commissioner shall enter an order pursuant to Subsection C(1) above.

(a) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's representative shall be under oath and preserved for the record. Nothing contained in this section shall require the department to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(b) The hearing shall proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. Thereafter the company and the department may present testimony relevant to the investigation. Cross examination shall be conducted only by the commissioner or the commissioner's representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

E. Publication and Use

(1) Upon the adoption of the examination report under Subsection C(1) above, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of [insert number] days except to the extent provided in Subsection B. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

Drafting Note: The time period may correspond to the amount of time allowed for a party to seek administrative review under state law or it should at a minimum allow a company adequate time, not less than two (2) days following receipt of the adopted report to obtain an equitable stay if provided for under state law.

(2) Nothing contained in this Code shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Act.

(3) In the event the commissioner determines that regulatory action is appropriate as a result of an examination, he or she may initiate any proceedings or actions provided by law.

F. Privilege for, and Confidentiality of Ancillary Information

(1) (a) Except as provided in Subsection E above and in this subsection, documents, materials or other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under this Act, or in the course of analysis by the commissioner of the financial condition or market conduct of a company shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(b) Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

(i) Created, produced or obtained by or disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries in the course of the National Association of Insurance Commissioners and its affiliates and subsidiaries assisting an examination made under this Act, or assisting a commissioner in the analysis of the financial condition or market conduct of a company; or

(ii) Disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries under Paragraph (3) of this subsection by a commissioner.

(c) For the purposes of Paragraph (1)(b), "Act" includes the law of another state or jurisdiction that is substantially similar to this Act.

(2) Neither the commissioner nor any person who received the documents, material or other information while acting under the authority of the commissioner, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to Paragraph (1).

(3) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Paragraph (1), with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information;

(b) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: Subsection F(3)(a) assumes that the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Paragraph (3).

(5) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(6) In this subsection "department," "insurance department," "law enforcement agency," "regulatory agency," and the "National Association of Insurance Commissioners" include, but are not limited to, their employees, agents, consultants and contractors.

Section 6. Conflict of Interest

A. An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section shall not be construed to automatically preclude an examiner from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

B. Notwithstanding the requirements of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

Section 7. Cost of Examinations

Drafting Comment: The NAIC Model State Insurance Department Funding Bill or such funding mechanism as may be currently authorized by law should be incorporated here by reference. Any funding mechanism should assure that the manner in which examinations are funded does not influence the scheduling, scope or conduct of examination.

Section 8. Immunity from Liability

A. No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or an examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Subsection A.

D. A person identified in Subsection A shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1991 Proc. I 9, 14, 26, 27-31 (adopted).
1999 Proc. 4th Quarter 15, 364, 369, 370-372 (amended).

This replaces an earlier model law entitled: Standard Law Relating to Procedures in Examining the Affairs of Insurance Companies
1956 Proc. II 328, 329-333 (adopted).

MODEL LAW ON EXAMINATIONS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL LAW ON EXAMINATIONS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-2-20 to 27-2-27 (1971/1993).
Alaska	ALASKA STAT. §§ 21.06.120 to 21.06.170 (1966/2006).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE §§ 20-6-1701 to 20-6-1704 (2005) (portions of model).		ARIZ. REV. STAT. ANN. § 20-142; §§ 20-156 to 20-160 (1954/2014); Circular Letter 92-7 (1992).
Arkansas	ARK. CODE ANN. §§ 23-61-201 to 23-61-303 (1959/2013).		
California	CAL. INS. CODE §§ 730 to 738 (1935/2010).		
Colorado	COLO. REV. STAT. §§ 10-1-201 to 10-1-207 (1992/2014).		
Connecticut	CONN. GEN. STAT. § 38a-14 (1949/2013).		CONN. GEN. STAT. § 38a-8 (1949/2013).
Delaware	DEL. CODE ANN. tit. 18, §§ 318 to 330 (1995/2014).		
District of Columbia	D.C. CODE §§ 31-1401 to 31-1407 (1993/2004).		

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 624.316 to 624.322 (1959/2014).
Georgia			GA. CODE ANN. §§ 33-2-11 to 33-2-16 (1960/2012); Dir. 93-RS-1 (1993).
Guam			22 GUAM CODE ANN. § 15316 (2007) (domestic); .22 GUAM CODE ANN. § 15403 (foreign); 22 GUAM CODE ANN. § 15505 (alien).
Hawaii	HAW. REV. STAT. §§ 431:2-301 to 431:2-308 (1988/2006).		
Idaho	IDAHO CODE ANN. §§ 41-219 to 41-230 (1961/2003).		
Illinois	215 ILL. COMP. STAT. 5/132.1 to 5/132.7 (1991/1995).		
Indiana	IND. CODE §§ 27-1-3.1-1 to 27-1-3.1-18 (1991/2013).		
Iowa	IOWA CODE §§ 507.1 to 507.17 (1965/2013).		
Kansas	KAN. STAT. ANN. §§ 40-222 (1991/2008).		
Kentucky	806 KY. ADMIN. REGS. § 2:120 (1992) (portions of model).		KY. REV. STAT. ANN. §§ 304.2-210 to 304.2-300 (1970/2010).
Louisiana	LA. REV. STAT. ANN. §§ 22:1981 to 22:1982 (1979/2010).		
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 221 to 228 (1970/1999).
Maryland			MD. CODE ANN., INS. §§ 2-205 to 2-215 (1963/2014); MD. CODE REGS. 31.04.20.01 (2010); 31.12.01.12 (2010/2012).

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts	MASS. GEN. LAWS ch. 175, § 4 (1993/2014).		
Michigan			MICH. COMP. LAWS § 500.222 (1957/1994).
Minnesota	MINN. STAT. § 60A.031 (1961/1992).		
Mississippi	MISS. CODE ANN. §§ 83-5-201 to 83-5-217 (1992/2012).		
Missouri	MO. REV. STAT. §§ 374.202 to 374.207 (1992/1999).		MO. CODE REGS. ANN. tit. 20, §§ 100-8.002 to 100-8.040 (2008).
Montana	MONT. CODE ANN. §§ 33-1-401 to 33-1-413 (1959/2015).		
Nebraska	NEB. REV. STAT. §§ 44-5901 to 44-5910 (1993/2009).		
Nevada			NEV. REV. STAT. §§ 679B.230 to 679B.300 (1971/1997).
New Hampshire	N.H. REV. STAT. ANN. § 400-A:37 (1979/2005).		
New Jersey	N.J. REV. STAT. §§ 17:23-20 to 17:23-26 (1993).		N.J. ADMIN. CODE §§ 11:1-36.1 to 11:1-36.5 (1993/2001).
New Mexico	N.M. STAT. ANN. §§ 59A-4-4 to 59A-4-21 (1985/1999).		
New York			N.Y. INS. LAW §§ 309 to 313 (1984/2014).
North Carolina	N.C. GEN. STAT. §§ 58-2-131 to 58-2-136 (1991/2002).		
North Dakota	N.D. CENT. CODE §§ 26.1-03-19.1 to 26.1-03-19.7 (1993/2003).		
Northern Marianas			4 N. MAR. ISLAND CODE § 7201 (1984).

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio			OHIO REV. CODE ANN. §§ 3901.07 to 3901.071 (1978/2014); § 3901.045 (2002); § 3901.36 (1971/2002).
Oklahoma	OKLA. STAT. tit. 36, §§ 309.1 to 309.7 (1991/2012).		
Oregon	OR. REV. STAT. §§ 731.300 to 731.316 (1967/2001).		
Pennsylvania	40 PA. STAT. ANN. §§ 323.1 to 323.8 (1921/1993).		NOTICE 2010-4 (2010); NOTICE 2011-5 (2011).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 214 to 226 (1996).
Rhode Island	R.I. GEN. LAWS §§ 27-13.1-1 to 27-13.1-7 (1992/2009).		R.I. GEN. LAWS §§ 27-1-11 to 27-1-12 (1896/1956); § 27-13-1 (1896/2009).
South Carolina	S.C. CODE ANN. §§ 38-13-10 to 38-13-60 (1987/1994).		
South Dakota			S.D. CODIFIED LAWS §§ 58-3-1 to 58-3-27 (1966/2014).
Tennessee	TENN. CODE ANN. §§ 56-1-408 to 56-1-413 (1895/1996).		TENN. CODE ANN. § 56-1-401 (1932); § 56-8-107 (2009).
Texas			TEX. ADMIN. CODE § 7.84 (2010); TEX. INS. CODE ANN. §§ 401.001 to 401.255 (2007).
Utah			UTAH CODE ANN. §§ 31A-2-203 to 31A-2-205 (1985/2004); UTAH ADMIN. CODE r. 590-150-1 to 590-150-4 (1992).
Vermont	VT. STAT. ANN. tit. 8, §§ 3563 to 3576 (1967/1999).		VT. STAT. ANN. tit. 8, § 3561 (2009).
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 101 to 108 (1993).		

MODEL LAW ON EXAMINATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1317 to 38.2-1321.1 (1986/2001).		
Washington	WASH. REV. CODE ANN. §§ 48.03.010 to 48.03.075 (1947/1993); § 48.02.065 (2001/2005).		WASH. REV. CODE ANN. § 48.02.060 (1947/2009).
West Virginia	W. VA. CODE § 33-20-12 (1957/2006); § 33-2-9 (1957/2006).		W. VA. CODE R. §§ 114-15-1 to 114-15-8 (1987/2008).
Wisconsin	WIS. ADMIN. CODE INS. § 50.50 (1993) (portions of model).		WIS. STAT. §§ 601.43 to 601.45 (1969/1992).
Wyoming	WYO. STAT. ANN. §§ 26-2-116 to 26-2-131 (1925/2001) (adopted by reference).		

PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM MODEL ACT

Table of Contents

Section 1. Scope

The provisions of this Act shall apply to all domestic, foreign and alien insurers who are authorized to transact business in this state.

Section 2. Filing Requirements

A. Each domestic, foreign and alien insurer who is authorized to transact insurance in this state shall annually on or before March 1 of each year file with the National Association of Insurance Commissioners (NAIC) a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the Commissioner shall also be filed with the NAIC.

B. Foreign insurers that are domiciled in a state which has a law substantially similar to Subsection A of this section shall be deemed in compliance with this section.

Section 3. Immunity

In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Commissioner under the authority of this Act and shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required hereunder.

Section 4. Confidentiality

A. All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the NAIC's Insurance Regulatory Information System and in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection C(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

Section 5. Revocation of Certificate of Authority

The Commissioner may suspend, revoke or refuse to renew the Certificate of Authority of any insurer failing to file its annual statement when due or within any extension of time which the Commissioner, for good cause, may have granted.

Section 6. Effective Date

This Act will be effective immediately.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1985 Proc. I 19, 37, 179, 326, 343 (adopted).
1986 Proc. II 12, 17, 204, 333, 306-361 (amended and reprinted).
1999 Proc. 4th Quarter 15, 364, 369, 378 (amended).

PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) MODEL ACT

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PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) MODEL ACT

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE r. 102 (1994).	
Alaska			ALASKA STAT. § 21.09.200 (1966/2002); § 21.06.060 (2002/2010).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. § 20-234 (1991/1996).	
Arkansas		ARK. CODE ANN. § 23-63-216 (1991/2013) (portions of model).	
California		CAL. INS. CODE §§ 930 to 934 (1992/2005).	
Colorado		COLO. REV. STAT. § 10-3-208 (1991/1997).	
Connecticut		CONN. GEN. STAT. § 38a-53a (1992/2007).	BULLETIN FS-4-2014 (2014).
Delaware		DEL. CODE ANN. tit. 18, § 526 (1953/1998).	
District of Columbia		D.C. CODE §§ 31-1901 to 31-1904 (1993/2004).	

PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 624.4241 (1985/1986).
Georgia		GA. CODE ANN. § 33-3-21.3 (1991).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:3-302 to 431:3-304 (1988/2003).	
Idaho			IDAHO CODE ANN. § 41-335 (1991/2004).
Illinois	215 ILL. COMP. STAT. 5/136 (1985/2009).		
Indiana			IND. CODE § 27-1-20-33 (1992/1999).
Iowa		IOWA ADMIN. CODE r. § 191-5.26 (1991/1999).	
Kansas			KAN. STAT. ANN. § 40-225 (1927/1997).
Kentucky		KY. REV. STAT. ANN. § 304.2-205 (1986/1998) (portions of model).	KY. REV. STAT. ANN. § 304.2-150 (1986/1994).
Louisiana			LA. REV. STAT. ANN. § 22:572 (1991).
Maine		ME. REV. STAT. ANN. tit. 24-A, § 414 (1992).	
Maryland			MD. CODE REGS. § 31.04.04.02 (1994).
Massachusetts		MASS. GEN. LAWS. ANN. ch. 175, § 25 (1993).	
Michigan		MICH. COMP. LAWS § 500.438a (1992/1994).	
Minnesota		MINN. STAT. §§ 60A.91 to 60A.94 (1991).	

PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi		MISS. CODE ANN. §§ 83-5-301 to 83-5-309 (1994).	
Missouri		MO. REV. STAT. § 375.041 (1986/1992).	MO. CODE REGS. ANN. tit. 20, § 200-1.030 (2010).
Montana		MONT. CODE ANN. §§ 33-2-1502 to 33-2-1504 (1993).	
Nebraska		NEB. REV. STAT. §§ 44-322 to 44-322.01 (1913/2003).	
Nevada		NEV. REV. STAT. § 680A.270 (1971/2003) (portions of model).	NEV. ADMIN. CODE § 680A.160 (1991/2003).
New Hampshire		N.H. REV. STAT. ANN. §§ 400-A:36-a to 400-A:36-c (1988/1995).	
New Jersey		N.J. STAT. ANN. §§ 17:23B-1 to 17:23B-3 (1993).	
New Mexico			N.M. STAT. ANN. § 59A-5-29 (1984/1993).
New York	NO CURRENT ACTIVITY		
North Carolina		N.C. GEN. STAT. §§ 58-4-1 to 58-4-25 (1985/1999); § 58-2-220 (1991).	
North Dakota		N.D. CENT. CODE §§ 26.1-03-11.1 to 26.1-03-11.3 (1987/2001).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. § 3901.42 (1986).	
Oklahoma		OKLA. STAT. tit. 36, § 311 (1986/2004).	
Oregon		OR. REV. STAT. §§ 731.730 to 731.737 (1993/2001).	

PARTICIPATION IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico		P.R. REGS. 3463 (Rule LX) (1987).	
Rhode Island		R.I. GEN. LAWS §§ 27-12.1-1 to 27-12.1-5 (1991/1996).	
South Carolina		S.C. CODE ANN. § 38-13-85 (1988/1993).	
South Dakota		S.D. CODIFIED LAWS § 58-6-80 (1992) (portions of model).	
Tennessee		TENN. CODE ANN. §§ 56-44-101 to 56-44-104 (1991/1995).	
Texas			TEX. INS. CODE ANN. §§ 802.051 to 802.056 (2003).
Utah		UTAH CODE ANN. § 31A-4-113.5 (1992/2003) (portions of model).	
Vermont		VT. STAT. ANN. tit. 8, §§ 3569 to 3572 (1991/1995).	
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 230 to 230b (1993).	
Virginia		VA. CODE ANN. § 38.2-1306.1 (1987/2001); § 38.2-1300 (1986/2009).	VA. CODE ANN. § 38.2-4307.1 (1990/2000) (HMOs).
Washington		WASH. REV. CODE ANN. § 48.05.400 (1987).	
West Virginia	W. VA. CODE § 33-4-14 (1957/1992).		
Wisconsin			WIS. ADMIN. CODE INS. § 50.25 (1993).
Wyoming		WYO. STAT. ANN. §§ 26-3-201 to 26-3-204 (1987/2004).	

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].

Section 2. Purpose and Intent

The purpose of this Act is to provide for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations. This Act is designed to operate in conjunction with and as a companion to other state laws that establish standards for the regulation of health maintenance organizations, such as [insert state law equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) the *Quality Assessment and Improvement Model Act* (#71), the *Health Care Professional Credentialing Verification Model Act* (#70), the *Utilization Review and Benefit Determination Model Act* (#73), the *Health Carrier Grievance Procedure Model Act* (#72), the *Health Carrier External Review Model Act* (#75), the *Health Information Privacy Model Act* (#55), the *Unfair Trade Practices* (#880), the *Unfair Claims Settlement Practices Model Act* (#900), the *Insurance Holding Company System Regulatory Act* (#440) and the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)].

Drafting Note: This model act presumes the existence of state laws that are based on the listed NAIC model acts described in this section. States that have not already adopted these laws should consider adopting them to ensure that a comprehensive system of regulation for health maintenance organizations is in place.

Drafting Note: Former Section 14—Continuation of Benefits and Section 20—Uncovered Expenditures provide consumer protections for health maintenance organization enrollees in the event of a health maintenance organization insolvency in the absence of guaranty association protection for health maintenance organization enrollees. Those sections (along with Section 3HH, defining the term "uncovered expenditures") have been repealed to reconcile this Act with the *Life and Health Insurance Guaranty Association Model Act* (#520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain provisions, comparable to former Sections 3HH, 14 and 20, requiring health maintenance organizations to develop advance insolvency plans that include procedures to facilitate continuation of benefits after an insolvency, and to post deposits to secure any uncovered expenditures in excess of 10% of total health care expenditures. The language from former Section 14, former Section 20 and the former definition of "uncovered expenditures" in Section 3HH can be found in Appendix A. Former Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency was repealed as obsolete due to the provisions of the federal Affordable Care Act (ACA).

Section 3. Definitions

A. "Adverse determination" means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

B. "Basic health care services" includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

C. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

D. "Coinsurance" means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

E. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

F. "Copayment" means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

G. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

H. "Covered person" means any person eligible to receive covered benefits under the terms of a health benefit plan.

I. "Deductible" means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.

J. "Enrollee" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

K. "Evidence of coverage" means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.

L. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.

M. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. "Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

(1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(2) Claims payment, handling or reimbursement for health care services; or

(3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.

O. "Group contract" means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

P. "Group contract holder" means a person, other than an individual, to which a group contract has been issued.

Q. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. "Health care professional" means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.

S. "Health care provider" or "provider" means a health care professional or facility.

T. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: The term "hospital or medical service corporation," as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as "Blue Cross Blue Shield-type" plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

V. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

W. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.

X. "Insolvent" or "insolvency" shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

Y. "Intermediary organization" means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

Z. "Network" means the group of participating providers providing services to a health maintenance organization.

AA. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

BB. "Participating provider" means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.

CC. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.

DD. "Policyholder" means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.

EE. "Qualified actuary" means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.

FF. "Replacement coverage" means the benefits provided by a succeeding carrier.

GG. "Risk bearing entity" means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

HH. "Utilization review" means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 4. Applicability and Scope

This Act applies to all health maintenance organizations and risk bearing entities doing business in this state.

Section 5. Establishment of Health Maintenance Organizations

Option A:

A. Notwithstanding any law of this state to the contrary, any person other than an individual may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert reference to applicable state law] and compliance with all provisions of this Act and other applicable state laws.

Drafting Note: State laws differ as to whether a health maintenance organization is required to be a domestic corporation. This provision should be adopted if your state wants to permit a foreign corporation to qualify under this Act if it registers to do business in a state as a foreign corporation and complies with all provisions of this Act and other applicable state laws.

Option B:

A. Notwithstanding any law of this state to the contrary, any organization may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this Act.

Drafting Note: State laws differ as to whether a health maintenance organization may be a foreign corporation. This option does not differentiate between foreign and domestic corporations. Whether or not to allow foreign corporations to become health maintenance organizations should be determined in light of a particular state's regulatory framework.

B. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall demonstrate, set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) (a) A disclosure of the internal organizational structure identifying senior management employees;

(b) A disclosure of the external organizational structure identifying all parent, subsidiary and affiliate organizations; and

(c) If the applicant is a member of a holding company:

(i) Identification of the holding company; and

(ii) A copy of the most recent holding company Form B that includes current financial information for the ultimate controlling party;

(4) The applicant's federal identification number, NAIC number if applicable, corporate address and mailing address;

(5) (a) The names, addresses, official positions and biographical affidavit of the individuals who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to all members of the board of directors, executive committee, and the principal officers accompanied by a completed release of information for each of these individuals, on forms acceptable to the commissioner; and

(b) A disclosure of any person owning or having the right to acquire five percent (5%) or more of the voting securities or subordinated debt of the applicant;

(6) A detailed plan of operation for [insert state name];

(7) A description of the applicant and its personnel, and, where applicable, its facilities, including, but not limited to, location, hours of operation and telephone numbers;

(8) A copy of:

(a) Any contract made or to be made between the applicant and an affiliated or unaffiliated person for managerial or administrative services, including, third party administrators, marketing consultants or persons listed in Paragraph (5); and

(b) Sample contract forms proposed for use between the applicant and persons providing health care services to covered persons, including, participating providers and intermediary organizations.

Drafting Note: Section 11A of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) requires the filing of substantially similar information to the filing of sample provider contracts required in Paragraph (8)(b). States that have adopted the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) should consider whether it is necessary to include a similar requirement in this Act as well.

(9) A copy of each type of evidence of coverage and identification card or similar document to be issued to the enrollees;

(10) A copy of each type of individual or group policy, contract or agreement to be used;

(11) A copy of all marketing materials;

(12) A copy, if applicable, of the most recent financial examination report made of the health maintenance organization within the previous three (3) years, certified by the insurance regulatory agency of the applicant's state of domicile;

(13) (a) A copy of the applicant's financial statements showing the applicant's assets, liabilities and sources of financial support, including a copy of the applicant's most recent audited financial statement that complies with [insert reference to state law equivalent to *Model Regulation Requiring Annual Audited Financial Reports*] and an unaudited current financial statement; or

(b) If the information in Subparagraph (a) of this paragraph is not applicable to the applicant, a list of the assets representing the initial net worth of the applicant;

Drafting Note: States should ensure that the state law equivalent to the *Model Regulation Requiring Annual Audited Financial Reports* is applicable to health maintenance organizations before referencing it in Paragraph (13)(a).

(14) A financial plan that provides a three-year projection of operating results, including:

(a) A projection of balance sheets;

(b) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year;

(c) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state;

(d) Detailed enrollment projections;

(e) The methodology for determining premium rates to be charged that has been certified by a qualified actuary; and

(f) A statement as to the sources of working capital as well as any other sources of funding;

(15) The names and addresses of the applicant's qualified actuary and external auditors;

(16) If the applicant has a parent company and the commissioner determines that additional solvency guarantees are necessary, the parent company's guaranty, on a form acceptable to the commissioner, that the applicant will maintain the minimum net worth required under this Act. If no parent company exists, a statement regarding the availability of future funds if needed;

(17) A description of the nature and extent of any reinsurance program to be implemented, including a detailed risk retention schedule indicating direct, assumed, ceded and net maximum risk exposures on any one risk;

(18) A demonstration that errors and omission insurance or other arrangements satisfactory to the commissioner will be in place upon the applicant's receipt of a certificate of authority;

(19) Information regarding the proposed fidelity bond required pursuant to Section 21B of this Act;

(20) If the applicant is a foreign corporation, a statement from the appropriate regulatory agency of the applicant's state of domicile stating that:

(a) The applicant is authorized to operate as a health maintenance organization in the state of domicile;

(b) The regulatory agency has no objection to the applicant applying for a certificate of authority in this state; and

(c) The applicant is in good standing in the applicant's state of domicile;

(21) The name and address of the applicant's [insert state name] statutory agent for service of process, notice, or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(22) A description of the proposed policies, standards and procedures for the management of health information, including proposed policies, standards and procedures that guard against the unauthorized collection, use or disclosure of protected health information, that complies with [insert reference to state law equivalent to the *Health Information Privacy Model Act* (#55)];

(23) A description of the proposed quality assessment and improvement activities that comply with [insert reference to state law equivalent to the *Quality Assessment and Improvement Model Act* (#71)] regarding the maintenance and improvement of the quality of health care services provided to covered persons;

(24) If the health maintenance organization will not operate statewide, a statement or map describing the service area;

(25) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

(26) A description of the proposed network adequacy standards that assure the adequacy, accessibility and quality of health care that complies with [insert reference to state law equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74)];

(27) A description of the proposed health care provider credentialing program in compliance with [insert reference to state law equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70)];

(28) If the health maintenance organization will provide or perform utilization review services, a description of the proposed utilization review procedures that comply with [insert reference to state law equivalent to the *Utilization Review and Benefit Determination Model Act* (#73)] regarding the ongoing assessment and management of health care services;

(29) A description of the proposed internal grievance procedures that comply with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)] regarding the investigation and resolution of covered persons' complaints and grievances;

(30) A description of the proposed external review procedures that comply with [insert reference to state law equivalent to the *Health Carrier External Review Model Act* (#75)] regarding the external independent review of covered persons' grievances; and

(31) Any other information the commissioner may require.

Section 6. Issuance or Denial of Certificate of Authority

A. Within ninety (90) days of receipt of a completed application, the commissioner shall issue a certificate of authority when the commissioner is satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) The name of the health maintenance organization is not the same as, or deceptively similar to, the name of a domestic insurer, or of a foreign or alien company authorized to transact business in this state, nor does the name of the health maintenance organization tend to deceive or mislead as to the authorization of the health maintenance organization to engage in a specific line of business;

(3) The health maintenance organization will provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, coinsurance or deductibles; and

(4) The health maintenance organization is in compliance with the requirements of this Act.

B. A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 26 of this Act.

Section 7. Powers of Health Maintenance Organizations

A. The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.,) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations, intermediary organizations or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

Drafting Note: States that allow health maintenance organizations to offer a point of services contract may wish to consider additional requirements for those organizations, including but not limited to, additional ongoing net worth and capital, additional deposits, more detailed annual and quarterly financial statement filings, limitations on out-of-plan expenditures and additional reinsurance coverage.

B. (1) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in Subsection A(1), (2) or (4) that may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if, in the commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty (30) days of the filing, it shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a *de minimis* effect.

(3) Transactions between affiliated entities shall be subject to [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act* (#440)].

Section 8. Contract Requirements

A. Each group or individual contract holder is entitled to a group or individual contract within thirty (30) days of the effective date of a new or amended contract.

B. The contract shall not contain provisions or statements that:

(1) Are unjust, unfair, inequitable, misleading, or deceptive; or

(2) Encourage misrepresentation as defined by [reference to state law equivalent to the NAIC *Unfair Trade Practices Act* (#880)].

C. (1) The contract shall contain a clear statement of the following:

(a) Name and address of the health maintenance organization;

(b) Eligibility requirements;

(c) Benefits and services within the service area;

(d) Emergency care benefits and services;

(e) Out of area benefits and services (if any);

(f) Copayments, coinsurance, deductibles or other out-of-pocket expenses, the financial responsibility of the covered person and how the covered person's obligation is determined;

(g) Provider hold harmless provisions;

(h) Limitations and exclusions;

(i) covered person termination;

(j) covered person reinstatement (if any);

(k) Claims procedures;

(l) Utilization review procedures;

(m) Grievance procedures;

(n) Procedures for requesting independent external review;

(o) Continuation of coverage;

(p) Conversion;

(q) Extension of benefits (if any);

(r) Coordination of benefits (if applicable);

(s) Subrogation (if any);

(t) Description of the service area;

(u) Procedures for obtaining a provider directory;

(v) The existence of a formulary and procedures for obtaining a copy of the formulary list (if applicable);

(w) Entire contract provision;

(x) Term of coverage;

(y) Cancellation of group or individual contract holder;

(z) Renewal;

(aa) Reinstatement of group or individual contract holder (if any);

(bb) Grace period; and

(cc) Conformity with state law.

(2) An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraph (1).

D. (1) In addition to the provisions required in Subsection C(1), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded.

(2) If services were received during the ten-day period, and the individual returns the contract to receive a refund of the premium paid, the individual must pay for those services.

E. The commissioner may adopt regulations establishing readability standards for individual and group contract forms.

Drafting Note: The commissioner may adopt standards in the NAIC *Life and Health Insurance Policy Language Simplification Act*.

Section 9. Risk Bearing Entity Registration and Contracting Requirements

A. Registration Requirements.

(1) All risk bearing entities shall register annually with the commissioner in this state unless already subject to state insurance regulation.

Drafting Note: A state may wish to exempt a risk bearing entity from the registration requirements of this subsection, or modify the provisions of this subsection as they apply to a risk bearing entity, where a risk bearing entity accepts risk exclusively from a single health maintenance organization, provides direct care to covered persons of that health maintenance organization, and where detail of claims payments is available for examination from the health maintenance organization. A state may want to require the health maintenance organization to demonstrate to the commissioner that the contractual arrangement with the risk bearing entity will allow it to fulfill the provisions of its contract for the contract year. Health maintenance organizations contracting with risk bearing entities that are exempt from this subsection, or subject to modified registration requirements, should be subject to Subsections C and D of this section and Section 18 of this Act.

(2) The registration shall be in a form approved by the commissioner and shall include:

(a) The name of the risk bearing entity;

(b) The business address of the risk bearing entity;

(c) The principal contact person for risk bearing entity;

(d) The names and positions of senior officers of risk bearing entity, including, President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Executive Vice Presidents, Treasurer and Secretary;

(e) A list of all entities on whose behalf the risk bearing entity has contracts or agreements to provide health care services;

(f) A matrix listing of all major categories of health care services provided by the risk bearing entity;

(g) An approximate number of total covered persons served in all the risk bearing entity's contracts or agreements;

(h) An annual audited Generally Accepted Accounting Principles (GAAP) financial statement;

(i) A list of all subcontractors of the risk bearing entity;

(j) Sample contract forms proposed for use between subcontractors and the risk bearing entity;

(k) A list of all stop loss arrangements; and

(l) Any other information or financial information requested by the commissioner.

(3) The commissioner may charge a registration fee sufficient to cover the cost of implementing this section.

(4) The risk bearing entity shall permit the commissioner to:

(a) Inspect the risk bearing entity's books and records; and

(b) Examine, under oath, any officer or agent of the risk bearing entity with respect to the use of its funds and compliance with the terms and conditions of its contracts to provide covered benefits under the health benefit plan.

(5) A risk bearing entity shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this section, together with such supporting documents as are necessary to explain the modification.

B. Contracting Requirements

(1) Except as provided in Paragraph (2), a health maintenance organization shall not contract with a risk bearing entity that has not registered in accordance with this section.

(2) The requirements of this section shall apply to any contract entered into, amended or renewed after the effective date of this section and shall apply to all contracts no later than two (2) years after the effective date of this section.

(3) A health maintenance organization shall:

(a) Unless already specified in the contract with the risk bearing entity, provide the following, upon request, to the risk bearing entity with which it contracts:

(i) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;

(ii) At the time payment is made, the basis of the calculation of that payment;

(iii) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;

(iv) At the time the contract is entered into, a copy of the health maintenance organization's most recent annual statement filed with the NAIC;

(v) Once the contract is in effect, the quarterly or annual statement filed with the NAIC; and

(vi) Any other information requested by the commissioner.

(b) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization at the time a contract is entered into and annually thereafter:

(i) Annual audited GAAP report;

(ii) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and

(iii) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure;

(c) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization a quarterly status report that includes:

(i) GAAP financial statements;

(ii) An aging report of the percentage of claims that have been paid, pended or denied, across all contracts with risk bearing entities; and

(iii) On a monthly basis, a report of the estimated reported claims and incurred but not reported claims liability of the risk bearing entity; and

(d) Require that a risk bearing entity with which the health maintenance organization contracts provide notice within thirty (30) days to the health maintenance organization of:

(i) Any changes involving the ownership structure of the risk bearing entity;

(ii) Financial or operational concerns regarding the financial viability of the risk bearing entity; or

(iii) Loss of registration.

(4) A health maintenance organization shall provide to the commissioner on a quarterly basis a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity, and any additional information the commissioner may require.

(5) A health maintenance organization shall include in its contracts with a risk bearing entity a provision that allows the commissioner, in the event that a risk bearing entity fails to comply with any provision of this Act, to assign for six (6) months, the risk bearing entity's contract with providers to furnish covered services.

C. Oversight Responsibility

(1) A health maintenance organization shall have procedures in place to notify the commissioner within a reasonable time that a risk bearing entity has materially failed to perform under its contract with the health maintenance organization. A health maintenance organization is not in violation of this paragraph if it acts in good faith in its attempt to comply. The commissioner may by rule enumerate more specific circumstances under which a report may be filed.

(2) A health maintenance organization shall maintain systems and controls for, including but not limited to, reviewing the information provided to the health maintenance organization by the risk bearing entity pursuant to this Act.

(3) Any information that has been provided to the commissioner by a health maintenance organization pursuant to this subsection is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer readable form. If the information is disclosed pursuant this subsection, the health maintenance organization providing the notice shall not be liable for the disclosure or any subsequent use or misuse of the information. The health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the entity that provided the information to the health maintenance organization is entitled to claim.

(4) Any person acting as a director, officer, employee, contractor or agent of a health maintenance organization, who, in good faith and without malice, makes any decision or takes any action to provide a notice of the type contemplated by this subsection shall not be subject to liability for civil damages or any legal action in consequence of that decision or action, nor shall the health maintenance organization, or any other director, officer, employee, contractor or agent be liable for the activities of the person.

(5) In the event that a health maintenance organization has been notified that the registration of a risk bearing entity has been terminated, revoked, non- renewed or forfeited for any reason, a health maintenance organization shall terminate its contract with the risk bearing entity unless specific permission is provided by the commissioner to maintain the contract at the request of both parties, or enter into an agreement pursuant to which the risk bearing entity ceases to bear risk. The commissioner may set conditions on any agreements between the risk bearing entity and the health maintenance organization.

(6) This subsection is not intended to create a private right of action.

D. Continuity of Care.

Notwithstanding any agreement to the contrary, the health maintenance organization shall:

(1) Retain full responsibility on a prospective basis for the provision of health care services pursuant to any applicable health benefit plan; and

(2) At all times, be able to demonstrate to the satisfaction of the commissioner that the health maintenance organization can fulfill its non-transferable obligation to provide health care services to covered persons in any event, including the failure, for any reason, of a risk bearing entity.

E. Enforcement Against Risk Bearing Entities.

(1) If the commissioner determines that a risk bearing entity has not complied with any provision of this Act, the commissioner may terminate the risk bearing entity's registration, institute a corrective action against the risk bearing entity, or use any of the commissioner's other enforcement powers to obtain compliance with this Act.

(2) The commissioner shall, within five (5) business days, inform each health maintenance organization with which a risk bearing entity contracts, in writing:

(a) Of any corrective action undertaken by the commissioner against a risk bearing entity; and

(b) If the registration of a risk bearing entity has been revoked, non-renewed, forfeited or terminated.

(3) The commissioner may, in the event that a risk bearing entity fails to comply with any provision of this Act, require the assignment of the risk bearing entity's contract to furnish covered services for a period not to exceed six (6) months.

(4) The commissioner may assess fines on a risk bearing entity for every day that the entity has failed to meet the registration requirements of this section.

Section 10. Form and Rate Filing Requirements

Drafting Note: States that require prior approval of policy forms and premium rates should adopt Option A. States that have a system of file and use for policy forms and premium rates should adopt Option B.

Option A. Prior Approval

A. Subject to Subsections B and C, no group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner.

B. (1) Every form required by this section shall be filed with the commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the commissioner may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer must notify the commissioner in writing prior to using a form that is deemed approved.

(2) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw approval of a form, effective at the end of the thirty-day period.

(3) Whenever the commissioner disapproves a form or withdraws approval of a form, the commissioner shall notify the health maintenance organization in writing of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing.

C. (1) A health maintenance organization shall not use a premium rate until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

(2) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

(3) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

(4) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Paragraph (2) are met. If the commissioner disapproves the filing, the commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. If the commissioner does not take action on the schedule or methodology within thirty (30) days of the date of the filing of the schedule or methodology, it shall be deemed approved.

D. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a form or rate filing made pursuant to this section.

Option B. File and Use

A. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form and rates have been filed with the commissioner at least thirty (30) days prior to its issuance or delivery.

B. (1) At any time, after its issuance and delivery, and for cause shown, the commissioner may disapprove the use of a form. The disapproval shall be effective thirty (30) days after the health maintenance organization receives the notice described in Paragraph (2).

(2) The commissioner shall notify the health maintenance organization, in writing, of the reasons for disapproval of the form. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for hearing shall stay the effect of the disapproval.

C. (1) A health maintenance organization shall not use a premium rate unless the premium rate or a methodology for determining the premium rate has been filed with the commissioner at least thirty (30) days prior to its use.

(2) The health maintenance organization shall certify that the rates meet the requirements of Paragraph (4).

(3) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

(4) A specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A qualified actuary or other qualified person acceptable to the commissioner must certify the appropriateness of the use of the methodology, based on

reasonable assumptions, backed by adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

(5) At any time after its implementation, and for good cause shown, the commissioner may disapprove the use of a specific rate or rating methodology. The commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for a hearing shall stay the effect of the disapproval.

Section 11. Evidence of Coverage

A. (1) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(2) The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by [insert reference to state law equivalent to the NAIC *Unfair Trade Practices Act* (#880)].

(3) The evidence of coverage shall contain a clear statement of the provisions required in Section 8C of this Act.

B. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval.

Section 12. Marketing and Advertising Materials

A. The advertising and marketing materials of health maintenance organizations are subject to the requirements of [insert reference to state law equivalent to the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation* (#40)].

B. The advertising and marketing materials of health maintenance organizations marketing Medicare supplement insurance are subject to the requirements of [insert reference to state law equivalent to the *NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)].

C. The advertising and marketing materials of health maintenance organizations marketing long-term care insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Regulation* (#641)].

Section 13. Information to Enrollees and Covered Persons

A. A health maintenance organization shall provide, within thirty (30) days, notice to enrollees of any material change in the operation of the organization that will affect them directly.

B. (1) The health maintenance organization shall make written copies of provider directories available to enrollees upon enrollment and re-enrollment.

(2) The health maintenance organization shall provide written copies of provider directories to covered persons upon request.

(3) The health maintenance organization shall provide the directory and any updates to enrollees, in writing or by electronic means, in accordance with the terms of its contract.

C. (1) A health maintenance organization shall notify covered persons of the termination of the primary care provider who currently provides health care services to that covered person.

(2) A health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to receive notice in writing or by electronic means, of the termination of the primary care provider who currently provides health care services to that covered person.

(3) The health maintenance organization shall provide assistance to the covered person in transferring to another participating primary care provider.

D. The health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to obtain information in writing or by electronic means, on how services may be obtained, where additional information on access to services may be obtained and a telephone number where covered persons may contact the health maintenance organization, at no cost to the covered person.

Drafting Note: For the purpose of this section any major change in the provider network is considered a material change.

Section 14. Coordination of Benefits

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health benefit plans.

B. If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with [insert reference to state law equivalent to NAIC *Coordination of Benefits Model Regulation* (#120)] in general use in the state for coordinating coverage between two (2) or more group health insurance or health benefit plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination consistent with [insert reference to state law equivalent to NAIC *Coordination of Benefits Model Regulation* (#120)], health maintenance organizations shall make payments for services that are:

(1) Received from non-participating providers;

(2) Provided outside their service areas; or

(3) Not covered under the terms of their group contracts or evidence of coverage.

Section 15. Initial Net Worth and Capital Requirements

A. Before the commissioner issues a certificate of authority in accordance with Section 6 of this Act, an applicant seeking to establish or operate a health maintenance organization shall have the greater of:

(1) The amount of capital required under [insert reference in state law equivalent to the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)];

(2) An initial net worth of $3,000,000; or

(3) At the commissioner's discretion, an amount greater than required under Paragraph (1) or (2), as indicated by a business plan and a projected risk-based capital calculation after the first full year of operation based on the most current NAIC Health Annual Statement Blank.

Section 16. Ongoing Net Worth and Capital Requirements

A. A health maintenance organization shall maintain minimum net worth equal to the greater of $2,500,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)].

B. The amount in Subsection A may be adjusted annually for inflation, at the commissioner's discretion.

Drafting Note: The following definition of "managed hospital payment basis" and formulation for ongoing net worth, based on the 1989 amended version of HMO Model Act, have been included for the benefit of states that have not adopted the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315):

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services. Examples of managed hospital payment basis agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and a health maintenance organization and which are under common ownership or control.

C. A health maintenance organization shall maintain a minimum net worth equal to the greater of $2,500,000; or an amount equal to the sum of:

(1) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Section 17. Deposit Requirements

A. Unless otherwise provided in this section, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a market value of not less than $1,000,000.

B. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

C. All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.

D. The deposit shall be used to protect the interests of the health maintenance organization's covered persons and to assure continuation of health care services to covered persons of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a rehabilitation, receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

E. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all covered persons, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Section 18. Hold Harmless Provision Requirements for Covered Persons

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect

a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

> "Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons."

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general's office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 19. Investment Powers

With the exception of investments made in accordance with Section 7A(1) of this Act, the investment practices of a health maintenance organization shall be governed by [insert reference to state law equivalent to the NAIC *Health Maintenance Organization Investment Guidelines*].

Section 20. Accounting Practices

Every health maintenance organization shall maintain its financial records in accordance with [insert reference to state law equivalent to NAIC *Accounting Practices and Procedures Manual*].

Section 21. Fiduciary Responsibilities

A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the health maintenance organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees and officers, directors and partners in an amount not less than $1,000,000 for each health maintenance organization or a maximum of $10,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the commissioner.

Drafting Note: As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 22. Annual and Quarterly Financial Statement Filing Requirements

A. (1) Every health maintenance organization shall file annual and quarterly financial statements, as provided in Paragraph (2), with the commissioner and with the National Association of Insurance Commissioners (NAIC).

(2) The annual statement shall be filed by March 1 for the preceding year and a quarterly financial statement by May, August and November 15 for the preceding quarter.

B. The annual and quarterly financial statements shall be prepared on the most current NAIC Health Annual Statement Blank in accordance with the NAIC Annual Statement Instructions and the NAIC *Accounting Practices and Procedures Manual*.

Section 23. Reporting Requirements

A. (1) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year. The report shall be on forms prescribed by the commissioner.

(2) In addition, the health maintenance organization shall file by March 1, unless otherwise stated:

(a) Audited financial statements on or before June 1;

(b) A list of participating providers in a form approved by the commissioner; and

(c) (i) A description of the grievance procedures; and

(ii) The total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. (1) Unless otherwise provided in this Act, a health maintenance organization shall file notice with the commissioner within thirty (30) days of the effective date of a change, describing any material modifications to the documents required to be filed with the application for a certificate of authority as set forth in Section 5B(1) and (2) of this Act.

(2) Unless otherwise provided in this Act, a health maintenance organization shall file with the commissioner advance notice, or if advance notice is not practicable, notice filed as soon as possible, but in no event more than thirty (30) days after the effective date of a change, describing any material

modifications to the health maintenance organization's operations as set forth in the information required by Section 5B of this Act that affects any of the following:

(a) The solvency of the health maintenance organization;

(b) The health maintenance organization's continued provision of health care services that it has contracted to provide;

(c) The manner in which the health maintenance organization conducts its business; or

(d) Any other matters the commissioner may prescribe by regulation.

C. The commissioner may require additional reports as necessary to carry out the commissioner's duties under this Act.

Section 24. Powers of Insurers and [Hospital and Medical Service Corporations]

A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law, which may be inconsistent, any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care services by a health maintenance organization owned or operated by an insurer or its subsidiary.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The covered persons of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Section 25. Examinations

A. The commissioner may make an examination of the affairs of a health maintenance organization, providers and risk bearing entities with which the health maintenance organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every five (5) years.

B. An examination conducted under this section shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC *Model Law on Examinations*].

C. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner.

D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state provided that the provisions of [insert state law equivalent to Section 3C of the NAIC *Model Law on Examinations*] are satisfied.

Section 26. Suspension or Revocation of Certificate of Authority

A. A certificate of authority issued under this Act may be suspended or revoked, and an application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 5 of this Act, unless amendments to those submissions have been filed with

and approved by the commissioner;

(2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 9 of this Act;

(3) The health maintenance organization does not provide or arrange for basic health care services;

(4) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to covered persons or prospective covered persons;

(6) The health maintenance organization has failed to correct any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

Drafting Note: States that have not adopted *Risk Based Capital (RBC) for Health Organizations Model Act* (#315) should consider including a provision that provides for early warning and correction of insufficient net worth by a health maintenance organization.

(7) The health maintenance organization has failed to implement internal grievance procedures in compliance with [insert reference to state law equivalent to the *Health Carrier Grievance Procedure Model Act* (#72)];

(8) The health maintenance organization has failed to implement the external review procedures required by [insert reference to state law equivalent to the *Health Carrier External Review Model Act* (#75)];

Drafting Note: States that have adopted Options 1 or 2 of the NAIC *Health Carrier External Review Model Act* (#75) should not adopt this provision.

(9) The health maintenance organization, or any person acting on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(10) The continued operation of the health maintenance organization would be hazardous to its covered persons;

(11) The health maintenance organization has otherwise failed substantially to comply with this Act or any regulation adopted pursuant to this Act; or

(12) The health maintenance organization or applicant has violated any other provision of the state insurance code.

Drafting Note: States that have adopted an Administrative Procedures Act should adopt Option A. States that have not adopted an Administrative Procedures Act should adopt Option B.

Option A.

B. The provisions of the [insert reference to state Administrative Procedure Act] of this state shall apply to proceedings under this section.

Option B.

B. (1) Suspension or revocation of a certificate of authority or the denial of an application pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) day period.

(2) If the health maintenance organization or applicant requests a hearing pursuant to this subsection the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:

(a) A specific time for the hearing, which may not be less than twenty (20) days nor more than thirty (30) days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization's or applicant's principal place of business is located.

C. (1) With respect to individual contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall not:

(a) Enroll any additional covered persons except newborn children or other newly acquired dependents of existing covered persons; and

(b) Engage in any advertising or solicitation.

(2) With respect to group contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall enroll additional enrollees and their eligible dependents and newly acquired eligible dependents of existing enrollees, including individuals who become newly acquired eligible dependents of an enrollee through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan.

Drafting Note: Under Section 2701(f) of the Public Health Service Act, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the group market, health maintenance organizations are required during special enrollment periods to enroll individual eligible employees and dependents of eligible employees and newly acquired dependents of already enrolled eligible employees, including individuals who become dependents through marriage, birth or adoption or placement for adoption. The language in Paragraph (2) is intended to reflect this requirement.

D. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit further operation of the organization found to be in the best interest of covered persons, to the end that covered persons will be afforded the greatest practical opportunity to obtain continuing health care coverage.

E. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

Section 27. Summary Orders and Supervision

A. Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to covered persons, creditors, or the general public, or that it has violated any provision of this Act, the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take other steps the commissioner may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this Act.

C. The commissioner is authorized to adopt regulations to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to covered persons, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the purposes expressed in Subsection A.

D. The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of [insert reference to state law equivalent to Section 10 of the NAIC *Rehabilitation and Liquidation Model Act*].

Section 28. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

A. A rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in [insert reference to state rehabilitation law], or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the covered persons or to the people of this state. Covered persons shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For purpose of determining the priority of distribution of general assets, claims of covered persons shall have the same priority as established in [insert reference to state law relating to liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If a covered person is liable to a provider for services provided pursuant to and covered by the health benefit plan, that liability shall have the status of a covered person claim for distribution of general assets. A provider who is obligated by statute or agreement to hold covered persons harmless from liability for services provided pursuant to and covered by a health benefit plan shall have a priority of distribution of the general assets immediately following that of covered persons as described herein, and immediately preceding the priority of distribution described in [insert reference to state liquidation procedures].

Section 29. Penalties and Enforcement

A. In addition to or in lieu of suspension or revocation of a certificate of authority or the denial of an application pursuant to Section 26 of this Act, the applicant or the health maintenance organization may be subjected to an administrative penalty of up to $[insert number] for each cause for suspension or revocation or application denial.

B. (1) If the commissioner shall for any reason have cause to believe that a violation of this Act has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this Act are satisfied.

C. Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act or fails to correct its net worth to bring it into compliance with the requirements of this Act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its covered persons.

Drafting Note: In addition to the actions provided in this section that a commissioner may use to enforce a health maintenance organization's compliance with the provisions of this Act, some states may authorize the commissioner to issue an order to a health maintenance organization or a representative of the health maintenance organization to cease and desist from engaging in an act or practice that is violation of this Act. In addition, the commissioner may also be authorized to institute an action seeking to obtain injunctive or other relief if the health maintenance organization fails to comply with the order to cease and desist. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 30. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The rules and regulations shall be subject to review in accordance with [insert reference to state law relating to administrative rulemaking and review of rules].

Section 31. Statutory Construction and Relationship to Other Laws

A. Except as otherwise provided in this Act or in other laws expressly referring to health maintenance organizations, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health care professionals.

C. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [insert reference to state law relating to the practice of medicine].

Section 32. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 23 of this Act, and any other information that is considered privileged or confidential under state or federal law.

Section 33. Insurance Holding Company System Regulatory Act

All health maintenance organizations shall meet the requirements of [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act* (#440)].

Drafting Note: States that have not included health maintenance organizations within the scope of their state law equivalent to the NAIC *Insurance Holding Company System Regulatory Act* (#440) should not adopt this section.

Section 34. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 35. Effective Date

This Act shall be effective [insert date].

APPENDIX A

Former Section 3HH, Section 14 and Section 20

Below are the sections deleted to reconcile the provisions of this model with the 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations as members of the guaranty association.

Section 3HH. Definition of Uncovered Expenditures

"Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization's insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements to assure that benefits are continued as specified above.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization's outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value exceeds the amount of the required deposit; or

(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
1973 Proc. II 139 (synopsis of model).
1974 Proc. I 12, 14, 405, 413 (amended).
1982 Proc. I 19, 28, 431, 498-499, 530-554 (amended and reprinted).
1989 Proc. I 9, 22, 180-181, 327, 331-335 (amended).
1989 Proc. II 13, 25-26, 40, 51-79 (amended and reprinted).
1990 Proc. I 6, 26, 171, 374-376, 377-379 (amended).
1991 Proc. I 9, 19-20, 86, 108 (technical amendment).
2002 Proc. 4th Quarter 278, 285-317 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 16 (adopted by Plenary).
Fall 2020 (amended).

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-21A-1 to 27-21A-32 (1986).	
Alaska		ALASKA STAT. §§ 21.86.010 to 21.86.900 (1990/2011).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1079 (1973/1990) (Health Care Service Organizations).	
Arkansas	ARK. CODE ANN. §§ 23-76-101 to 23-76-132 (1975/2013).		
California			CAL. HEALTH & SAFETY CODE §§ 1340 to 1399.64 (1979/2009) (Knox-Keene Health Care Services Plan).
Colorado		COLO. REV. STAT. §§ 10-16-401 to 10-16-429 (1992/2013).	3 COLO. CODE REGS. § 702-4:4-7-1 (1999/2012).
Connecticut			CONN. GEN. STAT. §§ 38a-175to 38a-194 (1971/2017) (Health Care Centers).

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware			DEL. CODE ANN. tit. 18, §§ 6401 to 6420 (1987).
District of Columbia		D.C. CODE §§ 31-3401 to 31-3431 (1996/2004); D.C. MUN. REGS. tit. 26, §§ 3500 to 3599 (1999).	
Florida			FLA. STAT. §§ 641.17 to 641.3923 (1985/2013) (point of service).
Georgia		GA. CODE ANN. §§ 33-21-1 to 33-21-29 (1979/1986).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 432D-1 to 432D-24 (1996/2015).	
Idaho			IDAHO CODE ANN. §§ 41-3901 to 41-3932 (1974/1998).
Illinois			215 ILL. COMP. STAT. 125/1-2 to 125/5-10 (1974/2014) (point of service).
Indiana		IND. CODE §§ 27-13-1-1 to 27-13-33-2 (1994/2003).	IND. ADMIN. CODE tit. 760, §§ 1-70-1 to 1-70-8 (2005) (in case of receivership).
Iowa		IOWA CODE §§ 514B.1 to 514B.33 (1973/2009).	IOWA CODE § 514C.13 (1997) (point of service).
Kansas		KAN. STAT. ANN. §§ 40-3201 to 40-3236 (1974/2000).	
Kentucky			KY. REV. STAT. ANN. §§ 304.38-010 to 304.38-230 (1982/2004).
Louisiana		LA. REV. STAT. ANN. §§ 22:241 to 22:272 (2009/2010).	

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4201 to 4260 (1975/2001).	ME. REV. STAT. ANN. tit. 24-A, § 4202-A (1991); § 4204-A (1989); § 4207-A (1992) (point of service).
Maryland			MD. CODE REGS. § 31.12.06 (1997).
Massachusetts			MASS. GEN. LAWS ch. 176G, §§ 1 to 33 (1976/2013).
Michigan			MICH. COMP. LAWS §§ 500.3501 to 500.3573 (2000/2002).
Minnesota		MINN. STAT. §§ 62D.01 to 62D.30 (1973/2013).	MINN. STAT. §§ 62Q.51 (1996) (point of service).
Mississippi		MISS. CODE ANN. §§ 83-41-301 to 83-41-365 (1995).	
Missouri		MO. REV. STAT. §§ 354.400 to 354.551 (1983/2013).	
Montana		MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987/2011).	
Nebraska		NEB. REV. STAT. §§ 44-3292 to 44-32,180 (1990).	
Nevada			NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/2013).
New Hampshire			N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:25 (1977/2011) (point of service).
New Jersey		N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973) (Dept. of Health).	

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico		N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-32 (1985/1994).	
New York			N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976/2013).
North Carolina		N.C. GEN. STAT. §§ 58-67-1 to 58-67-185 (1979/2003).	11 N.C. ADMIN. CODE §§ 1401 to 1403 (1994) (point of service).
North Dakota		N.D. CENT. CODE §§ 26.1-18.1-01 to 26.1-18.1-25 (1993/2005).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. §§ 1751.01 to 1751.89 (1999/2014).	
Oklahoma		OKLA. STAT. tit. 36, §§ 6901 to 6936 (2003/2005).	
Oregon			OR. REV. STAT. §§ 750.003 to 750.065 (1985/2014).
Pennsylvania			40 PA. STAT. ANN. §§ 1551 to 1567 (1981); 31 PA. CODE §§ 301.201 to 301.204 (statement of policy on point of service).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1901 to 1928 (2003).
Rhode Island		R.I. GEN. LAWS §§ 27-41-1 to 27-41-35 (1983/2005).	
South Carolina		S.C. CODE ANN. §§ 38-33-10 to 38-33-310 (1988/2000).	
South Dakota			S.D. CODIFIED LAWS §§ 58-41-1 to 58-41-97 (1974/2014).

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee		TENN. CODE ANN. §§ 56-32-101 to 56-32-138 (1986/2013).	
Texas		TEX. INS. CODE ANN. §§ 843.001 to 843.464 (2003/2005).	
Utah			UTAH CODE ANN. §§ 31A-8-101 to 31A-8-408 (1986/2014) (point of service); UTAH ADMIN. CODE r. 590-76 (2009).
Vermont		VT. STAT. ANN. tit. 8, §§ 5101 to 5115 (1979/2014).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		VA. CODE ANN. §§ 38.2-4300 to 38.2-4321 (1986/2013).	VA. CODE ANN. § 38.2-3407.12 (1998/2014) (point of service); § 38.2-1016.1 (2007); 14 VA. ADMIN. CODE 5-211-10 (2011).
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.930 (1975/2013).	
West Virginia		W. VA. CODE §§ 33-25A-1 to 33-25A-35 (1977/2013).	
Wisconsin			WIS. STAT. §§ 609.91 to 609.98 (1985/1989); § 628.36 (authority to make rules for HMOs); WIS. ADMIN. CODE INS. §§ 9.02 to 9.15 (2000/2002) (financial standards); §§ 9.30 to 9.42 (2000/2001) (market conduct standards).
Wyoming		WYO. STAT. ANN. §§ 26-34-101 to 26-34-135 (1986/2004).	

PROJECT HISTORY - 2020

HEALTH MAINTENANCE ORGANIZATION MODEL ACT (#430)

1. Description of the Project, Issues Addressed, etc.

In May 2018, the Health Insurance and Managed Care (B) Committee received a referral from the Receivership and Insolvency (E) Task Force. The Task Force requested the Committee to review all NAIC models involving health maintenance organizations (HMOs) to determine if conforming changes are needed to provide options for the states that have adopted or are adopting the 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), which added HMOs as members of the life and health insurance guaranty association.

In June 2018, the Committee decided to accept the referral from Receivership and Insolvency (E) Task Force to review relevant HMO NAIC models to determine if revisions need to be made for consistency with the 2017 revisions to Model #520. The Committee directed the Regulatory Framework (B) Task Force to conduct this review and report back to the Committee with any recommendations. At the 2018 Summer National Meeting, the Regulatory Framework (B) Task Force formed a new subgroup, the Health Maintenance Organization (HMO) Issues (B) Subgroup, to carry out this work. Kentucky volunteered to chair the Subgroup.

To assist the Subgroup in carrying out its work, NAIC staff reviewed several NAIC models having the most potential for being affected by the Model #520 revisions, including the *Health Maintenance Organization Model Act* (#430). NAIC staff recommended that the Subgroup review the following Model #430 provisions to develop its recommendations to the Committee regarding any potential revisions because of the Model #520 revisions:

- Section 3—Definitions, specifically the definition of "uncovered expenditures" in Section 3HH.
- Section 5—Establishment of Health Maintenance Organizations, specifically the provisions in Option B: Section 5B(16).
- Section 14—Continuation of Benefits.
- Section 18—Deposit Requirements.
- Section 19—Hold Harmless Provision Requirements for Covered Persons.
- Section 20—Uncovered Expenditures Deposit.
- Section 21—Open Enrollment and Replacement Coverage in Event of Insolvency.
- Section 31—Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations.

The Subgroup met Oct. 18, 2018, and Nov. 1, 2018, via conference call to discuss whether it was necessary to revise Model #430 and if so, the scope of the potential revisions, such as revising Model #430 narrowly to address any inconsistencies with the revised Model #520 or revising Model #430 more broadly to include other revisions not related to the revised Model #520. The Subgroup recommended to the Regulatory Framework (B) Task Force that Model #430 be opened for revision, but the Subgroup decided to defer to the Task Force the scope of the revisions.

The Regulatory Framework (B) Task Force presented the Subgroup's recommendation to the Committee. The Committee accepted the Task Force's recommendation to open Model #430 to address any conflicts and inconsistencies with the 2017 revisions to Model #520 during its Feb. 14, 2019, meeting. During its Feb. 26, 2019, meeting, the Task Force directed the Subgroup to move forward with developing and adopting a 2019 charge to revise Model #430 and pursue adoption of a Request for NAIC Model Law Development to revise Model #430. Virginia volunteered to chair the Subgroup to complete its work to revise Model #430 to address any conflicts and inconsistencies with the 2017 revisions to Model #520.

During its April 29, 2019, meeting, the Subgroup adopted its 2019 charge to revise Model #430 to revise provisions in Model #430 to address conflicts and redundancies with the provisions in Model #520. The Subgroup also developed a Request for NAIC Model Law Development to revise Model #430 consistent with its charge. The Regulatory Framework (B) Task Force adopted the Subgroup's 2019 charge and its Request for NAIC Model Law Development May 15, 2019. The Committee adopted the Task Force's 2019 revised charges and the Request for NAIC Model Law Development in June 2019. The Executive (EX) Committee adopted the Request for NAIC Model Law Development at the 2019 Summer National Meeting.

The Subgroup met May 16, 2019, and June 24, 2019 via conference call to discuss its next steps for moving forward while waiting for adoption of its Request for NAIC Model Law Development. The Subgroup requested comments from stakeholders. The Subgroup met Sept. 16, 2019, and Nov. 21, 2019, via conference call to discuss proposals from the Virginia Insurance Bureau and the Maine Department of Insurance (DOI) for revising Model #430 consistent with its charge. The Subgroup decided to use the Maine DOI approach.

In late December 2019, the Subgroup exposed a draft for a public comment period ending March 18, 2020. The Subgroup discussed the comments received on the draft June 11, 2020, via conference call. The Subgroup decided to accept some of the suggested revisions and exposed a revised draft for comment. The Subgroup adopted the revised draft July 13, 2020, via conference call. The Regulatory Framework (B) Task Force adopted the proposed revisions to Model #430 Sept. 24, 2020, via conference call. The Committee adopted the revisions Nov. 2, 2020, via conference call.

The revisions delete several provisions in Model #430 to reconcile it with the 2017 revisions to Model #520. The deleted provisions include Section 14—Continuation of Benefits, Section 20—Uncovered Expenditures Deposit and Section 3HH, the definition of "uncovered expenditures." For states that do not intend to adopt the 2017 revisions to Model #520, for reference, a new appendix to the model includes these deleted provisions. The Subgroup also deleted Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because the section's provisions are obsolete due to the federal Affordable Care Act (ACA).

2. Name of Group Responsible for Drafting the Model and States Participating

The Health Maintenance Organization (HMO) Issues (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed revisions to Model #430. The members of the Subgroup were: Colorado, Florida, Illinois, Kentucky, Maine, Missouri, Nebraska, Virginia, Washington, West Virginia and Wisconsin. Kentucky chaired the Subgroup in 2018. Virginia chaired the group in 2019 and 2020.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force established the Health Maintenance Organization (HMO) Issues (B) Subgroup in 2019 to carry out the charge below:

"Revise provisions in the *Health Maintenance Organization Model Act* (#430) to address conflicts and redundancies with provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520)."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2019 and ending in July 2020, the Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and guaranty association representatives. Each draft of proposed revisions was posted to the Subgroup's web page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call in open meetings throughout the drafting process.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2019 and ending in July 2020, the Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and guaranty association representatives. Each draft of proposed revisions was posted to the Subgroup's web page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call in open meetings throughout the drafting process.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

There were no significant items of controversy raised during the drafting process. However, the Subgroup extensively discussed what approach to take to revising Model #430 given that some states will not adopt the 2017 revisions to Model #520 and preserving those sections removed from Model #430 for those states. The Subgroup considered a few options, including: 1) retaining the sections that needed to be deleted to reconcile Model #430 with Model #520 and add explanatory drafting notes; or 2) deleting the necessary sections and adding explanatory drafting notes. The Subgroup decided the best approach to address this issue was to delete the section and include the deleted sections in a new appendix to Model #430.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2003

HEALTH MAINTENANCE ORGANIZATION MODEL ACT (#430)

1. Description of the project, issues addressed, etc.

This model act was revised to take into account changes in the marketplace since the Health Maintenance Organization Model Act was adopted by the NAIC in 1984. Revisions were made to the existing reporting requirements and solvency provisions in the model act. The model act was revised to reference other existing NAIC model acts where appropriate, rather than include duplicate sections. In addition, a new section was added for the registration of downstream risk arrangements.

2. Name of group responsible for draft the model:

Managed Care Organization Working Group of the Regulatory Framework (B) Task Force.

States Participating:

Kathy Greenlee, Chair	Kansas
Kenney Shipley	Florida
Joan Krosch	Idaho
Bill McAndrew	Illinois
Richard O'Shee	Louisiana
Manuel Montelongo	Nebraska
Alexander Feldvebel	New Hampshire
Ed Unger	New Jersey
Guy Perkins	Nevada
Barbara Morales Burke	North Carolina
David Fogarty	Ohio
Randy Moses	South Dakota
Fred Nepple	Wisconsin
Bob Wright	Virginia

3. Project authorized by what charge and date first given to the group:

The Special Ad Hoc Committee on HMO Insolvency (HMO Insolvency Committee), formed at the 1999 Summer National Meeting, had its final meeting at the 1999 Winter National Meeting. The charge of the HMO Insolvency Committee was to evaluate the adequacy of current solvency and consumer protection measures with regard to managed care organizations. The HMO Insolvency Committee was intended to be short-lived, and the final recommendations included suggesting charges for the Health Insurance and Managed Care (B) Committee related to consumer protection and managed care solvency.

At the 1999 Winter National Meeting, the B Committee delegated the task of revising the HMO Model Act to the Regulatory Framework Task Force and the task force formed the Managed Care Organization Working Group. The following charges were given to the Managed Care Organization Working Group:

Study the issue of risk sharing arrangements and the implications of downstream risk assumption in particular, including the effects of an insolvency of an entity assuming downstream risk. Make recommendations as appropriate. Report by Winter 2001 National Meeting.

Update and revise the Health Maintenance Organization Model Act as appropriate, paying particular attention to strengthening solvency standards and insolvency protections for managed care organizations. Report by Winter National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions were drafted by the working group. Numerous interested parties participated, including industry representatives, such as the American Association of Health Plans (AAHP), the Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association (BCBSA), the EOSHealth. Inc., Kaiser Permanente, and the Group

Health Cooperative of Puget Sound, and consumer representatives, such as AARP, National Partnership for Women and Families; and other interested parties, such as the National Committee for Quality Assurance (NCQA) and the federal government through the Centers for Medicare and Medicaid Services (CMS).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There have been more than fifteen drafts of revisions to the model since the project began in 2000. Each draft was circulated for comment to interested parties prior to discuss at NAIC quarterly meetings. In addition, all drafts of the proposed model were posted on the NAIC web site. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the working group.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

The most significant issue that arose during the drafting of revisions to the model act concerned the extent to which the model should regulate entities assuming downstream risk. The working group heard presentations on the issue, reviewed how other states have addressed the issue, and consulted the National Association of Managed Care Regulators White Paper on Downstream Risk. The working group decided not to license risk bearing entities, but to create a registration requirement, placing the responsibility for monitoring the continuing financial health of the risk bearing entity on the health maintenance organization. The model act includes requirements for the exchange of information among the health maintenance organization, the risk bearing entity and the regulator.

Another significant issue that arose during the drafting of revisions to the model act concerned whether it was appropriate to exempt staff and group model HMOs from the requirements on downstream risk. Because there is mutual exclusivity between a provider group and the health plan in group and staff model HMOs, the financial health of both are deeply intertwined. Several states and the Health Organizations Risk Based Capital (HORBC) Model Act contemplate special treatment for these Kaiser-type plans. The working group agreed to include an exemption for entities similar to that contained the HORBC Model Act.

7. Any other important information (e.g., amending an accreditation standard).

None.

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

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PREAMBLE

In 1989 the NAIC adopted a significantly revised version of the Model HMO Act. In order to reflect those changes, the NAIC model HMO regulations have been revised to incorporate language that compliments the revised model act, and to delete provisions that are no longer supported by the model. The range of issues for which various states have regulations continue to exceed the regulatory requirements that are common to the majority of states. Further, the range of issues appears to exceed the range of topics specifically addressed in the NAIC model act. This is due, in part, to the rapid evolution of the HMO industry over the past several years coupled with the rapid shift to a more business-oriented environment.

Authorities created by statute vary substantially from state to state and even though it is likely that no single state currently addresses all of the topics presented in this regulation, it was the consensus of the committee that the purview of the model regulation be broad enough to address the entire range of topics that have been identified, rather than remaining silent on certain issues on the basis of uncertainty of jurisdiction in individual states. Because of the variation of authorities that exist, it is incumbent on individual states to ascertain the limits of that authority in the application of the model regulation. Each state will thus be required to limit application of the model regulation, or seek appropriate statutory authority where authority does not appear to presently exist.

Section 1. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite section of law enacting the state Health Maintenance Organization Act and any other appropriate sections of law regarding the authority to issue or promulgate rules and regulations vested in the commissioner and the Commissioner of Health where applicable].

Section 2. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the state Health Maintenance Organization Act] to assure the availability, accessibility and quality of services provided by health maintenance organizations (HMOs) and to provide reasonable standards for terms and provisions contained in HMO group and individual contracts and evidences of coverage.

Section 3. Applicability and Scope

This regulation shall apply to all HMOs that are required to obtain a certificate of authority in this state. In the event of conflict between the provisions of this regulation and the provisions of any other regulation issued by the commissioner, the provisions of this regulation shall be controlling as to HMOs.

Section 4. Effective Date

A. This regulation shall be effective on [insert date].

B. All group and individual contracts written or issued on or after [use a date six months from the effective date of these regulations] shall conform with the provisions of these regulations. [Give specific citations to clarify that this includes the entire set of regulations and not just this section.]

C. No group or individual contract or evidence of coverage shall be reissued, renewed, amended or extended in this state on or after [date in Subsection A above] unless it complies with this regulation. A group or individual contract or evidence of coverage approved before [date from Subsection A] shall be deemed to be reissued, renewed, amended or extended on the date the health maintenance organization changes the terms of the group or individual contract or evidence of coverage or adjusts the premiums charged. A group or individual contract or evidence of coverage shall comply with this regulation when amended but in no event later than twelve (12) months after the effective date of this regulation.

Section 5. Definitions

A group or individual contract or evidence of coverage delivered or issued for delivery to any person in this state by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below. The definitions shall comply with the requirements of this section. Definitions other than those set forth in this regulation may be used as appropriate providing that they do not contradict these requirements. All definitions used in the group or individual contract and evidence of coverage shall be in alphabetical order. As used in this regulation and as used in the group or individual contract and evidence of coverage:

A. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

B. "Copayment" means the amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

C. "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the HMO begins to pay the costs or provide the services associated with treatment.

D. "Eligible dependent" means a member of a subscriber's family who meets the eligibility requirements set forth in Section 6B of this regulation.

E. "Emergency care services" means:

(1) Within the service area: covered health care services rendered by affiliated or non-affiliated providers under unforeseen conditions that require immediate medical attention. Emergency care services within the service area shall include covered health care services from non-affiliated providers only when delay in receiving care from the HMO could reasonably be expected to cause severe jeopardy to the enrollee's condition.

(2) Outside the service area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the HMO's service area.

F. "Enrollee" means an individual who is covered by an HMO.

G. "Evidence of coverage" means a statement of the essential features and services of the HMO coverage that is given to the subscriber by the HMO or by the group contract holder.

H. "Extension of benefits" means the continuation of coverage of a particular benefit provided under a group or individual contract following termination with respect to an enrollee who is totally disabled on the date of termination.

I. "Grievance" means a written complaint submitted in accordance with the HMO's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the HMO relative to the enrollee.

J. "Group contract" means a contract for health care services which by its terms limits eligibility to enrollees of a specified group. The group contract may include coverage for dependents.

K. "Group contract holder" means the person to which a group contract has been issued.

L. "Health maintenance organization" or "HMO" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and deductibles.

M. "Hospital" means a duly licensed institution that provides general and specialized inpatient medical care. The term "hospital" shall not include a convalescent facility, nursing home, or an institution or part of an institution that is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

N. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

O. "Medical necessity" or "medically necessary" means appropriate and necessary services as determined by a provider affiliated with the HMO that are rendered to an enrollee for a condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience. This does not preclude the HMO from establishing standards by which providers make their decisions as to what is medically necessary or from penalizing providers for failure to meet these standards.In the case of emergency medical services, the HMO has the right to make the final determination of whether services should be covered.

Drafting Note: This definition gives the provider the authority to determine what is medically necessary.

P. "Non-basic health care services" means health care services, other than basic health care services, that may be provided in the absence of basic health care services.

Q. "Out-of-area services" means the health care services that an HMO covers when its enrollees are outside of the service area.

R. "Participating provider" means a provider as defined in Subsection U below who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the HMO.

S. "Physician" means a licensed doctor of medicine or osteopathy practicing within the scope of the license.

T. "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, and who initiates their referral for specialist care and maintains continuity of patient care.

U. "Provider" means a physician, hospital or other person licensed or otherwise authorized to furnish health care services.

V. "Replacement coverage" means the benefits provided by a succeeding carrier.

W. "Service area" means the geographical area as approved by the commissioner within which the HMO provides or arranges for health care services that are available and accessible to enrollees.

X. "Skilled nursing facility" means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed physician.

Y. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

Z. "Supplemental health care services" means any health care services that are provided in addition to basic health care services.

Section 6. Requirements for Contracts and Evidence of Coverage

Each subscriber shall be entitled to receive an individual contract or evidence of coverage in a form that has been approved by the commissioner. Each group contract holder shall be entitled to receive a group contract as approved by the commissioner. Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to subscribers or group contract holders within a reasonable time after enrollment, but not more than fifteen (15) days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment.

A. Health Maintenance Organization Information. The group or individual contract and evidence of coverage shall contain the name, address and telephone number of the HMO, and where and in what manner information is available as to how services may be obtained. A telephone number within the service area for calls, without charge to members, to the health maintenance organization's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for enrollee services, problems or questions. An HMO shall provide a method by which the enrollee may contact the HMO, at no cost to the enrollee. This may be done through the use of toll-free or collect telephone calls, etc. The enrollee shall be informed of the method by notice in the handbook, newsletter or flyer. The group or individual contract or evidence of coverage may indicate the manner in which the number will be disseminated rather than list the number itself.

B. Eligibility Requirements

(1) The group or individual contract and evidence of coverage shall contain eligibility requirements indicating the conditions that shall be met to enroll as a subscriber or eligible dependent, the limiting age for subscribers and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children.

(2) A group or individual contract or evidence of coverage shall not contain a provision excluding or limiting coverage for a newborn child. Medically diagnosed congenital defects and birth abnormalities shall be treated the same as any other illness or injury for which coverage is provided. The group or individual contract and evidence of coverage may require that notification of birth of a newborn child and payment of any required premium shall be furnished to the HMO within thirty-one (31) days after the date of birth in order to have coverage continue beyond the thirty-one-day period. The HMO is entitled to premium for the first thirty-one (31) days of coverage, unless the coverage is rejected by the subscriber prior to the birth of the child.

Drafting Note: Although state laws vary as to coverage for eligible dependents and newborns, many states require coverage; therefore suggested provisions have been included. If a state does not have authority in these areas, only the first paragraph should be included when adopting this regulation.

(3) The definition of an eligible dependent shall include:

(a) The spouse of the subscriber; and

(b) An unmarried dependent child of the subscriber who:

(i) Has not reached age [insert age]; or

(ii) Has reached [insert age] through [insert age] who is attending a recognized college or university, trade or secondary school on a full-time basis; or

(iii) Has reached age [insert age] but who is incapable of self-support because of mental retardation, mental illness or physical incapacity which began before the child reached age [insert age], and who is chiefly dependent upon the subscriber for support and maintenance.

Drafting Note: Paragraph (3) is an optional provision that may be used to define eligible dependents, if the state has that authority.

(4) The definition of a dependent child of a subscriber shall include a child who:

(a) Is related to the subscriber as a natural child, a legally adopted child or a stepchild; or

(b) Resides in the subscriber's household and who qualifies as a dependent of the subscriber or the subscriber's spouse under the U.S. Internal Revenue Code and the federal tax regulations; or

(c) Is eligible by virtue of a court order making the subscriber responsible for health care services for the dependent child.

Drafting Note: Paragraph (4) is an optional provision that may be used to define the dependent child of a subscriber.

C. Benefits and Services within the Service Area. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available within the service area.

D. Emergency Care Benefits and Services. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies twenty-four (24) hours a day, seven (7) days a week, including disclosure of any restrictions on emergency care services. No group or individual contract or evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

E. Out of Area Benefits and Services. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area.

F. Copayments and Deductibles. The group or individual contract and evidence of coverage shall contain a description of any copayments or deductibles that must be paid by enrollees.

G. Limitations and Exclusions. The group or individual contract and evidence of coverage shall contain a description of any limitations or exclusions on the services, kind of services, benefits or kind of benefits including any limitations or exclusions due to preexisting conditions, waiting periods or an enrollee's refusal of treatment.

H. Enrollee Termination

(1) An HMO shall not cancel or terminate coverage of services provided an enrollee under an HMO group or individual contract except for one or more of the following reasons:

(a) Failure to pay the amounts due under the group or individual contract;

(b) Fraud or material misrepresentation in enrollment or in the use of services or facilities;

(c) Material violation of the terms of the group or individual contract;

(d) Failure to meet the eligibility requirements under a group contract;

(e) Termination of the group contract under which the enrollee was covered;

(f) Failure of the enrollee and the primary care physician to establish a satisfactory patient-physician relationship if:

(i) It is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative primary care physician;

(ii) The enrollee has repeatedly refused to follow the plan of treatment ordered by the physician; and

(iii) The enrollee is notified in writing at least thirty (30) days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination; or

(g) Other good cause agreed upon in the group or individual contract and approved by the commissioner. However, coverage shall not be cancelled or terminated on the basis of the status of the enrollee's health or because the enrollee has exercised his or her rights under the HMO's grievance procedure by registering a grievance against the HMO.

(2) An HMO shall not cancel or terminate an enrollee's coverage for services provided under an HMO group or individual contract without giving the enrollee at least fifteen (15) days written notice of termination. Notice will be considered given on the date of mailing or, if not mailed, on the date of delivery. This notice shall include the reason for termination. If termination is due to nonpayment of premium, the grace period required in Section 6W of this regulation shall apply. Advance notice of termination shall not be required to be given for termination due to non-payment of premium.

(3) (a) An HMO shall not terminate coverage of a dependent child upon attainment of the limiting age if the child is and continues to be both:

(i) Incapable of self support because of mental retardation, mental illness or physical incapacity, and

(ii) Chiefly dependent upon the subscriber for support and maintenance.

(b) Proof of incapacity and dependency shall be furnished to the HMO by the subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as reasonably required by the HMO.

I. Enrollee Reinstatement. If an HMO permits reinstatement of an enrollee's coverage, the group or individual contract and evidence of coverage shall include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated coverage.

J. Claims Procedures. The group or individual contract and evidence of coverage shall contain procedures for filing claims that include:

(1) Any required notice to the HMO;

(2) If any claim forms are required, how, when and where to obtain and submit them;

(3) Any requirements for filing proper proofs of loss;

(4) Any time limit of payment of claims;

(5) Notice of any provisions for resolving disputed claims, including arbitration; and

(6) A statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

K. Enrollee Grievance Procedures and Arbitration. In compliance with Section 9D of this regulation, the group or individual contract and evidence of coverage shall contain a description of the HMO's method for resolving enrollee grievances, including procedures to be followed by the enrollee in the event any dispute arises under the contract, including any provisions for arbitration.

L. Continuation of Coverage. A group contract and evidence of coverage shall contain a provision that an enrollee who is an inpatient in a hospital or a skilled nursing facility on the date of discontinuance of the group contract shall be covered in accordance with the terms of the group contract until discharged from the hospital or skilled nursing facility. The enrollee may be charged the appropriate premium for coverage that was in effect prior to discontinuance of the group contract.

Drafting Note: Group contracts and evidences of coverage are required to contain a continuation of coverage provision to protect enrollees who are in the hospital or a skilled nursing facility when a contract is discontinued. Requirements concerning medically necessary care, copayments and deductible would still apply.

M. Conversion of Coverage

(1) (a) The group or individual contract and evidence of coverage shall contain a conversion provision that provides that each enrollee has the right to convert coverage to an individual HMO contract in the following circumstances:

(i) Upon termination of eligibility for coverage under a group or individual contract; or

(ii) Upon termination of the group contract.

(b) To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment to the HMO within thirty-one (31) days after the date the enrollee's eligibility for coverage terminates.

(2) A conversion contract shall not be required to be made available if:

(a) The enrollee's termination of coverage occurred for any of the reasons listed in Subsection H(1)(a), (b), (c), (f) or (g);

(b) The enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act (Medicare);

(c) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under state or federal law;

(d) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group;

(e) The enrollee is covered for similar benefits by an individual policy or contract; or

(f) The enrollee has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(3) The conversion contract shall provide basic health care services to its enrollees as a minimum.

(4) The conversion contract shall begin coverage of the enrollee formerly covered under the group or individual contract on the date of termination from the group or individual contract.

(5) Coverage shall be provided without requiring evidence of insurability and shall not impose any preexisting condition limitations or exclusions as described in Section 7A other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of the enrollee's coverage under the prior group or individual contract.

(6) If an HMO does not issue individual or conversion contracts, the HMO may use a non-cancelable group contract to provide coverage for enrollees who are eligible for conversion coverage.

N. Extension of Benefits for Total Disability

(1) Each group contract issued by an HMO shall contain a reasonable extension of benefits upon discontinuance of the group contract with respect to enrollees who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.

(2) Upon payment of premium at the current group rate, coverage shall remain in full force and effect until the first of the following to occur:

(a) The end of a period of 180 days starting with the date of termination of the group contract;

(b) The date the enrollee is no longer totally disabled; or

(c) The date a succeeding carrier provides replacement coverage to that enrollee without limitation as to the disabling condition.

(3) Upon termination of the extension of benefits, the enrollee shall have the right to convert coverage as provided in Subsection M of this section.

O. Coordination of Benefits. The group or individual contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in the jurisdiction. Any provisions or rules for coordination of benefits established by an HMO shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. The HMO shall be required to provide covered health care services first and then, at its option, seek coordination of benefits.

P. Subrogation for Injuries Caused by Third Parties. The group or individual contract and evidence of coverage shall not contain any provisions concerning subrogation for injuries caused by third parties unless the wording has been approved by the commissioner.

Q. Description of the Service Area. The group or individual contract and evidence of coverage shall contain a description of the approved service area.

R. Entire Contract Provision. The group or individual contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the HMO shall be part of the contract unless set forth in full in the contract or attached to it. However, the evidence of coverage may be attached to and made a part of the group contract.

S. Term of Coverage. The group or individual contract and evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage shall also contain the time and date or occurrence upon which coverage will terminate.

T. Cancellation or Termination. The group or individual contract shall contain the conditions upon which cancellation or termination may be effected by the HMO, the group contract holder or the subscriber.

U. Renewal. The group or individual contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

V. Reinstatement of Group or Individual Contract Holder. If an HMO permits reinstatement of a group or individual, the contract and evidence of coverage shall include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated contract.

W. Grace Period

(1) The group or individual contract shall provide for a grace period of not less than thirty (30) days for the payment of any premium except the first, during which time the coverage shall remain in effect if payment is made during the grace period. The evidence of coverage shall include notice that a grace period exists under the group contract and that coverage continues in force during the grace period.

(2) During the grace period:

(a) The HMO shall remain liable for providing the services and benefits contracted for;

(b) The contract holder shall remain liable for the payment of premium for coverage during the grace period; and

(c) The subscriber shall remain liable for any copayments and deductibles.

(3) If the premium is not paid during the grace period, coverage is automatically terminated at the end of the grace period. Following the effective date of termination, the HMO shall deliver written notice of the termination to the contract holder.

X. Conformity with State Law. A group or individual contract and evidence of coverage delivered or issued for delivery in this state shall include a provision that states that any provision not in conformity with [cite section of law that sets forth the state's Health Maintenance Organization Act], this regulation or any other applicable law or regulation in this state shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this state.

Y. Right to Examine Contract. An individual contract shall contain a provision stating that a person who has entered into an individual contract with a health maintenance organization shall be permitted to return the contract within ten (10) days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the HMO or to the agent through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for the person by the HMO during the ten-day examination period and the person returns the contract to receive a refund of the premium paid, the person shall be required to pay for these services.

Section 7. Prohibited Practices

A. Preexisting Conditions

(1) An HMO may include in its individual contract a provision setting forth reasonable exclusions or limitations of services for preexisting conditions at time of enrollment. However, no such exclusions or limitations shall be for a period greater than two (2) years.

(2) An HMO shall not exclude or limit services for a preexisting condition when the enrollee transfers coverage from one individual contract to another or when the enrollee converts coverage under his conversion option, except to the extent of a preexisting condition limitation or exclusion remaining unexpired under the prior contract. Any required probationary or waiting period shall be deemed to have commenced on the effective date of coverage under the prior contract. The HMO contract shall disclose any preexisting condition limitations or exclusions that are applicable when an enrollee transfers from a prior HMO contract.

(3) A preexisting condition shall not be defined more restrictively than the following:

(a) The existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of coverage under the health care plan; or

(b) A condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year period preceding the effective date of coverage under the health care plan.

(4) No group contract or evidence of coverage shall exclude or limit services for a preexisting condition.

B. Unfair Discrimination. An HMO shall not unfairly discriminate against an enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. However, nothing shall prohibit an HMO from setting rates or establishing a schedule of charges in accordance with relevant actuarial data. An HMO shall not expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of the health status or health care needs of the individuals or enrollees.

Section 8. Services

A. Access to Care

(1) An HMO shall establish and maintain adequate arrangements to provide health services for its enrollees, including:

(a) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

(b) Reasonable hours of operation and after-hours services;

(c) Emergency care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week; and

(d) Sufficient providers, personnel, administrators and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

(2) An HMO shall make available to each enrollee a primary care physician and provide accessibility to medically necessary specialists through staffing, contracting or referral. An HMO shall provide for continuity of care for enrollees referred to specialists.

(3) An HMO shall have written procedures governing the availability of services utilized by enrollees, including at least the following:

(a) Well-patient examinations and immunizations;

(b) Emergency telephone consultation on a twenty-four (24) hours per day, seven (7) days per week basis;

(c) Treatment of emergencies;

(d) Treatment of minor illness; and

(e) Treatment of chronic illnesses.

B. Basic Health Care Services. An HMO shall provide, or arrange for the provision of, as a minimum, basic health care service, which shall include the following:

(1) Emergency care services, as defined in Section 5 of this regulation;

(2) Inpatient hospital services, meaning medically necessary hospital services including, but not limited to, room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory and other diagnostic tests; drugs, medications, biologicals, anesthesia and oxygen services; special nursing when medically necessary; physical therapy, radiation therapy and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services;

(3) Inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other providers including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services; and

(4) Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a non-hospital-based health care facility or at a hospital. Outpatient medical services shall include but are not limited to diagnostic services; treatment services; laboratory services; x-ray services; referral services; and physical therapy, radiation therapy and inhalation therapy. Outpatient services shall also include preventive health services, which shall include at least a broad range of voluntary family planning services, services for infertility, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

C. Out-of-Area Services and Benefits

(1) Out-of-area services shall be subject to the same copayment requirements set forth in Section 6F.

(2) When an enrollee is traveling or temporarily residing out of an HMO's service area, an HMO shall provide benefits for reimbursement for emergency care services and transportation that is medically necessary and appropriate under the circumstances to return the enrollee to an HMO provider, subject to the following conditions:

(a) The condition could not reasonably have been foreseen;

(b) The enrollee could not reasonably arrange to return to the service area to receive treatment from the HMO's provider;

(c) The travel or temporary residence must be for some purpose other than the receipt of medical treatments; and

(d) The HMO is notified by telephone within twenty-four (24) hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the HMO in those time limits.

(3) Services received by a enrollee outside of the HMO's service area will be covered only so long as it is unreasonable to return the enrollee to the service area.

D. Supplemental Health Care Services. In addition to the basic health care services required to be provided in Subsection B above, an HMO may offer to its enrollees any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

E. Non-Basic Health Care Services. An HMO may offer non-basic health care services to a group or individual on a prepaid basis, subject to the same conditions as for supplemental health care services, as described in Subsection D above, except that the HMO need not provide basic health care services as a condition to providing non-basic health care services.

Drafting Note: The intent of Subsections D and E above are to permit an HMO to provide coverages that are not basic health care services on either a supplement to basic health care services or on a stand-alone basis. The provisions of Subsection E above are not intended to permit the unbundling of basic health care services or the writing of limited forms of basic health care services on a free-standing basis. Subsection E may not be applicable unless state law permits single service HMOs.

Section 9. Other Requirements

A. Description of Providers

(1) An HMO shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued and upon reenrollment. If a provider is no longer affiliated with an HMO, the HMO shall provide notice of the change to its affected subscribers within thirty (30) days. Subject to the approval of the commissioner, an HMO may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

(2) A list of providers shall contain a notice regarding the availability of the listed primary care physicians. The notice shall be in not less than twelve-point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

> "Enrolling in [name of HMO] does not guarantee services by a particular provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [name of HMO]."

B. Description of the Services Area. An HMO shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the group or individual contract and evidence of coverage is issued and upon request thereafter. If the description of the service area is changed, the HMO shall provide at such time a new description of the service area to its subscribers.

C. Copayments and Deductibles. An HMO may require copayments or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments for basic health care services shall be shown in the group or individual contract and evidence of coverage as a specified dollar amount. Copayments and deductibles shall be the only allowable charge, other than premiums, assessed to subscribers for basic, supplemental and non-basic health care services.

D. Grievance Procedure

(1) A grievance procedure shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written grievances.

(2) An HMO shall provide grievance forms to be given to enrollees who wish to register written grievances. The forms shall include the address and telephone number to which grievances must be directed and shall also specify any required time limits imposed by the HMO.

(3) The grievance procedure shall provide for (i) written acknowledgement of grievances and (ii) grievances to be resolved or to have a final determination of the grievance by the HMO within a reasonable period of time, but not more than ninety (90) days from the date the grievance is received. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance, or (ii) by the mutual written agreement of the HMO and the enrollee.

(4) Prior to the resolution of a grievance filed by a subscriber or enrollee, coverage may not be terminated for any reason that is the subject of the written grievance, except where the HMO has, in good faith, made a reasonable effort to resolve the written grievance through its grievance procedure and coverage is being terminated as provided for in Section 6H.

(5) If enrollee's grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the grievance is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any HMO that makes binding arbitration a condition of enrollment shall fully disclose this requirement to its enrollees in the group or individual contract and evidence of coverage.

Section 10. Penalties

Any violation of this regulation shall be punished as provided for in [cite applicable section of law] and any other applicable law of this state.

Section 11. Severability

If any provision of this regulation or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 21, 22, 24-34 (adopted).
1991 Proc. I 9, 19-20, 86, 109-120 (amended and reprinted).

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-079 (1987/2004).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware			18 DEL. CODE REGS. § 1403 (1988/2003).
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 3500 to 3599 (1999/2003).		
Florida			FLA. ADMIN. CODE ANN. r. 69O-191.021 to 69O-191.300 (1988/2007).

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. COMP. R. & REGS. 120-2-33 (1980/2007).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 50, § 4521 (1976/2014).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-40.1 to 191-40.26 (1974/2003).
Kansas	NO CURRENT ACTIVITY		
Kentucky			806 KY. ADMIN. REGS. 38:010 to 38:080 (1975/1997).
Louisiana	NO CURRENT ACTIVITY		
Maine			02-031 ME. CODE R. ch. 191 (1996).
Maryland			MD. CODE REGS. 31.12.02.01 to 31.12.02.13 (1977/2013); 31.12.03.01 to 31.12.03.03 (1996) (point of service).
Massachusetts			211 MASS. CODE REGS. §§ 43.01 to 43.13 (1996/2010).
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri			MO. CODE REGS. ANN. tit. 20, §§ 400-7.030 to 400-7.095 (1988/2004).
Montana	MONT. ADMIN. R. 6.6.2501 to 6.6.2510 (1987/1998).		
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. ADMIN. CODE §§ 695C.010 to 695C.550 (1974/2013).
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. 2201.01 to 2201.09 (1982/2016).
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. CODE R. 13.10.13 (1997/1998).
New York			N.Y. COMP. CODES R. & REGS. tit. 10, §§ 98-1.1 to 98-1.22 (1985/2005).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. ADMIN. CODE 45-06-07-01 to 45-06-07-10 (1994/1996).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. ADMIN. CODE §§ 365:40-1-1 to 365:40-3-33 (2003); § 365:40-5-130 (2004/2014).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania			31 PA. CODE §§ 301.1 to 301.126 (1987/1992); §§ 301.301 to 301.321 (1996); §§ 301.201 to 301.204 (1991) (statement of policy on point of service).

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. REGS. 69-22 (1990).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 11.1 to 11.1604 (1980/2014); §§ 11.2501 to 11.2503 (2001/2006); §§ 21.2901 to 21.2902 (2001) (point of service).
Utah	UTAH ADMIN. CODE r. 590-76 (1989/2002).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE R. §§ 114-43-1 to 114-43-6 (1996).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. CODE R. 044.0002.13 (1986/1997).

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

Table of Contents

Section 1. Definitions

As used in this Act, the following terms shall have these meanings unless the context shall otherwise require:

A. "Affiliate." An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. "Commissioner." The term "commissioner" shall mean the insurance commissioner, the commissioner's deputies, or the Insurance Department, as appropriate.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.

C. "Control." The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

D. "Group-wide supervisor." The regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 7.1 to have sufficient significant contacts with the internationally active insurance group.

E. "Group Capital Calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

F. "Insurance Holding Company System." An "insurance holding company system" consists of two (2) or more affiliated persons, one or more of which is an insurer.

G. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Drafting Note: References in this model act to "Chapter" are references to the entire state insurance code.

Drafting Note: States should consider applicability of this model act to fraternal societies and captives.

H. "Internationally active insurance group." An insurance holding company system that (1) includes an insurer registered under Section 4; and (2) meets the following criteria: (a) premiums written in at least three countries, (b) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums, and (c) based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000).

I. "Enterprise Risk." "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner's authority over companies deemed to be in hazardous financial condition].

J. "NAIC" means the National Association of Insurance Commissioners.

K. "NAIC Liquidity Stress Test Framework." The "NAIC Liquidity Stress Test Framework" is a separate NAIC publication which includes a history of the NAIC's development of regulatory liquidity stress testing, the Scope Criteria applicable for a specific data year, and the Liquidity Stress Test instructions and reporting templates for a specific data year, such Scope Criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

L. "Person." A "person" is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

M. "Scope Criteria." The "Scope Criteria," as detailed in the NAIC Liquidity Stress Test Framework, are the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

N. "Securityholder." A "securityholder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

O. "Subsidiary." A "subsidiary" of a specified person is an affiliate controlled by such person directly or indirectly through one or more intermediaries.

P. "Voting Security." The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

Section 2. Subsidiaries of Insurers

A. Authorization. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

Drafting Note: This bill neither expressly authorizes noninsurance subsidiaries nor restricts subsidiaries to insurance related activities. It is believed that this is a policy decision which should be made by each individual state. Attached as an appendix are alternative provisions which would authorize the formation or acquisition of subsidiaries to engage in diversified business activity.

B. Additional Investment Authority. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus as regards policyholders, provided that after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

Drafting Note: When considering whether to amend its Holding Company Act to exempt health maintenance organizations and other similar entities from certain investment limitations, a state should consider whether the solvency and general operations of the entities are regulated by the insurance department. In addition to, or in place of, the term "health maintenance organizations" in Paragraph (1) above, a state may include any other entity which provides or arranges for the financing or provision of health care services or coverage over which the commissioner possesses financial solvency and regulatory oversight authority.

(2) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) or in Sections [insert applicable section] through [insert applicable section] of this Chapter applicable to the insurer. For the purpose of this paragraph, "the total investment of the insurer" shall include:

(a) Any direct investment by the insurer in an asset, and

(b) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary;

(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

C. Exemption from Investment Restrictions. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this Chapter applicable to such investments of insurers [except the following:].

Drafting Note: The last phrase is optional in those states having certain special qualitative limitations, such as prohibitions on investments in stock of mining companies, which the state may wish to retain as a matter of public policy.

D. Qualification of Investment; When Determined. Whether any investment made pursuant to Subsection B meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

E. Cessation of Control. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this Chapter, and the insurer has so notified the commissioner.

Section 3. Acquisition of Control of or Merger with Domestic Insurer

A. Filing Requirements.

(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner prescribed in this Act.

(2) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in Paragraph (1) is otherwise filed, this paragraph shall not apply.

(3) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in Section 3.1C(1). A failure to file the notification may be subject to penalties specified in Section 3.1E(3).

(4) For purposes of this section a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

B. Content of Statement. The statement to be filed with the commissioner shall be made under oath or affirmation and shall contain the following:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection A is to be effected (hereinafter called the "acquiring party"), and

(a) If the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(b) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;

(2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing consideration; provided, however, that where a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party (or for such lesser period as the acquiring party and any predecessors shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in Subsection A which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in Subsection A, and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in Subsection A which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in Subsection A in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

(8) A description of the purchase of any security referred to in Subsection A during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) A description of any recommendations to purchase any security referred to in Subsection A made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection A, and (if distributed) of additional soliciting material relating to them;

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Subsection A for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

Drafting Note: An insurer required to file information pursuant to sub-sections 3B(12) and 3B(13) may satisfy the requirement by providing the commissioner with the most recently filed parent corporation reports that have been filed with the SEC, if appropriate.

(12) An agreement by the person required to file the statement referred to in Subsection A that it will provide the annual report, specified in Section 4L(1), for so long as control exists;

(13) An acknowledgement by the person required to file the statement referred to in Subsection A that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in Subsection A is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Subsection A is a corporation, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change.

C. Alternative Filing Materials.

If any offer, request, invitation, agreement or acquisition referred to in Subsection A is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Subsection A may utilize the documents in furnishing the information called for by that statement.

D. Approval by Commissioner: Hearings.

(1) The commissioner shall approve any merger or other acquisition of control referred to in Subsection A unless, after a public hearing, the commissioner finds that:

(a) After the change of control, the domestic insurer referred to in Subsection A would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:

(i) The informational requirements of Section 3.1C(1) and the standards of Section 3.1D(2) shall apply;

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by Section 3.1D(3) exist; and

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referred to in Paragraph (1) shall be held within thirty (30) days after the statement required by Subsection A is filed, and at least twenty (20) days notice shall be given by the commissioner to the person filing the statement. Not less than seven (7) days notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within the sixty (60) day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the [insert title] Court of this state. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in Paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection A. Such person shall file the statement referred to in Subsection A with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in Subsection A. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A

commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 3A(1) of this Act.

(5) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

E. Exemptions. The provisions of this section shall not apply to:

(1) [Any transaction which is subject to the provisions of Sections [insert applicable section] and [insert applicable section] of the laws of this state, dealing with the merger or consolidation of two or more insurers].

Drafting Note: Optional for use in those states where existing law adequately governs standards and procedures for the merger or consolidation of two or more insurers.

(2) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. Violations. The following shall be violations of this section:

(1) The failure to file any statement, amendment or other material required to be filed pursuant to Subsection A or B; or

(2) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

G. Jurisdiction, Consent to Service of Process. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his last known address.

Section 3.1 Acquisitions Involving Insurers Not Otherwise Covered

A. Definitions. The following definitions shall apply for the purposes of this section only:

(1) "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(2) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. Scope

(1) Except as exempted in Paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(2) This section shall not apply to the following:

(a) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under Section 1C, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(b) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with Section 3.1C(1) thirty (30) days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of Section 3.1B(2);

(c) The acquisition of already affiliated persons;

(d) An acquisition if, as an immediate result of the acquisition,

(i) In no market would the combined market share of the involved insurers exceed five percent (5%) of the total market,

(ii) There would be no increase in any market share, or

(iii) In no market would

(I) The combined market share of the involved insurers exceeds twelve percent (12%) of the total market, and

(II) The market share increase by more than two percent (2%) of the total market.

For the purpose of this Paragraph (2)(d), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(e) An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(f) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

C. Pre-acquisition Notification; Waiting Period. An acquisition covered by Section 3.1B may be subject to an order pursuant to Section 3.1E unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Section 8 of this Act.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under Section 3.1B(2)(d), cause the acquisition not to be exempted from the provisions of this

section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of Section 3.1D. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

D. Competitive Standard

(1) The commissioner may enter an order under Section 3.1E(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with Section 3.1C.

(2) In determining whether a proposed acquisition would violate the competitive standard of Paragraph (1) of this subsection, the commissioner shall consider the following:

(a) Any acquisition covered under Section 3.1B involving two (2) or more insurers competing in the same market is *prima facie* evidence of violation of the competitive standards.

(i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

(ii) Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two columns in the table is *prima facie* evidence of violation of the competitive standard in Paragraph (1) of this subsection. For the purpose of this item, the insurer with the largest share of the market shall be deemed to be Insurer A.

(b) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under Section 3.1B involving two (2) or more insurers competing in the same market is *prima facie* evidence of violation of the competitive standard in Paragraph (1) of this subsection if:

(i) There is a significant trend toward increased concentration in the market;

(ii) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

(iii) Another involved insurer's market is two percent (2%) or more.

(c) For the purposes of Section 3.1D(2):

(i) The term "insurer" includes any company or group of companies under common management, ownership or control;

(ii) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;

(iii) The burden of showing *prima facie* evidence of violation of the competitive standard rests upon the commissioner.

(d) Even though an acquisition is not *prima facie* violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is *prima facie* violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered under Section 3.1E(1) if:

(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(b) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

E. Orders and Penalties

(1) (a) If an acquisition violates the standards of this section, the commissioner may enter an order:

(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(ii) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(b) Such an order shall not be entered unless:

(i) There is a hearing;

(ii) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing; and

(iii) The hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the pre-acquisition notification with the commissioner.

Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(c) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the commissioner under Paragraph (1) and while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:

(a) A monetary penalty of not more than $10,000 for every day of violation; or

(b) Suspension or revocation of the person's license.

(3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than $50,000.

F. Inapplicable Provisions. Sections 10B, 10C, and 12 do not apply to acquisitions covered under Section 3.1B.

Section 4. Registration of Insurers

A. Registration. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) Section 4;

(2) Section 5A(1), 5B, 5D; and

(3) Either Section 5A(2) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by [insert date] of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Section 4C or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

B. Information and Form Required. Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the NAIC, which shall contain the following current information:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(2) The identity and relationship of every member of the insurance holding company system;

(3) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(b) Purchases, sales or exchange of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders; and

(h) Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

Drafting Note: Neither option below is intended to modify applicable state insurance and/or corporate law requirements.

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

Alternative Section 4B(7):

(7) Statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the commissioner by rule or regulation.

C. Summary of Changes to Registration Statement. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

D. Materiality. No information need be disclosed on the registration statement filed pursuant to Subsection B if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise; sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of the 31st day of December next preceding shall not be deemed material for purposes of this section. The definition of materiality provided in this subsection shall not apply for purposes of the Group Capital Calculation or the Liquidity Stress Test Framework.

E. Reporting of Dividends to Shareholders. Subject to Section 5B, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

F. Information of Insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this Act.

G. Termination of Registration. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

H. Consolidated Filing. The commissioner may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.

I. Alternative Registration. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Subsection A and to file all information and material required to be filed under this section.

J. Exemptions. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation or order shall exempt the same from the provisions of this section.

K. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

L. Enterprise Risk Filings.

(1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners;

(2) Group Capital Calculation. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. Insurance holding company systems described below are exempt from filing the group capital calculation:

(a) An insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state, and assumes no business from any other insurer;

(b) An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing;

(c) An insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction as described in [insert cross-reference to appropriate section of Credit for Reinsurance Law] that recognizes the U.S. state regulatory approach to group supervision and group capital;

Drafting Note: On September 22, 2017, the United States and the European Union (EU) entered into the "*Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.*" A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements are considered to be a "covered agreement" entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that addresses the U.S. state regulatory approach to group supervision and group capital, and provides that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group. Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to the EU and UK Covered Agreements treated as Reciprocal Jurisdictions, but any other Qualified Jurisdiction can also qualify as Reciprocal Jurisdiction if they provide written confirmation that they recognize and accept the U.S. state regulatory approach to group supervision and group capital.

(d) An insurance holding company system:

(i) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook, and

(ii) Whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction.

Drafting Note: The phrase "Recognizes and accepts" does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not apply its own version of a group capital filing to U.S. insurance groups.

(e) Notwithstanding the provisions of Sections 4L(2)(c) and 4L(2)(d), a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(f) Notwithstanding the exemptions from filing the group capital calculation stated in Section 4L(2)(a) through Section 4L(2)(d), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.

(g) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(3) Liquidity Stress Test. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year's Liquidity Stress Test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners:

(a) The NAIC Liquidity Stress Test Framework includes Scope Criteria applicable to a specific data year. These Scope Criteria are reviewed at least annually by the Financial Stability Task Force or its successor. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the Scope Criteria are considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year. Similarly, insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year.

(i) Regulators wish to avoid having insurers scoped in and out of the NAIC Liquidity Stress Test Framework on a frequent basis. The lead state insurance commissioner, in consultation with the Financial Stability Task Force or its successor, will assess this concern as part of the determination for an insurer.

(b) The performance of, and filing of the results from, a specific year's Liquidity Stress Test shall comply with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in consultation with the Financial Stability Task Force or its successor, provided within the Framework.

Drafting Note: The delay included in the change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured being effective on January 1 of the year following the calendar year when such changes are adopted is present to: 1) allow sufficient time for states needing to adopt by rule the NAIC Liquidity Stress Test Framework for a given data year and 2) to ensure scoped in insurers have adequate time to comply with the requirements for a given data year .

M. Violations. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

A. Transactions Within an Insurance Holding Company System

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(f) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs.

(g) If an insurer subject to this Act is deemed by the commissioner to be in a hazardous financial condition as defined by [insert citation for Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer's discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the commissioner required the deposit or the bond.

In determining whether a deposit or a bond is required, the commissioner should consider whether concerns exist with respect to the affiliated person's ability to fulfill the contract(s) or agreement(s) if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding, and a deposit or bond is necessary, the commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s);

Drafting Note: This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and actuarial services, data management, investment portfolio management and support and policy and policyholder services. (Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements). The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond, (deposit vs. bond to be determined by the insurer) and in specifying an amount, the commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action, including supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.

(h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer's business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer's business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement; and,

Drafting Note: The "at no additional cost to the insurer" language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

(i) Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to [the receivership act of the state].

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

Drafting Note: When reviewing the notification required to be submitted pursuant to Section 5A(2)(f), the commissioner should examine prior and existing investments of this type to establish that these investments separately or together with other transactions, are not being made to contravene the dividend limitations set forth in Section 5B. However, an investment in a controlling person or in an affiliate shall not be considered a dividend or distribution to shareholders when applying Section 5B of this Act.

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.

(4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

(6) Supervision, seizure, conservatorship or receivership proceedings.

(a) Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to Subsection 5A(2)(d) shall be subject to the jurisdiction of any supervision, seizure, conservatorship or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that:

(i) Are an integral part of the insurer's operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment or any other similar functions; or

(ii) Are essential to the insurer's ability to fulfill its obligations under insurance policies.

(b) The commissioner may require that an agreement or contract pursuant to Subsection 5A(2)(d) for the provision of services described in (i) and (ii) above specify that the affiliate consents to the jurisdiction as set forth in this Subsection 5A(6).

Drafting Note: Subsection 5A(6) is not intended to subject affiliates, in particular those that may be subject to regulation in other jurisdictions, to the general jurisdiction of pending supervision, seizure, conservation or receivership court proceedings in this state or the general authority of a supervisor, conservator or receiver for a domestic insurer. Rather, the jurisdiction and authority conferred by this provision is limited to ensuring that a domestic insurer continues to receive essential services from an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Subsection 5A(6)(b) gives the commissioner discretion to require documentation of an affiliate's consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a commissioner may require such provision, the commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrants requirement of such a provision.

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(1) Ten percent (10%) of the insurer's surplus as regards policyholders as of the 31st day of December next preceding; or

(2) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.

Drafting Note: The following Subsection C entitled "Management of Domestic Insurers Subject to Registration" is optional and is to be adopted according to the needs of the individual jurisdiction.

C. Management of Domestic Insurers Subject To Registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).

(3) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's investment portfolio;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 6. Examination

A. Power of Commissioner. Subject to the limitation contained in this section and in addition to the powers which the commissioner has under Sections [insert applicable sections] relating to the examination of insurers, the commissioner shall have the power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. Access to Books and Records.

(1) The commissioner may order any insurer registered under Section 4 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this Chapter.

(2) To determine compliance with this Chapter, the commissioner may order any insurer registered under Section 4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of $[insert amount] for each day's delay, or may suspend or revoke the insurer's license.

C. Use of Consultants. The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under Subsection A above. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

D. Expenses. Each registered insurer producing for examination records, books and papers pursuant to Subsection A above shall be liable for and shall pay the expense of examination in accordance with Section [insert applicable section].

E. Compelling Production. In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in [insert appropriate statutory reference to trial-level court in that state], which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

Section 7. Supervisory Colleges

A. Power of Commissioner. With respect to any insurer registered under Section 4, and in accordance with Subsection C below, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

B. Expenses. Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with Subsection C below, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

C. Supervisory College. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 6, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with Section 8C providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Section 7.1. Group-wide Supervision of Internationally Active Insurance Groups

A. The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section.. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States, but not in this state; or

(3) Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in Subsections B and F that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets or liabilities;

(2) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state, or otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in Paragraphs (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

C. Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(1) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or

(2) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to Subsection B.

D. Pursuant to Section 6, the commissioner is authorized to collect from any insurer registered pursuant to Section 4 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to Section 4 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the [insert name of state administrative record] and on its Internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

E. If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

(a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and

(b) Reasonable and effective mitigation measures are in place;

(2) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(a) Governance, risk assessment and management,

(b) Capital adequacy, and

(c) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 8, through supervisory colleges as set forth in Section 7 or otherwise;

(5) Enter into agreements with or obtain documentation from any insurer registered under Section 4, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

F. If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The commissioner's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

G. The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 4, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. The commissioner may promulgate regulations necessary for the administration of this section.

I. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Section 8. Confidential Treatment

A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 are recognized by this state as being proprietary and to contain trade secrets, and shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(1) For purposes of the information reported and provided to the Department of Insurance pursuant to Section 4L(2), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.

(2) For purposes of the information reported and provided to the [Department of Insurance] pursuant to Section 4L(3), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

Drafting Note: This group capital calculation and group capital ratio includes confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. Similarly, the liquidity stress test may include confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. The confidential treatment afforded to group capital calculation filings includes any Federal Reserve Board group capital filings and information.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC, and with any third-party consultants designated by the commissioner, with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has

verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, including propriety and trade-secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(4) Shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this Act consistent with this subsection that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain such confidentiality;

(b) Specify that ownership of information shared with the NAIC or a third party consultant pursuant to this Act remains with the commissioner and the NAIC's or a third-party consultant's, as designated by the commissioner, use of the information is subject to the direction of the commissioner;

(c) Excluding documents, material or information reported pursuant to Section 4L(3), prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

(d) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production; and

(e) Require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act.

(f) For documents, material or information reported pursuant to Section 4L(3), in the case of an agreement involving a third-party consultant , provide for notification of the identity of the consultant to the applicable insurers.

D. The sharing of information by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

F. Documents, materials or other information in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

G. The group capital calculation and resulting group capital ratio required under Section 4L(2) and the liquidity stress test along with its results and supporting disclosures required under Section 4L(3) are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Drafting Note: In Section 8C(4) above, the exclusion in subitem 4(c) is the result of the Liquidity Stress Test primary purpose, which is to be used as a tool for assessing macroprudential risks by the NAIC Financial Stability Task Force assisted by NAIC staff, including trend analysis over time. Provisions against the NAIC owning the information, databasing the results and disclosures, and obtaining written consent from the insurer when a consultant is involved were deemed inappropriate.

Section 9. Rules and Regulations

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 10. Injunctions, Prohibitions Against Voting Securities, Sequestration of Voting Securities

A. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this Act or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to the [insert title] Court for the county in which the principal officer of the insurer is located or if the insurer has no office in this state then to the [insert title] Court for [insert county] County for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate this Act or any rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

B. Voting of Securities; When Prohibited. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this Act or of any rule, regulation or order issued by the

commissioner hereunder; the insurer or the commissioner may apply to the [insert title] Court for the county in which the insurer has its principle place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Section 3 or any rule, regulation or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditor and shareholders or the public may require.

C. Sequestration of Voting Securities. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this Act or any rule, regulation or order issued by the commissioner hereunder, the [insert title] Court for [insert county] County or the [insert title] Court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this Act.

Notwithstanding any other provisions of law, for the purposes of this Act the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Section 11. Sanctions

A. Any insurer failing, without just cause, to file any registration statement as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day's delay, to be recovered by the commissioner of Insurance and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to Section 4A, 5A(2), or 5B, or which violate this Act, shall pay, in their individual capacity, a civil forfeiture of not more than $[insert amount] per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

C. Whenever it appears to the commissioner that any insurer subject to this Act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to Section 5 of this Act and which would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this Act, the commissioner may cause criminal proceedings to be instituted by the [insert title] Court for the county in which the principal office of the insurer is located or if the insurer has no office in this state, then by the [insert county] Court for [insert title] County against the insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this Act may be fined not more than $[insert amount]. Any individual who willfully violates this Act may be fined in his or her individual capacity not more than $[insert amount] or be imprisoned for not more than one to three (3) years or both.

E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his or her duties under this Act, upon conviction shall be imprisoned for not more than [insert amount] years or fined $[insert amount] or both. Any fines imposed shall be paid by the officer, director or employee in his or her individual capacity.

F. Whenever it appears to the commissioner that any person has committed a violation of Section 3 of this Act and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with [insert appropriate statutory reference related to orders of supervision.

Section 12. Receivership

Whenever it appears to the commissioner that any person has committed a violation of this Act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in Section [insert applicable section] of this Chapter to take possessions of the property of the domestic insurer and to conduct its business.

Section 13. Recovery

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, (i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of Subsections B, C, and D of this section.

B. No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under Subsection A which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

E. To the extent that any person liable under Subsection C of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

Section 14. Revocation, Suspension, or Nonrenewal of Insurer's License

Whenever it appears to the commissioner that any person has committed a violation of this Act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer's license or authority to do business in this state for such period as the commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Section 15. Judicial Review, Mandamus

A. Any person aggrieved by any act, determination, rule, regulation or order or any other action of the commissioner pursuant to this Act may appeal to the [insert title] Court for [insert county] County. The court shall conduct its review without a jury and by trial *de novo*, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial *de novo* as to those parties so stipulating.

B. The filing of an appeal pursuant to this section shall stay the application of any rule, regulation, order or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

C. Any person aggrieved by any failure of the commissioner to act or make a determination required by this Act may petition the [insert title] Court for [insert county] County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make a determination.

Section 16. Conflict with Other Laws

All laws and parts of laws of this state inconsistent with this Act are hereby superseded with respect to matters covered by this Act.

Section 17. Separability of Provisions

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and for this purpose the provisions of this Act are separable.

Section 18. Effective Date

This Act shall take effect thirty (30) days from its passage.

APPENDIX
ALTERNATE PROVISIONS

Alternative Section 1. Findings

A. It is hereby found and declared that it may not be inconsistent with the public interest and the interest of policyholders and shareholders to permit insurers to:

(1) Engage in activities which would enable them to make better use of management skills and facilities;

(2) Diversify into new lines of business through acquisition or organization of subsidiaries;

(3) Have free access to capital markets which could provide funds for insurers to use in diversification programs;

(4) Implement sound tax planning conclusions; and

(5) Serve the changing needs of the public and adapt to changing conditions of the social, economic and political environment, so that insurers are able to compete effectively and to meet the growing public demand for institutions capable of providing a comprehensive range of financial services.

B. It is further found and declared that the public interest and the interests of policyholders and shareholders are or may be adversely affected when:

(1) Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders or shareholders;

(2) Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this state;

(3) An insurer which is part of an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms which are not fair and reasonable; or

(4) An insurer pays dividends to shareholders which jeopardize the financial condition of such insurers.

C. It is hereby declared that the policies and purposes of this Act are to promote the public interest by:

(1) Facilitating the achievement of the objectives enumerated in Subsection A;

(2) Requiring disclosure of pertinent information relating to changes in control of an insurer;

(3) Requiring disclosure by an insurer of material transactions and relationships between the insurer and its affiliates, including certain dividends to shareholders paid by the insurer; and

(4) Providing standards governing material transactions between the insurer and its affiliates.

D. It is further declared that it is desirable to prevent unnecessary multiple and conflicting regulation of insurers. Therefore, this state shall exercise regulatory authority over domestic insurers and unless otherwise provided in this Act, not over nondomestic insurers, with respect to the matters contained herein.

Alternative Section 2. Subsidiaries of Insurers

A. Authorization. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(1) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(2) Acting as an insurance broker or as an insurance agent for its parent or for any of its parent's insurer subsidiaries;

(3) Investing, reinvesting or trading in securities for its own account, that of its parent, a subsidiary of its parent, or an affiliate or subsidiary;

(4) Management of an investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(5) Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(6) Rendering investment advice to governments, government agencies, corporations or other organizations or groups;

(7) Rendering other services related to the operations of an insurance business, such as actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

(8) Ownership and management of assets which the parent corporation could itself own or manage;

Drafting Note: The aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this paragraph should not exceed the limitations applicable to such investments by the insurer.

(9) Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

(10) Financing of insurance premiums, agents and other forms of consumer financing;

(11) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; and

(12) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1969 Proc. II 736, 737, 738-751, 756 (adopted).
1972 Proc. I 14, 16, 443, 449 (corrected).
1980 Proc. II 22, 26, 29, 42-46 (amended, added Section 3.1).
1983 Proc. I 6, 37, 96, 99 (amended).
1985 Proc. I 19, 37,178, 183-200 (amended and reprinted).
1985 Proc. II 11, 24-25, 74, 75-92 (amended and reprinted).
1986 Proc. I 10, 25, 72 (amended).
1986 Proc. II 12, 19-20, 93-94, 94-109 (amended and reprinted).
1993 Proc. 4th Quarter 16, 31, 57, 61-62 (amended).
1995 Proc. 4th Quarter 11, 33, 307, 310, 312-328 (amended and reprinted).
1996 Proc. 1st Quarter 124, 270, 272-275 (amendments adopted later printed here).
1997 Proc. 4th Quarter 11 (amendments adopted).
1999 Proc. 4th Quarter 15, 364, 369, 379-380 (amended).
2001 Proc. 2nd Quarter 11, 14, 319, 339, 342-348 (amended).
2011 Proc. 1st Quarter I 3-11 (amended).
2014 Proc. 3rd Quarter, Vol. I 122, 136, 140, 183, 243-266 (amended).
2020 Fall National Meeting (amended).
2021 Summer National Meeting (amended).
Spring 2024 (technical edit).

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

*** Please refer to the map contained in the link below for state adoption of the Group Capital Calculation and Liquidity Stress Test amendments:** https://content.naic.org/sites/default/files/smi_state_adoption_maps_models.pdf

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-29-1 to 27-29-14 (1973/2022).	BULLETIN 4-2-2010 (2010).
Alaska		ALASKA STAT. §§ 21.22.010 to 21.22.200 (1976/2019).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-481 to 20-481.33 (1978/2019).	
Arkansas		ARK. CODE ANN. §§ 23-63-501 to 23-63-532 (1971/2019).	
California		CAL. INS. CODE §§ 1215 to 1215.18 (1969/2021).	BULLETIN 93-6 (1993).
Colorado		COLO. REV. STAT. §§ 10-3-801 to 10-3-816 (1963/2019).	
Connecticut	CONN. GEN. STAT. §§ 38a-129 to 38a-140 (1969/2022).	CONN. GEN. STAT. § 38a-14a (1992/2012) (examination).	
Delaware	DEL. CODE ANN. tit. 18, §§ 5001 to 5016 (1973/2022).		
District of Columbia		D.C. CODE §§ 31-701 to 31-714 (1993/2019).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida		FLA. STAT. §§ 628.801 to 628.805 (1985/2018); §§ 628.451 to 628.461 (1959/2014); FLA. ADMIN. CODE ANN. r. 69O-143.046 to 69O-143.050 (1970/2017).	
Georgia	GA. CODE ANN. §§ 33-13-1 to 33-13-15 (1970/2022).		
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:11-101 to 431:11-117 (1988/2019).	
Idaho		IDAHO CODE ANN. §§ 41-3801 to 41-3825 (1972/2019).	
Illinois		215 ILL. COMP. STAT. 5/131.1 to 5/131.30 (1997/2016).	BULLETIN 2013-13 (2013).
Indiana		IND. CODE ANN. §§ 27-1-23-1 to 27-1-23-13 (1971/2018).	
Iowa		IOWA CODE §§ 521A.1 to 521A.13 (1970/2018).	
Kansas		KAN. STAT. ANN. §§ 40-3301 to 40-3318 (1975/2019).	
Kentucky		KY. REV. STAT. ANN. §§ 304.37-010 to 304.37-160 (1972/2019).	KY. REV. STAT. ANN. §§ 304.37-500 to 304.37-580 (1996/2012).
Louisiana	LA. REV. STAT. ANN. §§ 22:691.1 to 22:691.27 (2012/2022).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 222 (1969/2022).		
Maryland		MD. CODE ANN., INS. §§ 7-101 to 7-807 (1969/2013); § 2-209.2 (2019).	
Massachusetts	MASS. GEN. LAWS ch. 175, §§ 206 to 206D (1993/2022).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.1301 to 500.1379 (1970/2015).	
Minnesota		MINN. STAT. §§ 60D.09 to 60D.30 (1971/2019).	
Mississippi		MISS. CODE ANN. §§ 83-6-1 to 83-6-47 (1974/2017).	
Missouri		MO. REV. STAT. §§ 382.010 to 382.302 (1983/2019).	
Montana		MONT. CODE ANN. §§ 33-2-1101 to 33-2-1125 (1971/2019).	
Nebraska		NEB. REV. STAT. §§ 44-2120 to 44-2155 (1991/2016).	
Nevada		NEV. REV. STAT. §§ 692C:010 to 692C:490 (1973/2017).	
New Hampshire	N.H. REV. STAT. ANN. §§ 401-B:1 to 401-B:16 (2013/2022).		
New Jersey		N.J. STAT. ANN. §§ 17:27A-1 to 17:27A-14 (1970/2022).	N.J. STAT. ANN. §§ 17:27B-1 to 17:27B-6 (1971).
New Mexico		N.M. STAT. ANN. §§ 59A-37-1 to 59A-37-32 (1985/2014).	
New York		N.Y. INS. LAW § 302 (2013); §§ 1501 to 1510; §§ 1601 to 1612; §§ 1701 to 1719 (1984/2013).	CIRCULAR LETTER 2010-10 (2010).
North Carolina	S.B. No. 452 (2023).	N.C. GEN. STAT. §§ 58-19-1 to 58-19-70 (1971/2019).	
North Dakota		N.D. CENT. CODE §§ 26.1-10-01 to 26.1-10-13 (1983/2015).	
Northern Marianas	NO CURRENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio	OHIO REV. CODE ANN. §§ 3901.32 to 3901.37 (1971/2022).		
Oklahoma	OKLA. STAT. tit. 36, §§ 1631 to 1648 (1970/2022).		
Oregon		OR. REV. STAT. §§ 732.517 to 732.592 (1971/2017).	
Pennsylvania	40 P.A. CODE §§ 991.1401 to 991.1413 (1993/2022).		
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 4401 to 4414 (2012).	
Rhode Island		R.I. GEN. LAWS §§ 27-35-1 to 27-35-14 (1971/2015).	
South Carolina		S.C. CODE ANN. §§ 38-21-10 to 38-21-390 (1988/2019).	
South Dakota		S.D. CODIFIED LAWS §§ 58-5A-1 to 58-5A-80 (1972/2017).	
Tennessee	TENN. CODE ANN. §§ 56-11-101 to 56-11-119 (1986/2023).		
Texas		TEX. INS. CODE ANN. §§ 823.001 to 823.503 (2017); 28 TEX. ADMIN. CODE § 7.215 (2022) (GCC only).	
Utah	UTAH CODE ANN. §§ 31A-16-101 to 31A-16-119 (1986/2022).		
Vermont		VT. STAT. ANN. tit. 8, §§ 3681 to 3696 (1971/2016).	
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 320 to 339 (2017).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1322 to 38.2-1334.2:3 (1986/2019).		VA. CODE ANN. §§ 38.2-4230 to 38.2-4235 (1989/2001) (regarding non-stock corporation members of holding company system).
Washington		WASH. REV. CODE ANN. §§ 48.31B.005 to 48.31B.902 (1993/2015).	
West Virginia		W. VA. CODE §§ 33-27-1 to 33-27-14 (1974/2019).	
Wisconsin		WIS. STAT. §§ 617.01 to 617.25 (1969/2014).	
Wyoming		WYO. STAT. ANN. §§ 26-44-101 to 26-44-119 (1991/2019).	

PROJECT HISTORY-2021

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)
(Receivership)

1. Description of the Project, Issues Addressed, etc.

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

> *"Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership."*

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.

3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI's proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5.A.(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties' revisions.

7. List the key provisions of the model (sections considered most essential to state adoption).

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- Section 5A(1) of Model #440
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- Section 5A(6) of Model #440
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- Section 19 of Model #450
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

8. Any Other Important Information (e.g., amending an accreditation standard).

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

PROJECT HISTORY - 2020

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)
(Liquidity Stress Testing)

1. Description of the Project, Issues Addressed, etc.

In April 2017, the Executive (EX) Committee adopted a new charge for the Financial Stability (EX) Task Force at the Spring National Meeting. The charge is still active and reads as follows:

> ***"Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed."***

Prior to, and prompting the need for, the adoption of this charge, the Financial Stability (EX) Task Force performed a review of other jurisdictions' activities in the macroprudential space. Common themes noted in this review included a focus on: stress testing; liquidity assessments, both within specific sectors and cross-sector exposures; enhancing resolution planning and disclosures; and charts and discussions on various domestic economic/regional trends impacting the insurance sector.

After considering these common macroprudential activities against the U.S. system of insurance regulation, the Financial Stability (EX) Task Force adopted a Macroprudential Initiative (MPI) Framework during the 2017 Summer National Meeting. The MPI Framework contained four focused areas for potential enhancements: 1) liquidity; 2) recovery and resolution; 3) capital stress testing; and 4) exposure concentrations. During this meeting, liquidity risk was identified as a top priority for MPI, and the Liquidity Risk Assessment (EX) Subgroup was appointed to address this work and assigned the following charges:

- Review existing public and regulator only data related to liquidity risk, identify any gaps based on regulatory needs, and propose the universe of companies to which any recommendations may apply.
- Construct a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).

2. Name of Group Responsible for Drafting the Model and States Participating.

The Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force drafted the initial revisions to Model #440. The 2020 members of the Subgroup were: Nebraska (Chair); Connecticut; District of Columbia; Florida; Illinois; Iowa; Minnesota; Missouri; and Texas.

The Financial Stability (EX) Task Force finalized the liquidity stress test (LST) revisions to Model #440. The 2020 members of the Task Force were: New Jersey (Chair); Maine (Vice Chair); Arkansas; California; Connecticut; District of Columbia; Florida; Illinois; Iowa; Massachusetts; Missouri; Nebraska; New York; Oregon; Pennsylvania; and Texas.

3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1 above, the initial charge prompting a review of the U.S. system of insurance regulation to assess its ability to address macroprudential monitoring was assigned to the Financial Stability (EX) Task Force during the 2017 Spring National Meeting. However, the specific charge to create an LST framework—which includes the need to address regulatory authority for requiring the filing of LST reports and confidentiality protection of those filings—was assigned to the Liquidity Assessment (EX) Subgroup during the 2017 Summer National Meeting and reads as follows:

> *"Construct a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers)."*

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In late 2017, the Liquidity Assessment (EX) Subgroup began its work to address its first charge related to liquidity data gaps, resulting in two blanks proposals to add more product breakout data in the life statutory financial statement or blank. Once the blanks proposals were submitted to the Blanks (E) Working Group, the Subgroup began work on the LST Framework in early 2018. The Subgroup first addressed the scope criteria to determine which life insurers should be subject to an LST requirement, which was adopted by the Financial Stability (EX) Task Force during the 2019 Spring National Meeting.

To construct the actual LST proposal, the Subgroup utilized an unofficial study group, with members consisting of Nebraska (lead), Connecticut, Iowa, Minnesota, Missouri, New Jersey and Texas. Also, the study group included industry participants from some of the insurers triggering the initial scope criteria; specifically, John Hancock, Manulife, MassMutual, MetLife, New York Life, Principal and Prudential. At times, the lead states of, and industry participants from, all 23 insurers triggering the initial scope criteria were included in study group calls.

Work on the LST Framework proposal continued until the COVID-19 pandemic prompted the Financial Stability (EX) Task Force to place the LST Framework development on hold effective April 17, 2020. Importantly, this pause did not include any work related to addressing regulatory authority for the LST and confidentiality of the LST reports, which, pursuant to a Feb. 26, 2020 call of the Financial Stability (EX) Task Force, was to initially consider using revisions to Model #440. Instead, the Subgroup and study group were directed to obtain data from the 23 insurers to assess how liquidity stress was impacted by the pandemic and subsequent economic stresses. In November 2020, the study group expressed its intent to resume the work to develop the LST proposal.

For the actual proposed revisions to Model #440 required for LST needs, NAIC staff worked with Justin Schrader (NE), chair of the Liquidity Assessment (EX) Subgroup, to draft the initial exposure document. The current version of edits exposed by the Group Capital Calculation (E) Working Group were used as the baseline for Model #440 and were edited for LST needs.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On June 23, 2020, Justin Schrader (NE), chair of the Liquidity Assessment (EX) Subgroup, exposed proposed revisions to Model #440 for a public comment period ending July 29, 2020. Comments were received from the Texas Department of Insurance (TDI) and the American Council of Life Insurers (ACLI). The TDI comments were suggestions for how to organize the revisions within Model #440, consistent with similar comments made with respect to the Group Capital Calculation (E) Working Group's exposed revisions, and were all acceptable to the Liquidity Assessment (EX) Subgroup members. All but one of the ACLI comments, most with respect to governance and timing issues, were acceptable to the Liquidity Assessment (EX) Subgroup members.

On Aug. 31, 2020, an updated draft of proposed revisions to Model #440 was posted as materials for the Sept. 1, 2020, meeting of the Liquidity Assessment (EX) Subgroup. Because there were so few comments received during the initial comment period and all comments were accepted except one ACLI comment, a second exposure period was not deemed necessary for the Liquidity Assessment (EX) Subgroup. Rather, the Liquidity Assessment (EX) Subgroup voted to forward the proposed revisions to Model #440—as modified during its Sept. 1, 2020, conference call to partially address the outstanding ACLI comment—to the Financial Stability (EX) Task Force for a final exposure period.

On Sept. 3, 2020, Commissioner Marlene Caride (NJ), chair of the Financial Stability (EX) Task Force, exposed for a public comment period ending Oct. 5, 2020, the Liquidity Assessment (EX) Subgroup's modified proposed revisions to Model #440. One comment letter was received, from the ACLI, requesting several editorial changes that were made for the proposed revisions to Model #440 included as materials for the meeting of the Financial Stability (EX) Task Force held Oct. 13, 2020.

Several items were raised as concerns with respect to the proposed revisions during the Financial Stability (EX) Task Force's Oct. 13, 2020, conference call, but all were resolved with recommended changes that satisfied the members. As such, on the Oct. 13, 2020, conference call of the Financial Stability (EX) Task Force, the members voted to adopt the modified proposed revisions to Model #440 and forward them to the Financial Condition (E) Committee for its consideration.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

There were no issues of real significance raised during the exposure periods. However, these are the items discussed during the final consideration by the Financial Stability (EX) Task Force:

a. The ACLI request to limit the use of the LST data to macroprudential purposes only was rejected by state insurance regulators, given that microprudential oversight of legal entity insurers and groups will benefit from this data also.
b. Confirmed the need to change "assets and liabilities" to "exposure bases" in the scope criteria definition as recommended by the ACLI.
c. Agreed with the TDI request to specify that the LST data is still owned by the lead state when a consultant is used.
d. Changed "in conjunction with" to "in consultation with" to clarify that the lead state makes the final decision in terms of when an insurer is added to or removed from the list of insurers required to perform the LST for a specific year.

7. List the key provisions of the model (sections considered most essential to state adoption).

The changes to Section 4L(3) of Model #440 are the most important provisions in the proposed changes, as they require the ultimate controlling person of every insurer subject to registration and meeting the scope criteria to file the results of a specific year's LST to the lead state insurance commissioner. The filing shall be made in accordance with the procedures housed within the *Financial Analysis Handbook*.

Immediately following this provision in Section 4L(3)(a) of Model #440 is the information regarding the scope criteria and indication that the lead state commissioner, in consultation with the Financial Stability (EX) Task Force or its successor, will make the final determination regarding the insurers that will be scoped in and out of a specific data year's LST.

Section 4L(3)(b) of Model #440 indicates the performance of, and filing of the results from, a specific year's LST shall comply with the NAIC LST framework's instructions and reporting templates for that year, along with any lead state insurance commissioner determinations (in consultation with the Financial Stability (EX) Task Force or its successor).

Finally, Section 8(A)(2) of Model #440 provides key statutory authority to hold the LST confidential.

8. Any Other Important Information (e.g., amending an accreditation standard).

It is considered extremely important that lead states of insurance companies that are considered to be internationally active insurance groups (IAIGs) under Model #440 enact these LST revisions. However, it is also important to make the LST revisions to Model #440 an accreditation standard applicable to all states in order to develop a macroprudential surveillance program for the U.S. state-based insurance regulatory system. Each state has primarily microprudential goals in order to regulate individual insurers' solvency, which extend to insurance groups, as well. But all commissioners do have macroprudential goals with respect to having competitive markets in their respective states. However, no state has a complete purview of the entire U.S. insurance industry, or even the entire U.S. life insurance segment. Federal regulators and the U.S. insurance industry have strongly encouraged the creation of a macroprudential framework throughout the states, and this LST should become a baseline element in the overall financial solvency regulation of insurance.

PROJECT HISTORY - 2020

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)
(Group Capital Calculation (GCC))

1. Description of the Project, Issues Addressed, etc.

In 2015, the NAIC Plenary adopted a charge to the Financial Condition (E) with respect to the construction of a group capital calculation (GCC). The Financial Condition (E) Committee subsequently formed the Group Capital Calculation (E) Working Group to carry out the following charge:

> ***"Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation."***

The charge was developed primarily as a result of discussions that revealed that developing a GCC was a natural extension of work that state insurance regulators had already begun on group supervision as a result of the lessons learned from the 2008 financial crisis. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. More specifically, the GCC and related reporting provides more transparency to state insurance regulators regarding insurance groups and make risks more identifiable and more easily quantified.

It is important to understand that the GCC utilizes an aggregation approach to group capital where existing legal entity capital requirements [e.g., risk-based capital (RBC)] and existing valuation for capital (e.g., statutory accounting) are utilized. In selecting this approach, it was recognized as satisfying state regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and the industry, in addition to respecting other jurisdictions' existing capital regimes. To capture the risks associated with the entire insurance group, including the insurance holding company, calculations were developed in those instances where no RBC calculations currently exist (i.e., non-regulated entities) and are part of the GCC. The methods selected were tested in 2019 by more than 30 insurance groups representing 15 lead states. These methods have since been modified to consider the lessons learned from the testing and subsequent comments from the industry and state insurance regulators. The more significant items are discussed in paragraph 6 below.

Also important in finalizing the GCC was the scope of groups that would be required to complete it. Specifically, Model #440 exempts single-state companies, insurers located in reciprocal jurisdictions that have already recognized the U.S. approach to group supervision and group capital, as well as other jurisdictions that agree to recognize the U.S. approach to group capital. Model #450 also provides commissioners with additional discretion to exempt groups that have less than $1 billion in premium, provided the group has no non-U.S. insurers, has no banks or similar financial institutions, and has non-risky non-regulated entities within the group.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee drafted the revisions to Model #440 and Model #450. The 2020 members of the Working Group were: Florida (Chair); Connecticut (Vice Chair); California; District of Columbia; Illinois; Indiana; Iowa; Massachusetts; Michigan; Minnesota; Missouri; Nebraska; New Jersey; New York; North Carolina; Ohio; Oregon; Pennsylvania; Tennessee; Texas; Virginia; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group.

At the 2015 Fall National Meeting, the Financial Condition (E) Committee received the following charge:

> *"Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group*

capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Group Capital Calculation (E) Working Group began its work on the GCC in 2016 and spent the next two-and-one-half years constructing the calculation. Over the course of that time, the Working Group conducted numerous public conference calls to discuss the proposed construction on a topic-by-topic basis. In 2019, the Working Group set up a voluntary process under which the GCC was tested by more than 30 insurance groups represented by 15 lead states. This testing was completed in early 2020, at which time the Working Group began to make changes to the GCC to reflect the learnings from the testing. Simultaneously with this testing, at the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group's request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In addition to requiring the filing of the GCC with the lead state commissioner, the models would also provide information on the types of insurance groups that would be exempt from filing the GCC, as well as provide the necessary language to protect the confidentiality of the tool.

In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections, based on previous public comments made by Working Group members. The first draft of amendments to Model #440 and Model #450 were drafted based on decisions made by Working Group members, with previous input from the industry considered by the Working Group members. This continued to be the case with respect to future versions of the model(s), although the Sept. 18 version was drafted with specific input from a small drafting group consisting of California, Nebraska, Missouri, Texas and Wisconsin.

NAIC staff met via conference call with representatives of the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) on Sept. 10 and Oct. 14 to discuss their concerns regarding the consistency of the draft revisions to a covered agreement with the European Union (EU). (Please refer to discussion in paragraph 8.)

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

At the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group's request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections. Comments were received Feb. 17, 2020, but due to the COVID-19 pandemic, the first discussion of proposed changes to Model #440 and Model #450 did not occur until June 2, 2020.

During its June 2, 2020, call, the Working Group made several key decisions related to the comments on exemptions and subsequently released its first version of proposed changes to Model #440. Comments were received July 15, 2020, with numerous edits proposed by interested parties that were incorporated into a modified version for discussion by the Working Group on its July 21, 2020, call, including comments on subgroup reporting. Discussion on the subgroup reporting issue was deferred by the Working Group until decisions were made on all other comments, and the Working Group exposed for public comment proposed changes to Model #440, along with proposed changes to Model #450, on July 23, 2020. Comments on this exposure, which were largely focused on subgroup reporting, were discussed by the Working Group on its Sept. 18, 2020, call. The next version of Model #440 and Model #450 were exposed for a public comment period ending Oct. 5, 2020, with most of the changes from the July 23, 2020, version representing proposed revised wording from various interested parties intended to streamline both models. New versions of the models were produced and exposed following the Working Group's Oct. 20, 2020, call based on comments received Oct. 5, 2020, and discussed by the Working Group on its Oct. 20, 2020, call. The final versions of Model #440 and Model #450 were exposed Oct. 21, 2020, for a public comment period, and subsequently adopted by the Working Group on its Nov. 17, 2020, call.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

Significant issues which were ultimately addressed include:

1. Ability to exclude immaterial risky affiliates from the calculation.
2. Excluding recasting of XXX/AXXX transactions in the GCC.[1]
3. Allowing a proxy level of senior debt to be added to capital that represents the subordinated capital controlled by the commissioner's authority over approving extraordinary dividends.
4. Inclusion of the concept of scalars to recognize U.S. reserve requirements are often much higher than other jurisdictions.
5. The level at which the GCC is calibrated with RBC (200%).
6. A subgroup capital calculation under which a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system if it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. This particular aspect of Model #440 was the most controversial topic and was debated extensively, while other potential options failed to receive a majority vote.

7. List the key provisions of the model (sections considered most essential to state adoption).

The changes to Section 4L(2) of Model #440 are the most important provisions in the proposed changes, as they require the ultimate controlling person of every insurer subject to registration to concurrently file an annual GCC as directed by the lead state commissioner with the registration statement. Immediately following this provision in Section 4L(2)(a) through Section 4L(2)(d) are four types of holding company systems that are exempt from filing, which are also important to many parties. As previously discussed, Section 4L(2)(e) would permit, under certain circumstances, a subgroup capital calculation. Section 4L(2)(f) is also important, as it provides the commissioner the discretion to exempt other groups from filing that meet the criteria in Model #450. Finally, Section 8(A)(1) of Model #440 provides key statutory authority to hold the GCC confidential and actually prevents the group itself from sharing the GCC publicly. Model #450 provides more detailed aspects of the exemptions, including additional discretionary authority for exempting certain groups, as well as additional details of the NAIC process for maintaining a list of jurisdictions whose groups recognize and accept the GCC and are, therefore, exempt from filing the GCC.

8. Any Other Important Information (e.g., amending an accreditation standard).

a. Covered Agreement

Under Title V of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), the Treasury Department and the USTR are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the U.S. and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is "substantially equivalent" to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the Treasury Department and the USTR signed the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (Covered Agreement). On Dec. 18, 2018, a separate covered agreement was signed between the U.S. and the United Kingdom, which mirrors the language from the agreement with the EU and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

[1] "XXX/AXXX transactions" are those transactions required to be valued under Section 6 or Section 7 of the *Valuation of Life Insurance Policies Model Regulation* (#830).

Under Article 10(e) of the Covered Agreement, supervisory authorities in the EU shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the EU, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The GCC is intended to serve as an analytical tool for evaluating an insurer's capital position at the group level but is not intended to be applied as a group-level capital requirement or standard. The *Statement of the United States on the Covered Agreement with the European Union* provides further clarification with respect to this group capital assessment.

The Covered Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Covered Agreement also provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group-level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the U.S. The Covered Agreement does not require development of a group capital standard or group capital requirement in the U.S. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the NAIC, the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm's capital position at the group level. **The U.S. expects that the NAIC's GCC will satisfy the "group capital assessment" condition of Article 4(h), provided that the work is completed and implemented within five years of the date on which the Agreement is signed.** [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdome will need to adopt these legislative changes by Nov. 7, 2022, to effectuate compliance with the Covered Agreement.

b. Liquidity Stress Testing

In coordination with the work on the GCC, the Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force drafted revisions to Model #440 to incorporate a liquidity stress test (LST) and to provide confidentiality requirements with respect to the LST. These revisions to Model #440, while not directly related to the GCC, are also intended to be considered for adoption by the NAIC membership simultaneously with the GCC-related revisions to Model #440. A separate Project History has been prepared with respect to the LST.

c. Accreditation

The Group Capital Calculation (E) Working Group has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. However, it is expected that these revisions will be incorporated into the accreditation standard in order to encourage the states to effectuate compliance with the Covered Agreement.

PROJECT HISTORY - 2014

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

1. Description of the Project, Issues Addressed, etc.

In 2010, in the wake of the financial crisis, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These changes were intended to address one of the lessons learned from the financial crisis, which was the ability of state insurance regulators to be able to assess the enterprise risk within a holding company system and its impact on an insurer within the group.

Despite the changes, state financial regulators have come to expect that the additional changes would need to be made to the states' group supervision framework. At the 2013 Fall National Meeting, the Financial Condition (E) Committee adopted the following charge to consider further enhancements in statute:

> *Review the Model Insurance Holding Company Act (#440) and Regulation (#450) (HCA Model Act) and consider amendments to address issues that have arisen subsequent to the adoption of the Act and Regulation by the NAIC in 2010.*

At the 2014 Spring National Meeting, the Executive (EX) Committee approved a model law development request to begin work on this charge. Shortly after the 2014 Spring National Meeting, the chair of the Financial Condition (E) Committee distributed a memorandum to the Group Solvency Issues (E) Working Group and the Receivership and Insolvency (E) Task Force that set forth four specific areas to be considered in this review of potential changes to these models:

1. Clear legal authority and delineated powers to act as the group-wide supervisor for an internationally active insurance group (IAIG) and other large insurance groups.
2. Direct legal authority over the insurance holding company, including the authority to set group capital requirements.
3. Group-wide financial reporting for large insurance groups.
4. Resolution plans for IAIGs and other large insurance groups.

Subsequent to the 2014 Spring National Meeting, the Group Solvency Issues (E) Working Group began its work to address the issues assigned to it by first considering group-wide financial reporting. After significant discussion, the Working Group concluded that no additional specific group-wide financial reporting was necessary, but that further analytical procedures could be developed to encourage a more consistent approach among the states with respect to utilizing existing statutory authority provided for within Model #440, Section 6A. The development of such analytical procedures has been prioritized to a later date to enable the Working Group to focus on other potential changes to Model #440 because such analytical procedures would not require changes to Model #440 or Model #450.

Simultaneous to the Working Group's deliberations on group-wide financial reporting, the Receivership and Insolvency (E) Task Force discussed the benefits and costs associated with requiring resolution plans for large insurance groups. The Task Force concluded its discussions on these issues prior to the 2014 Summer National Meeting, at which time it delivered a recommendation to the Financial Condition (E) Committee on the issue. In summary, the Task Force concluded it was not the appropriate time to propose that insurers draft resolution plans and, as such, recommended the issue be tabled. However, the Task Force recognized the value in establishing a template checklist of information a particular insurance commissioner could request from an insurer or holding company when he or she believes the risk of insolvency has risen to the level where such information could be helpful in planning a potential rehabilitation or liquidation. Consequently, it was determined that no changes to Model #440 or Model #450 were necessary to address this issue.

Since the 2014 Summer National Meeting, the Group Solvency Issues (E) Working Group has been developing model statutory language to address the issue of clear legal authority and powers to act as a group-wide supervisor. The Working Group used statutory language enacted in Pennsylvania as a starting point, and subsequently met six times via conference call and once at a national meeting to consider changes proposed by the industry. On a Dec. 3, 2014, conference call, the Working Group adopted proposed changes to Model #440, which were subsequently adopted by the Financial Condition (E) Committee on a Dec. 4, 2014, conference call. The Working Group did not believe any changes were needed to Model #450 to address this issue. All of the changes included in the proposed revised Model #440 were intended to address this issue.

The Group Solvency Issues (E) Working Group did not discuss the issue of direct legal authority over the insurance holding company at any length during this project. It did, however, receive comments from the industry on this issue, along with comments on the other issues assigned to it during the spring and summer of 2014. The industry comments were focused on how such a proposal was premature, given the International Association of Insurance Supervisors (IAIS) had yet to develop certain group-wide supervision standards and that significant uncertainty internationally related to 1) the level at which the insurance group should be subject to group-wide supervisory requirements; 2) the legal means to achieve authority over entities not domiciled in the jurisdiction of the group-wide supervisor; 3) the legal means to achieve authority over non-insurance entities by an "insurance" supervisor; 4) the appropriate group-wide supervisor; and 5) other related issues. Additionally, as the Working Group was finalizing language related to clear legal authority and power to act as a group-wide supervisor, it concluded that the authority contained within the updated Model #440 to take certain action should be done in coordination with, and through the authority of, the regulatory officials of the jurisdictions where members of the insurance group are domiciled. For the above reasons, it was determined that no other changes were needed to Model #440 at that point in time to address this issue.

2. Name of Group Responsible for Drafting the Model and States Participating

The Group Solvency Issues (E) Working Group of the Financial Condition (E) Committee drafted the revisions to Model #440. The 2014 members of the Working Group, which drafted the revised models that were adopted Dec. 3, 2014, were Texas (Chair), Nebraska (Vice Chair), California, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Massachusetts, Michigan, Missouri, New Jersey, New York, Ohio, Pennsylvania, Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

At the 2013 Fall National Meeting, the Financial Condition (E) Committee adopted the following charge to consider further enhancements in statute:

> *Review the Model Insurance Holding Company Act (#440) and Regulation (#450) (HCA Model Act) and consider amendments to address issues that have arisen subsequent to the adoption of the Act and Regulation by the NAIC in 2010.*

At the 2014 Spring National Meeting, the Executive (EX) Committee approved a model law development request to begin work on this charge. Shortly after the 2014 Spring National Meeting, the chair of the Financial Condition (E) Committee distributed a memorandum to the Group Solvency Issues (E) Working Group and the Receivership and Insolvency (E) Task Force that set forth four specific areas to be considered in this review of potential changes to these models. On April 28, 2014, the Working Group held its first conference call to discuss all of the issues assigned to it. On an Oct. 3, 2014, conference call, the Working Group began discussions on the issues resulting in the proposed changes to Model #440.

4. A General Description of the Drafting Process and Due Process

Shortly after the 2014 Spring National Meeting, the chair of the Financial Condition (E) Committee distributed a memorandum to the Group Solvency Issues (E) Working Group that gave it broad direction on issues to be considered in addressing its charge. As it pertains to the specific changes to Model #440, the memorandum suggested the Working Group start the discussions dealing with the authority to act as the group-wide supervisor by first considering language included in the Pennsylvania statute that provides such authority. On Aug. 22, 2014, the Working Group exposed for a public comment period changes to Model #440 that incorporated language from the Pennsylvania statute. The Working Group received comments from the industry and discussed the comments during public conference calls held Oct. 3, Oct. 10, Oct. 16 and Oct. 24, 2014. The Oct. 3 and Oct. 10 conference calls were dedicated to allowing the industry to expand on their comments. The Oct. 16 and Oct. 24 conference calls were dedicated to making decisions to address the concerns of the industry. Subsequent to the Oct. 24 conference call, a revised Model #440 was drafted and then discussed on a Nov. 7 conference call. The Working Group received two comments letters regarding the Nov. 7, 2014, version of Model #440 and discussed those comments during its meeting at the 2014 Fall National Meeting. The Working Group received one additional comment letter and discussed it on a Dec. 3, 2014, conference call. On that conference call, the Working Group adopted a revised Model #440. In total, eight comment letters were received from interested parties.

5. A Discussion of the Significant Issues

The following topics were generally considered to be the most significant:

a. Section 1—Replace definition of "international insurance group" with "internationally active insurance group."
   - The Group Solvency Issues (E) Working Group originally proposed that the new section of Model #440 would apply to all international insurance groups, as contained within the Pennsylvania statute.
   - Numerous industry trade associations suggested the new section only apply to groups that would be subject to the IAIS' Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). The Working Group originally decided that the language should remain broad enough to encompass all international insurance groups, but later sought and received direction from certain regulators active in international work streams, who advised that the scope should encompass IAIGs only.
   - The revised Model #440 changes only apply to IAIGs as defined within the model law.

b. Section 7.1.A(2)—Add a discretionary provision to allow the insurance commissioner to apply the new section to more than just IAIGs.
   - The Group Solvency Issues (E) Working Group believed that such authority may be necessary for two reasons: 1) the IAIS may change the ComFrame criteria to where the figures may not capture all (or too many) of the groups that are expected to be subject to ComFrame; and 2) the understanding that the NAIC position was to support the use of a state's discretionary authority with respect to ComFrame.
   - Numerous industry trade associations suggested the new section only apply to groups that would be subject to ComFrame. The Working Group originally decided that the language should remain broad enough to encompass all international insurance groups, but later sought and received direction from certain regulators active in international work streams, who advised that the scope should encompass IAIGs only.
   - The Working Group discussed this concept on Nov. 7, Nov. 16 and Dec. 3, 2014. During this time period, there was some communication between the Working Group and the ComFrame Development and Analysis (G) Working Group related to this issue and a question concerning the need for discretionary language. This communication took place largely because of the correlation between the scope of groups covered under the changes to Model #440 and the scope of groups covered under ComFrame. However, on Dec. 3, the Working Group made it clear that it was not adopting ComFrame within the changes to this model, and that if the NAIC chooses to adopt portions of ComFrame, other future changes may need to be made to the model. However, completion of ComFrame is not expected for a significant period of time.
   - The revised Model #440 does not contain such regulator discretionary language.

c. Section 7.1.B—Factors for Determining the Group-Wide Supervisor.
   - The Group Solvency Issues (E) Working Group originally proposed factors as included in the Pennsylvania statute.
   - All industry trade associations expressed concerns with the proposed factors, including most notably the inclusion of a factor for the domicile of the ultimate controlling party. The industry trade associations suggested factors related to specific entities should be focused on the insurance legal entities as opposed to non-insurance legal entities. The Working Group agreed to make such changes.
   - The industry trade associations were split on the manner in which to consider the factors. Some industry trade associations were interested in a tiered approach that placed the greatest emphasis on 1) the place of domicile of the largest insurer(s) within the group; and 2) the place of domicile of the top-tiered insurer in the group. Under the tiered approach, other criteria would only be considered if the determination was unclear after applying these two factors. Other industry trade associations were interested in equal consideration of all factors being considered, similar to the existing *Financial Analysis Handbook* guidance.
   - The Working Group decided to reject the tiering approach and instead consider all factors. In adopting the all-factor approach, the Working Group adopted additional changes on its Dec. 3, 2014, conference call, including a proposal by one trade association intended to address concerns regarding the potential difference in results between the two approaches.
   - The revised Model #440 utilizes the all-factor approach.

d. Section 7.1.E(3)—Authority of the Group-Wide Supervisor.
   - The Group Solvency Issues (E) Working Group originally included authority as exists in the Pennsylvania statute.
   - All industry trade associations expressed concern with this aspect of the Pennsylvania language and, more specifically, how it may provide the insurance commissioner with extraterritorial jurisdiction over entities domiciled elsewhere. The industry developed revised language authorizing the commissioner to exercise authority to require mitigation of enterprise risks, but such authority must be exercised in coordination with other jurisdictions.
   - The revised Model #440 contains language as proposed by the industry.

e. Section 7.1.E(6)—Other Authority of the Group-Wide Supervisor.
   - The Group Solvency Issues (E) Working Group originally included authority as included in the Pennsylvania statute, including what has been described as a "catch-all provision."
   - All of the industry trade associations expressed concern that such authority was too broad, and needed to be narrowed to where such authority was specified, or at least consistent with the intended scope of considering the enterprise risk of the group. The Working Group rejected the industry suggestion of deleting the "catch-all provision," as well as alternative language proposed by the industry at the 2014 Fall National Meeting.
   - Subsequent to the 2014 Fall National Meeting, the industry trade associations submitted revised proposed language to address the intent of the Working Group. The Working Group adopted the revised language on a Dec. 3, 2014, conference call.

6. Any Other Important Information

Because the scope of the proposed changes to Model #440 limit its applicability to groups with a) premiums written in at least three countries; b) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums; and c) groups with total assets of the insurance holding company system are at least $50 billion or total gross written premiums of the insurance holding company of at least $10 billion, there may be some question whether this language is necessary for the states that would not be considered the lead state for such a group. However, because the groups that do meet the above criteria tend to operate in the vast majority of the states, and the proposed changes to Model #440 discuss the authority of domestic regulators to cooperate together to require certain action by the insurance holding company, it is recommended that all states consider enacting this statutory language.

PROJECT HISTORY – 2011

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)

1. Description of the Project, Issues Addressed, etc.

In the wake of the recent financial crisis as well as discussions regarding group supervision that have been taking place in the international regulatory community, U.S. state insurance regulators have become aware of the necessity to enhance the insurance Holding Company System Model Act (Model #440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (Model #450) to address group supervision. At the heart of the lessons learned from the recent financial crisis is the ability of regulators to be able to assess the enterprise risk within a holding company system and its impact on an insurer within the group.

As recommended by the Group Solvency Issues (EX) Working Group, the U.S. insurer solvency regime should consider incorporating certain prudential benefits of group supervision, providing a clearer window into group operations, while building upon, the existing walls which provide solvency protection. Ultimately, this enhanced "windows and walls" approach should provide greater and much needed breadth and scope to solvency regulation while retaining the highest level of policyholder protection that exists currently. The concepts addressed in the enhanced "windows and walls" approach include such items, such as: communication between regulators; supervisory colleges; access to and collection of information; and enforcement measures.

The first step to accomplish building better windows is by addressing some of these topics as well as lessons learned during the recent financial crisis through enhancements to the insurance holding company laws and regulations.

2. Name of Group Responsible for Drafting the Model and States Participating

The Group Solvency Issues Working Group of the Executive (EX) Committee was charged by the Financial Condition (E) Committee with drafting revisions to Model #440 and Model #450. The 2010 members of the Working Group that drafted and adopted the revised models on June 14, 2010, were: Nebraska and Texas (co-Chairs), California, Connecticut, Delaware, Florida, Illinois, Iowa, New York, Pennsylvania and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

During the February 11, 2009, conference call, the Financial Condition (E) Committee agreed to revise the holding company models, but suggested the technical work be delegated to a Working Group under the Solvency Modernization Initiative (EX) Task Force that was working on other group related initiatives. Based on this recommendation and referral, the Task Force drafted charges for a new working group that would focus on groups issues, including the NAIC Holding Company Models. The Working Group's charges related to the models were as follows:

- Study the need to modify the Holding Company Model Act by gathering input from all states regarding the use of the existing model and its effectiveness in addressing the issues that exist within insurer groups, particularly considering issues identified during this most recent economic downturn. At the conclusion of such study, provide a recommendation to the Financial Condition (E) Committee.
- Study the international solvency issues related to groups and the need to modify the Holding Company Model Act for any proposed changes in this area. This study should include consideration of the interaction between federal and state financial regulators and any changes that would be necessary to improve regulatory oversight provided by the Holding Company Model Act. At the conclusion of such study, provide a recommendation to the Financial Condition (E) Committee.

On August 18, 2009, the Financial Condition (E) Committee via electronic vote adopted the model law development form related to models #440 and #450. It was adopted by Executive and Plenary during the 2009 Fall National Meeting.

4. A General Description of the Drafting Process and Due Process

An initial survey of state insurance regulators and industry was conducted in June 2009 to gather ideas for areas of focus in drafting revisions to the Models focusing on area where the Models need improvement based on states' experience and the need for more focus on group issues. Twelve states submitted initial proposed language to address the eleven key topics identified in the initial survey.

Many open meetings were conducted to discuss this project. During these meetings, comment letters were discussed, and language was drafted (with some sections specifically assigned to interested parties or interested regulators to draft). Between May 2009 and June 2010, the Working Group conducted 15 public conference calls, five public meetings at NAIC National Meetings and one public interim hearing in June 2010. Financial Condition (E) Committee conducted three public conference calls.

Exposure drafts were released for public comment at multiple times. Public comment periods included December 2009, January 2010, March 2010, May 2010, June 2010 and July 2010.

All comment letters were considered and discussed by the Working Group in public sessions. In total, 27 comment letters were received from regulators and 36 comment letters were received from interested parties. Additionally, Financial Condition (E) Committee received and considered ten comment letters (one regulator and nine interested parties).

On June 18, 2010 the Working Group unanimously adopted revisions to Model #440 and #450 to be sent to Financial Condition (E) Committee for the Committee's consideration with the caveat that centralization data collection and confidentiality of enterprise risk supplemental filing should be addressed by Executive. E Committee met three times on August 5th adopted the revisions to the Models to be sent to Exec/Plenary.

Subsequent Discussions (Post Adoption by Financial Condition (E) Committee) – Director Ann Frohman and Danny Saenz, Chairs of GSIWG, and NAIC Legal and Executive Staff have engaged in numerous discussions with certain large industry trade organizations regarding the centralized filing of information at the NAIC. During these discussions these industry organizations were given significant time and opportunity to provide a compromise and to discuss these issues.

5. A Discussion of the Significant Issues

The following topics for revisions within the Models were discussed extensively with regulators and interested parties:

a. Model #440 Section 1—definitions of "enterprise risk".
   - Purpose of this change is to define a new term used in other revisions within the model.
   - This topic was addressed on GSIWG conference calls and the June 4th hearing. Interested party comments generally suggested replacing the definition of "contagion" with "enterprise risk', and voiced concerns with the phrase "has the potential" and with the term "contagion" being speculative. Comments were heard and discussed. Definitions of contagion was eliminated enterprise risk was incorporated in the model.

b. Model #440 Section 3A4—Notification of divestiture of controlling interests.
   - Purpose of this change is to allow for notification to the state of any divestiture of controlling interests. Regulators' have experienced divestitures that were not in the best interest of the policyholders and where regulators were not given prior notice.
   - This topic was introduced on the May 14th call with a separate exposure document released for comment. It was further discussed on the subsequent calls and the June 4th hearing. The GSIWG heard and discussed comments and made certain edits as a result.

c. Model #440 Sections 3B12, 3B13, 4B8, 11F and Model #450 Form A Item #13 & Form B Item #9—The filing of a report of the ultimate controlling person which identifies material risks within the insurance holding company system that could pose financial and/or reputational contagion to the insurer and potential sanctions.
   - This change is in response to recent economic downturns and worldwide discussions on contagion risk within the financial sector. It is also in response to regulators' experience regarding the financial impact that non-insurance entities within the group can have on an insurance company's financial solvency. The change is intended to provide regulators with more information about potential risks to the insurer.
   - This topic was discussed on multiple calls, revised and new draft language was re-released for public comment. Subsequent edits were also made. Interested party comments primarily focusing on this section being too broad, inconsistent, and creation of the presumption that insurers need to over-comply with the provision in order to cover all foreseeable circumstances in their reporting were heard and discussed on subsequent calls and the June 4th hearing.

d. Model #440 Section 4B5—Providing insurance holding company system financial statements.
   - This change is intended to provide regulators with access to more insurance holding company system information through the filing of holding company financial statements.
   - This topic was discussed on multiple GSIWG calls. Interested parties were heard and given the opportunity to submit optional draft language regarding SEC filings. Edits to the original draft language were made regarding the acceptance of SEC filings.

e. Revisions as they relate to corporate governance including 1) Model #440 section 4B7 —Statements of the Board of Directors; and 2) Model #440 Section 5C—Independence of Board of directors and committees no longer being optional language and the section edited so as not to conflict with the Model Audit Rule.
   - Section 4B7 requires the insurer's board of directors to make statements regarding the corporate governance and internal control responsibilities within the registration statement. Section 5C was changed to no longer be an "optional" section of the model by the Working Group but was revered by the E Committee. The section addresses board of director composition and committee responsibilities (which were edited to be in line with the Model Audit Rule). Additionally, a new paragraph with criteria for waiving the insurer from the requirements of the section was added.
   - These topics were discussed on multiple GSIWG calls and were referred to the Corporate Governance (EX) Working Group (CGWG). It was discussed by CGWG on two public conference calls where interested party comments were considered. Interested party concerns primarily related to suggestions to remove corporate governance language as it was felt is was not appropriate in these models or if not removed to modify the language to reflect that management was "responsible for" and that boards "oversee" rather than stating boards were "responsible for". CGWG made some edits, however retaining the "board is responsible for…" language and the no longer optional section 5C, and sent recommendations to GSIWG. GSIWG heard additional discussion at the June 4th hearing and made edits to section 5C waiver language.

f. Model #440 Section 4K—Disclaimer of affiliation.
   - The change includes language regarding disallowance of a disclaimer of affiliation and request for an administrative hearing.
   - GSIWG discussed this recommended change on the Feb. 26th call and the June 4th hearing. Comments regarding wording changes were heard and edits were made.

g. Model #440 Section 5A1b and Model #450 Section 19. Requirements of agreements for cost sharing services and management.
   - The intent of these changes is to provide minimum requirements for the agreements for cost sharing and management services in order to eliminate the potential for capital to flow out of the insurer through these types of agreements.
   - This topic was discussed on several GSIWG calls. Interested party comments were heard and considered. Numerous edits were made to the original draft language.

h. Model #440 Section 5A2—Amendments or modifications of affiliated agreements.
   - The change requires notification of amendments and modifications to affiliated transactions including requirements for the notification. Included in the change is the addition of notification of all reinsurance pooling agreements and agreements that are projected to be material to surplus.
   - This topic was discussed on several GSIWG calls and the June 4th hearing. Numerous edits were made to the original draft language.

i. Model #440 Section 6—Examination of affiliates, access to books and records and compelling production of information as it relates to examinations.
   - The changes to Section 6 are intended to give regulators power to examine the insurer and its affiliates, to provide better access to books and records of affiliated entities within the insurance holding company system and to compel the insurer to provide that access to those books and records in an effort to better ascertain the financial condition of the insurer and any contagion risk within the insurance holding company system.
   - The GSIWG addressed the topic on multiple conference calls including allowing interested parties to provide optional language. Interested parties expressed concerns about the potential for penalties and that the ability to examine an affiliate was overly broad and exceeded state jurisdictions. Proposed optional language was not accepted by GSIWG.

j. Model #440 Section 7—Supervisory Colleges.
   - As there is a world-wide push for more group-wide supervision of insurance holding company systems with international operations, this new section provides the regulators the authority to recoup expenses incurred for attending or conducting supervisory colleges from domestic insurers whose group is engaging in international activities.
   - The Supervisory Colleges and Methods of Cross-Border Communication (EX) Subgroup met in open session and drafted the language for this new section of Model #440.

- This topic was discussed on by the GSIWG and interested party comments were heard and considered. A few edits were made to the section by GSIWG.

6. Any Other Important Information

None

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS

Table of Contents

Section 1. Authority

These regulations are promulgated pursuant to the authority granted by Sections [insert applicable sections] and [insert applicable section] of the Insurance Law.

Drafting Note: Optional for those states in which similar provisions are normally used.

Section 2. Purpose

The purpose of these regulations is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the NAIC Insurance Holding Company System Regulatory Act [insert applicable sections] of the Insurance Code hereinafter referred to as "the Act." The information called for by these regulations is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this State.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

Drafting Note: Optional for those states in which similar provisions are normally used.

Section 3. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

Drafting Note: Optional for those states in which similar provisions are normally used.

Section 4. Forms - General Requirements

A. Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by Sections 3, 3.1, 4, and 5 of the Act. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

B. [Insert number] complete copies of each statement including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of [insert state and address], Attention: [insert name - title]. At least one of the copies shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

C. If an applicant requests a hearing on a consolidated basis under Section 3D(3) of the Act, in addition to filing the Form A with the commissioner, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

D. Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

Drafting Note: Section 4 may be omitted if it is included as instructions on Forms A, B, C, D, E and F.

Section 5. Forms - Incorporation by Reference, Summaries and Omissions

A. Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three (3) years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear or confusing.

B. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three (3) years and may be qualified in its entirety by such reference. In any case where two (2) or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

Drafting Note: Section 5 may be omitted if it is included as instructions on Forms A, B, D, E and F.

Section 6. Forms-Information Unknown or Unavailable and Extension of Time to Furnish

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there shall be filed with the Commissioner a separate document:

A. Identifying the information, document or report in question;

B. Stating why the filing thereof at the time required is impractical; and

C. Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Commissioner within [XX] days after receipt thereof enters an order denying the request.

Drafting Note: Section 6 may be omitted if it is included as instruction on Forms A, B, C, D, E and F.

Section 7. Forms - Additional Information and Exhibits

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: "Change No. [insert number] to" and shall indicate the date of the change and not the date of the original filing.

Drafting Note: Section 7 may be omitted if it included as instructions on Forms A, B, C, D, E and F.

Section 8. Definitions

A. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

B. "Ultimate controlling person" means that person which is not controlled by any other person.

C. Unless the context otherwise requires, other terms found in these regulations and in Section 1 of the Act are used as defined in the Act. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined by the Code.

Drafting Note: If regulation Section 2 is not adopted by the state, the following definition should be added to this section: "The Act" means the Insurance Holding Company System Regulatory Act [insert applicable sections of the Insurance Code].

Section 9. Subsidiaries of Domestic Insurers

The authority to invest in subsidiaries under Section 2B of the Act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

Section 10. Acquisition of Control - Statement Filing

A person required to file a statement pursuant to Section 3 of the Act shall furnish the required information on Form A, hereby made a part of this regulation. Such person shall also furnish the required information on Form E, hereby made a part of this regulation and described in Section 13 of this regulation.

Section 11. Amendments to Form A

The applicant shall promptly advise the Commissioner of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Commissioner's disposition of the application.

Section 12. Acquisition of Section 3A(4) Insurers

A. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of Section 3A(4) of the Act, the name of the domestic insurer on the cover page should be indicated as follows:

"ABC Insurance Company, a subsidiary of XYZ Holding Company."

B. Where a Section 3A(4) insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Section 13. Pre-Acquisition Notification

If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to Section 3A(1) of the Act, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to Section 3.1C(1) of the Act.

Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to Section 3.1 of the Act, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of Section 3.1 as set forth in Section 3.1B(2).

In addition to the information required by Form E, the Commissioner may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Section 14. Annual Registration of Insurers - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act shall furnish the required information on Form B, hereby made a part of these regulations.

Section 15. Summary of Registration - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act is also required to furnish information required on Form C, hereby made a part of these regulations.

Section 16. Amendments to Form B

A. An amendment to Form B shall be filed within fifteen (15) days after the end of any month in which there is a material change to the information provided in the annual registration statement.

B. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each amendment shall include at the top of the cover page "Amendment No. [insert number] to Form B for [insert year]" and shall indicate the date of the change and not the date of the original filings.

Drafting Note: Section 16 may be omitted if Section 5A(2) of the Model Act has been adopted and amendments to the registration statement are therefore not required by the Act.

Section 17. Alternative and Consolidated Registrations

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 4 of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this State. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its State of domicile, provided:

(1) The statement or report contains substantially similar information required to be furnished on Form B; and

(2) The filing insurer is the principal insurance company in the insurance holding company system.

B. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

C. With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under Subsection A above.

D. Any insurer may take advantage of the provisions of Section 4H or 4I of the Act without obtaining the prior approval of the Commissioner. The Commissioner, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

Section 18. Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

(1) The number of authorized, issued and outstanding voting securities of the subject;

(2) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;

(3) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

(4) A statement explaining why the person should not be considered to control the subject.

B. A request for termination of registration shall be deemed to have been granted unless the Commissioner, within thirty (30) days after receipt of the request, notifies the registrant otherwise.

Section 19. Transactions Subject to Prior Notice - Notice Filing

A. An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

(1) Identify the person providing services and the nature of such services;

(2) Set forth the methods to allocate costs;

(3) Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;

(4) Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

(5) State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

(6) Define records and data of the insurer to include all records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

(7) Specify that all records and data of the insurer are and remain the property of the insurer, and:

(a) Are subject to control of the insurer;

(b) Are identifiable; and

(c) Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer;

Drafting Note: The "at no additional cost to the insurer" language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

(8) State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

(9) Include standards for termination of the agreement with and without cause;

(10) Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;

(11) Specify that if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]:

(a) All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state];

(b) All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the commissioner;

Drafting Note: The "at no additional cost to the receiver or the commissioner" language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the receiver or the commissioner. Since records and data of the insurer are the property of the insurer, the receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

(c) A complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable; and,

Drafting Note: The fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

(d) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts];

(13) Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;

(14) Specify that the affiliate will continue to maintain any systems, programs or other infrastructure, notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court; and

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).

Section 20. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 4L(1) of the Act shall furnish the required information on Form F, hereby made a part of these regulations.

Section 21. Group Capital Calculation

A. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation if the lead state commissioner makes a determination based upon that filing that the insurance holding company system meets all of the following criteria:

(1) Has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000;

(2) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

(3) Has no banking, depository or other financial entity that is subject to an identified regulatory capital framework within its holding company structure;

(4) The holding company system attests that there are no material changes in the transactions between insurers and non-insurers in the group that have occurred since the last filing of the annual group capital; and

(5) The non-insurers within the holding company system do not pose a material financial risk to the insurer's ability to honor policyholder obligations.

B. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to accept in lieu of the group capital calculation a limited group capital filing if:

(1) The insurance holding company system has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000; and all of the following additional criteria are met:

(a) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

(b) Does not include a banking, depository or other financial entity that is subject to an identified regulatory capital framework; and

(c) The holding company system attests that there are no material changes in transactions between insurers and non-insurers in the group that have occurred since the last filing of the report to the lead state commissioner and the non-insurers within the holding company system do not pose a material financial risk to the insurers ability to honor policyholder obligations.

C. For an insurance holding company that has previously met an exemption with respect to the group capital calculation pursuant Section 21A or 21B of this regulation, the lead state commissioner may require at any time the ultimate controlling person to file an annual group capital calculation, completed in accordance with the NAIC Group Capital Calculation Instructions, if any of the following criteria are met:

(1) Any insurer within the insurance holding company system is in a Risk-Based Capital action level event as set forth in [insert cross-reference to appropriate section of Risk-Based Capital (RBC) Model Act] or a similar standard for a non-U.S. insurer; or

(2) Any insurer within the insurance holding company system meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [insert cross-reference to appropriate section of Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition]; or

(3) Any insurer within the insurance holding company system otherwise exhibits qualities of a troubled insurer as determined by the lead state commissioner based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

D. A non-U.S. jurisdiction is considered to "recognize and accept" the group capital calculation if it satisfies the following criteria:

(1) With respect to the [insert cross-reference to Section 4L(2)(d) of the Model Act]

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction; or

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a).

(2) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force.

E. A list of non-U.S. jurisdictions that "recognize and accept" the group capital calculation will be published through the NAIC Committee Process:

(1) A list of jurisdictions that "recognize and accept" the group capital calculation pursuant to [insert cross-reference to Sections 4L(2)(d)], is published through the NAIC Committee Process to assist the lead state commissioner in determining which insurers shall file an annual group capital calculation. The list will clarify those situations in which a jurisdiction is exempted from filing under [insert cross-reference to Sections 4L(2)(d)]. To assist with a determination under 4L(2)(e), the list will also identify whether a jurisdiction that is exempted under either [insert cross-reference to Sections 4L(2)(c) and 4L(2)(d)] requires a group capital filing for any U.S. based insurance group's operations in that non-U.S. jurisdiction.

(2) For a non-U.S. jurisdiction where no U.S. insurance groups operate, the confirmation provided to meet the requirement of Section 21D(1)(b) will serve as support for recommendation to be published as a jurisdiction that "recognizes and accepts" the group capital calculation through the NAIC Committee Process.

(3) If the lead state commissioner makes a determination pursuant to Section 4L(2)(d) that differs from the NAIC List, the lead state commissioner shall provide thoroughly documented justification to the NAIC and other states.

(4) Upon determination by the lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to "recognize and accept" the group capital calculation, the lead state commissioner may provide a recommendation to the NAIC that the non-U.S. jurisdiction be removed from the list of jurisdictions that "recognize and accepts" the group capital calculation.

Section 22. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(1) The amount of the proposed dividend;

(2) The date established for payment of the dividend;

(3) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

(4) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

(a) The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(b) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(c) If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

(d) If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and

(e) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two (2) calendar years;

(5) A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

(6) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

B. Subject to Section 5B of the Act, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsection A(4).

Section 23. Adequacy of Surplus

The factors set forth in Section 5D of the Act are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Commissioner instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

FORM A

STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

BY

_____
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

_____
(State of domicile of insurer being acquired)

Dated:_____, 20_____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

_____

ITEM 1. METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address.

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(c) Material occupations, positions, offices or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding 5 fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if the information is available. The statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or regulation Sections 4 and 6.

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 3 of the Act _____ has caused this application to be duly signed on its behalf in the City of _____ and State of on the _____ day of _____, 20_____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20_____, for and on behalf of _____(Name of Applicant); that (s)he is the _____(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath)_____

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) The principal business of the person;

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and

(i) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

Drafting Note: Commissioner may by rule, regulation or order provide otherwise.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Changes to Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _____ and State of _____ on the _____ day of _____, 20 _____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____(Name of Applicant); that (s)he is the _____(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath)_____

FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _____ and State of _____ on the _____ day of _____, 20 _____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____(Name of Applicant); that (s)he is the _____(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath)_____

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.;

(e) A description of the nature of the parties' business operations;

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under Section 5A(2)(a), (b), (c), (d), or (e) of the Act;

(b) A statement of the nature of the transaction;

(c) A statement of how the transaction meets the 'fair and reasonable' standard of Section 5A(1)(a) of the Act; and

(d) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by Section 5A(2)(c)(ii) of the Act, or a reinsurance pooling agreement or modification thereto as described by Section 5A(2)(c)(i) of the Act, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS.

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed;

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;

(b) A description of the period of time during which the agreement is to be in effect;

(c) A brief description of each party's expenses or costs covered by the agreement;

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement;

(e) A brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

(f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and

(g) A statement regarding compliance with the *NAIC Accounting Practices and Procedure Manual* regarding expense allocation.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 5 of the Act, _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 ____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20_____, for and on behalf of _____(Name of Applicant); that (s)he is the _____(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath)_____

FORM E

**PRE-ACQUISITION NOTIFICATION FORM
REGARDING THE POTENTIAL COMPETITIVE IMPACT
OF A PROPOSED MERGER OR ACQUISITION BY A
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS
STATE OR BY A DOMESTIC INSURER**

_____
Name of Applicant

_____
Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of

_____

Dated:_____, 20 _____

Name, title, address and telephone number of person completing this statement:

_____

_____

_____

_____

ITEM 1. NAME AND ADDRESS

State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES

State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION

State the nature and purpose of the proposed merger or acquisition.

ITEM 4. NATURE OF BUSINESS

State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.

ITEM 5. MARKET AND MARKET SHARE

State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in Section 3.1D of the Act. If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

Drafting Note: State Insurance Departments may additionally choose to make these calculations using their own data or data provided by the National Association of Insurance Commissioners.

FORM F

ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in [insert cross reference to definition of Enterprise Risk in Section 1F of the Act], provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;
- Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;
- Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;
- Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;
- Business plan of the insurance holding company system and summarized strategies for the next 12 months;
- Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in the last year;

- Identification of insurance holding company system capital resources and material distribution patterns;

- Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

- Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

- Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. IIB 1055-1066 (printed).
1971 Proc. I 54, 58, 134, 149 (adopted).
1986 Proc. II 12, 19-20, 93-94, 109-123 (amended).
1993 Proc. 1st Quarter 3, 33, 362, 364-370 (amended).
2011 Proc. 1st Quarter I 3-11 (amended).
2013 3rd Quarter (editorial revision).
2020 Fall National Meeting (amended).
2021 Summer National Meeting (amended).

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

*** Please refer to the map contained in the link below for state adoption of the Group Capital Calculation amendments:** https://content.naic.org/sites/default/files/smi_state_adoption_maps_models.pdf

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-055-.01 to 482-1-055-.021; Form A to Form F (1974/2018).
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 21.010 to 21.195 (1977/2015).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. ADMIN. CODE §§ R20-6-1401 to R20-6-1410; Apps. A to G (1993/2015).	
Arkansas		ARK. ADMIN. CODE §§ 054.00.15-1 to 054.00.15-23 (1971/2016).	
California		CAL. CODE REGS. tit. 10, §§ 2683 to 2683.23 (1971/2016); CAL. INS. CODE §1215.4 (1969/2012).	
Colorado		3 COLO. CODE REGS. § 702-3:3-4-1 (2012/2015).	
Connecticut		CONN. AGENCIES REGS. §§ 38a-138-1 to 38a-138-16 (1993/2018).	BULLETIN FS-28-2014 (2014).

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	18 DEL. CODE REGS. §§ 1801-1.0 to 1801-24.0 (1973/2022).		
District of Columbia		D.C. MUN. REGS. tit. 26-A, §§ 1600 to 1699 (1974/2015).	
Florida		FLA. ADMIN. R. 69O-143.046 (1970/2017).	
Georgia		GA. COMP. R. & REGS. §§ 120-2-23.01 to 120-2-23.22; Form A to Form F (1970/2015).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. CODE R. §§ 16-14-1 to 16-14-11 (1994/2016).	
Idaho		IDAHO ADMIN. CODE r. 18.01.23 (1973/2014).	
Illinois		ILL. ADMIN. CODE tit. 50, § 651 to 655 (1972/2022).	
Indiana		760 IND. ADMIN. CODE 1-15.1-1 to 1-15.1-16 (2007/2014).	
Iowa		IOWA ADMIN. CODE r. §§ 191-45.1 to 191-45.12 (1970/2015).	
Kansas		KAN. ADMIN. REGS. § 40-1-28 (1976/2015).	
Kentucky		806 KY. ADMIN. REGS. 37:010; Form A to Form F (1992/2014) (previous version of model).	
Louisiana		LA. ADMIN. CODE tit. 37, §§ XIII.101 to XIII.143 (Reg. 31) (1992/2016).	
Maine	02-031-180 ME. CODE R. §§ 1 to 22; Forms A to F (1975/2022).		

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland		MD. CODE REGS. 31.04.18.01 to 31.04.18.14 (2016).	BULLETIN 2015-15 (2015).
Massachusetts		211 MASS. CODE REGS. §§ 7.01 to 7.15 (1971/2014).	
Michigan		MICH. COMP. LAWS §§ 500.1301 to 500.1379 (1917/2015).	
Minnesota		MINN. R. 2720.0110 to 2720.9940 (1972/1983).	
Mississippi		19 MISS. CODE R. Pt. 1, §§ R. 20.01 to R. 20.30 (2012/2017).	
Missouri		MO. CODE REGS. ANN. tit. 20, §§ 200-11.101 to 200-11.150 (1992/2022) (GCC).	
Montana	MONT. ADMIN. R. 6.6.3701 to 6.6.3719 (1993/2022) (GCC).		
Nebraska		210 NEB. ADMIN. CODE § 24 (1972/2013) ; L.B. 863 (2022) (GCC)	
Nevada		NEV. ADMIN. CODE §§ 692C.010 to 692C.350 (1973/2022) (GCC).	NEV. REV. STAT. §§ 692C.010 to 692C.490 (1973/2017).
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. 1501 to 1501.2019; Form A to Form F (2007/2014).	
New Jersey		N.J. ADMIN. CODE §§ 11:1-35.1 to 11:1-35.14 (1993/2016).	N.J. INS. ORDER A15-104 (2015).
New Mexico		N.M. CODE R. §§ 13.2.2.1 to 13.2.2.18 (1997/2018).	
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 80-1.1 to 80-1.9 (1986/2017).	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 81-1.0 to 81-1.3 (1985/2013); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 82.1 to 82.5 (2014); CIRCULAR LETTER 2010-10 (2010).

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina		N.C. GEN. STAT. § 58-19-25 (2015).	
North Dakota		N.D. ADMIN. CODE §§ 45-03-05-01 to 45-03-05-19; Form A to Form F (1982/2016).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE §§ 3901:3-01 to 3901:3-02 (1991/2015).	
Oklahoma		OKLA. ADMIN. CODE §§ 365:25-7-20 to 365:25-7-31 (1971/2019).	
Oregon		OR. ADMIN. R. 836-027-0001 to 836-027-0180 (1976/2016).	
Pennsylvania		31 PA. CODE §§ 25.1 to 25 App. A (1982/2014); S.B. 1222 (2022) (GCC)	
Puerto Rico			P.R. RULE NO. 83 (2010).
Rhode Island	20-45-1 R.I. CODE R. §§ 1 to 28; Forms A to F (1971/2022).		
South Carolina		S.C. CODE ANN. REGS. 69-14 (1969/2015).	
South Dakota		S.D. ADMIN. R. 20:06:09:11 to 20:06:09:47 (1993/2015).	
Tennessee		TENN. COMP. R. & REGS. §§ 0780-1-67-.01 to 0780-1-67-.23; Form A to Form F (1995/2015).	
Texas	28 TEX. ADMIN. CODE §§ 7.201 to 7.214 (1976/2016).		
Utah		UTAH ADMIN. CODE R590-70-1 to R590-70-22 (2017).	
Vermont		4-3-2 VT. CODE R. §§ 1 to Form F (1971/2014).	4-6-5 VT. CODE R. §§ 1 to 18 (2012).

INSURANCE HOLDING COMPANY MODEL REGULATION WITH REPORTING FORMS & INSTRUCTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-260-10 to 5-260-110 (1980/2022).		
Washington		WASH. ADMIN. CODE 284-18-300 to 284-18-960 (1993/2015).	
West Virginia		W. VA. CODE R. §§ 114-35-1 to 114-35-20; Apps. A to F (1994/2012).	
Wisconsin	WIS. ADMIN. CODE INS. §§ INS. 40.01 to 40.21; Forms A to AA (1993/2022) (GCC).		
Wyoming		044-45 WYO. CODE R. §§ 1 to 21, Forms A to F (1991/2013).	

PROJECT HISTORY-2021

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)
(Receivership)

1. Description of the Project, Issues Addressed, etc.

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

> *"Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership."*

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.

3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI's proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5.A.(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties' revisions.

7. List the key provisions of the model (sections considered most essential to state adoption).

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- Section 5A(1) of Model #440
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- Section 5A(6) of Model #440
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- Section 19 of Model #450
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

8. Any Other Important Information (e.g., amending an accreditation standard).

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

PROJECT HISTORY - 2020

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)
(Group Capital Calculation (GCC))

1. Description of the Project, Issues Addressed, etc.

In 2015, the NAIC Plenary adopted a charge to the Financial Condition (E) with respect to the construction of a group capital calculation (GCC). The Financial Condition (E) Committee subsequently formed the Group Capital Calculation (E) Working Group to carry out the following charge:

> ***"Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation."***

The charge was developed primarily as a result of discussions that revealed that developing a GCC was a natural extension of work that state insurance regulators had already begun on group supervision as a result of the lessons learned from the 2008 financial crisis. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. More specifically, the GCC and related reporting provides more transparency to state insurance regulators regarding insurance groups and make risks more identifiable and more easily quantified.

It is important to understand that the GCC utilizes an aggregation approach to group capital where existing legal entity capital requirements [e.g., risk-based capital (RBC)] and existing valuation for capital (e.g., statutory accounting) are utilized. In selecting this approach, it was recognized as satisfying state regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and the industry, in addition to respecting other jurisdictions' existing capital regimes. To capture the risks associated with the entire insurance group, including the insurance holding company, calculations were developed in those instances where no RBC calculations currently exist (i.e., non-regulated entities) and are part of the GCC. The methods selected were tested in 2019 by more than 30 insurance groups representing 15 lead states. These methods have since been modified to consider the lessons learned from the testing and subsequent comments from the industry and state insurance regulators. The more significant items are discussed in paragraph 6 below.

Also important in finalizing the GCC was the scope of groups that would be required to complete it. Specifically, Model #440 exempts single-state companies, insurers located in reciprocal jurisdictions that have already recognized the U.S. approach to group supervision and group capital, as well as other jurisdictions that agree to recognize the U.S. approach to group capital. Model #450 also provides commissioners with additional discretion to exempt groups that have less than $1 billion in premium, provided the group has no non-U.S. insurers, has no banks or similar financial institutions, and has non-risky non-regulated entities within the group.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee drafted the revisions to Model #440 and Model #450. The 2020 members of the Working Group were: Florida (Chair); Connecticut (Vice Chair); California; District of Columbia; Illinois; Indiana; Iowa; Massachusetts; Michigan; Minnesota; Missouri; Nebraska; New Jersey; New York; North Carolina; Ohio; Oregon; Pennsylvania; Tennessee; Texas; Virginia; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group.

At the 2015 Fall National Meeting, the Financial Condition (E) Committee received the following charge:

> *"Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group*

capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Group Capital Calculation (E) Working Group began its work on the GCC in 2016 and spent the next two-and-one-half years constructing the calculation. Over the course of that time, the Working Group conducted numerous public conference calls to discuss the proposed construction on a topic-by-topic basis. In 2019, the Working Group set up a voluntary process under which the GCC was tested by more than 30 insurance groups represented by 15 lead states. This testing was completed in early 2020, at which time the Working Group began to make changes to the GCC to reflect the learnings from the testing. Simultaneously with this testing, at the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group's request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In addition to requiring the filing of the GCC with the lead state commissioner, the models would also provide information on the types of insurance groups that would be exempt from filing the GCC, as well as provide the necessary language to protect the confidentiality of the tool.

In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections, based on previous public comments made by Working Group members. The first draft of amendments to Model #440 and Model #450 were drafted based on decisions made by Working Group members, with previous input from the industry considered by the Working Group members. This continued to be the case with respect to future versions of the model(s), although the Sept. 18 version was drafted with specific input from a small drafting group consisting of California, Nebraska, Missouri, Texas and Wisconsin.

NAIC staff met via conference call with representatives of the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) on Sept. 10 and Oct. 14 to discuss their concerns regarding the consistency of the draft revisions to a covered agreement with the European Union (EU). (Please refer to discussion in paragraph 8.)

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

At the 2019 Fall National Meeting, the Executive (EX) Committee approved the Working Group's request to open Model #440 and Model #450 to develop the legal authority under which the GCC would be implemented. In January 2020, the Working Group exposed for public comment a draft memorandum that set forth possible exemptions, as well as the basic construct for the confidentiality protections. Comments were received Feb. 17, 2020, but due to the COVID-19 pandemic, the first discussion of proposed changes to Model #440 and Model #450 did not occur until June 2, 2020.

During its June 2, 2020, call, the Working Group made several key decisions related to the comments on exemptions and subsequently released its first version of proposed changes to Model #440. Comments were received July 15, 2020, with numerous edits proposed by interested parties that were incorporated into a modified version for discussion by the Working Group on its July 21, 2020, call, including comments on subgroup reporting. Discussion on the subgroup reporting issue was deferred by the Working Group until decisions were made on all other comments, and the Working Group exposed for public comment proposed changes to Model #440, along with proposed changes to Model #450, on July 23, 2020. Comments on this exposure, which were largely focused on subgroup reporting, were discussed by the Working Group on its Sept. 18, 2020, call. The next version of Model #440 and Model #450 were exposed for a public comment period ending Oct. 5, 2020, with most of the changes from the July 23, 2020, version representing proposed revised wording from various interested parties intended to streamline both models. New versions of the models were produced and exposed following the Working Group's Oct. 20, 2020, call based on comments received Oct. 5, 2020, and discussed by the Working Group on its Oct. 20, 2020, call. The final versions of Model #440 and Model #450 were exposed Oct. 21, 2020, for a public comment period, and subsequently adopted by the Working Group on its Nov. 17, 2020, call.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

Significant issues which were ultimately addressed include:

1. Ability to exclude immaterial risky affiliates from the calculation.
2. Excluding recasting of XXX/AXXX transactions in the GCC.[1]
3. Allowing a proxy level of senior debt to be added to capital that represents the subordinated capital controlled by the commissioner's authority over approving extraordinary dividends.
4. Inclusion of the concept of scalars to recognize U.S. reserve requirements are often much higher than other jurisdictions.
5. The level at which the GCC is calibrated with RBC (200%).
6. A subgroup capital calculation under which a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system if it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. This particular aspect of Model #440 was the most controversial topic and was debated extensively, while other potential options failed to receive a majority vote.

7. List the key provisions of the model (sections considered most essential to state adoption).

The changes to Section 4L(2) of Model #440 are the most important provisions in the proposed changes, as they require the ultimate controlling person of every insurer subject to registration to concurrently file an annual GCC as directed by the lead state commissioner with the registration statement. Immediately following this provision in Section 4L(2)(a) through Section 4L(2)(d) are four types of holding company systems that are exempt from filing, which are also important to many parties. As previously discussed, Section 4L(2)(e) would permit, under certain circumstances, a subgroup capital calculation. Section 4L(2)(f) is also important, as it provides the commissioner the discretion to exempt other groups from filing that meet the criteria in Model #450. Finally, Section 8(A)(1) of Model #440 provides key statutory authority to hold the GCC confidential and actually prevents the group itself from sharing the GCC publicly. Model #450 provides more detailed aspects of the exemptions, including additional discretionary authority for exempting certain groups, as well as additional details of the NAIC process for maintaining a list of jurisdictions whose groups recognize and accept the GCC and are, therefore, exempt from filing the GCC.

8. Any Other Important Information (e.g., amending an accreditation standard).

a. Covered Agreement

Under Title V of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), the Treasury Department and the USTR are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the U.S. and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is "substantially equivalent" to the level of protection achieved under U.S. state insurance laws. On Sept. 22, 2017, the Treasury Department and the USTR signed the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (Covered Agreement). On Dec. 18, 2018, a separate covered agreement was signed between the U.S. and the United Kingdom, which mirrors the language from the agreement with the EU and has the same timing requirements for implementation.

The Covered Agreement includes requirements on reinsurance collateral, group supervision and group capital. Specifically, Article 4(h) provides that the host supervisor (i.e., a supervisory authority from the territory in which an insurance group has operations but which is not the territory where the worldwide parent is domiciled or headquartered) may not impose a group capital assessment or requirement at the level of the worldwide parent, but only if the insurance group is subject to a group capital assessment imposed by the home supervisor. The group capital assessment of the home supervisor must include a worldwide group capital calculation capturing risk at the level of the entire group, and the home supervisor must have the authority to impose preventive, corrective or otherwise responsive measures on the basis of the assessment, including the authority to impose capital measures where appropriate.

[1] "XXX/AXXX transactions" are those transactions required to be valued under Section 6 or Section 7 of the *Valuation of Life Insurance Policies Model Regulation* (#830).

Under Article 10(e) of the Covered Agreement, supervisory authorities in the EU shall not impose a group capital requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group, with regard to a U.S. insurance or reinsurance group with operations in the EU, for 60 months after the date of provisional application of the Covered Agreement; i.e., Nov. 7, 2022. The GCC is intended to serve as an analytical tool for evaluating an insurer's capital position at the group level but is not intended to be applied as a group-level capital requirement or standard. The *Statement of the United States on the Covered Agreement with the European Union* provides further clarification with respect to this group capital assessment.

The Covered Agreement limits the worldwide application of EU prudential group insurance measures on U.S. insurers operating in the EU. The Covered Agreement also provides that U.S. insurers and reinsurers can operate in the EU without the U.S. parent being subject to the group-level governance, solvency and capital, and reporting requirements of Solvency II, and reinforces that the EU system of prudential insurance supervision is not the system in the U.S. The Covered Agreement does not require development of a group capital standard or group capital requirement in the U.S. Article 4(h) contemplates that the states will develop a group-wide capital assessment. Through the NAIC, the states are in the process of developing a group capital calculation which is intended to serve as an analytical tool for evaluating a firm's capital position at the group level. **The U.S. expects that the NAIC's GCC will satisfy the "group capital assessment" condition of Article 4(h), provided that the work is completed and implemented within five years of the date on which the Agreement is signed.** [Emphasis added].

Any state with U.S. groups operating in either the European Union or the United Kingdome will need to adopt these legislative changes by Nov. 7, 2022, to effectuate compliance with the Covered Agreement.

b. Liquidity Stress Testing

In coordination with the work on the GCC, the Liquidity Assessment (EX) Subgroup of the Financial Stability (EX) Task Force drafted revisions to Model #440 to incorporate a liquidity stress test (LST) and to provide confidentiality requirements with respect to the LST. These revisions to Model #440, while not directly related to the GCC, are also intended to be considered for adoption by the NAIC membership simultaneously with the GCC-related revisions to Model #440. A separate Project History has been prepared with respect to the LST.

c. Accreditation

The Group Capital Calculation (E) Working Group has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. However, it is expected that these revisions will be incorporated into the accreditation standard in order to encourage the states to effectuate compliance with the Covered Agreement.

PROJECT HISTORY – 2011

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)

INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)

1. Description of the Project, Issues Addressed, etc.

In the wake of the recent financial crisis as well as discussions regarding group supervision that have been taking place in the international regulatory community, U.S. state insurance regulators have become aware of the necessity to enhance the insurance Holding Company System Model Act (Model #440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (Model #450) to address group supervision. At the heart of the lessons learned from the recent financial crisis is the ability of regulators to be able to assess the enterprise risk within a holding company system and its impact on an insurer within the group.

As recommended by the Group Solvency Issues (EX) Working Group, the U.S. insurer solvency regime should consider incorporating certain prudential benefits of group supervision, providing a clearer window into group operations, while building upon, the existing walls which provide solvency protection. Ultimately, this enhanced "windows and walls" approach should provide greater and much needed breadth and scope to solvency regulation while retaining the highest level of policyholder protection that exists currently. The concepts addressed in the enhanced "windows and walls" approach include such items, such as: communication between regulators; supervisory colleges; access to and collection of information; and enforcement measures.

The first step to accomplish building better windows is by addressing some of these topics as well as lessons learned during the recent financial crisis through enhancements to the insurance holding company laws and regulations.

2. Name of Group Responsible for Drafting the Model and States Participating

The Group Solvency Issues Working Group of the Executive (EX) Committee was charged by the Financial Condition (E) Committee with drafting revisions to Model #440 and Model #450. The 2010 members of the Working Group that drafted and adopted the revised models on June 14, 2010, were: Nebraska and Texas (co-Chairs), California, Connecticut, Delaware, Florida, Illinois, Iowa, New York, Pennsylvania and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

During the February 11, 2009, conference call, the Financial Condition (E) Committee agreed to revise the holding company models, but suggested the technical work be delegated to a Working Group under the Solvency Modernization Initiative (EX) Task Force that was working on other group related initiatives. Based on this recommendation and referral, the Task Force drafted charges for a new working group that would focus on groups issues, including the NAIC Holding Company Models. The Working Group's charges related to the models were as follows:

- Study the need to modify the Holding Company Model Act by gathering input from all states regarding the use of the existing model and its effectiveness in addressing the issues that exist within insurer groups, particularly considering issues identified during this most recent economic downturn. At the conclusion of such study, provide a recommendation to the Financial Condition (E) Committee.
- Study the international solvency issues related to groups and the need to modify the Holding Company Model Act for any proposed changes in this area. This study should include consideration of the interaction between federal and state financial regulators and any changes that would be necessary to improve regulatory oversight provided by the Holding Company Model Act. At the conclusion of such study, provide a recommendation to the Financial Condition (E) Committee.

On August 18, 2009, the Financial Condition (E) Committee via electronic vote adopted the model law development form related to models #440 and #450. It was adopted by Executive and Plenary during the 2009 Fall National Meeting.

4. A General Description of the Drafting Process and Due Process

An initial survey of state insurance regulators and industry was conducted in June 2009 to gather ideas for areas of focus in drafting revisions to the Models focusing on area where the Models need improvement based on states' experience and the need for more focus on group issues. Twelve states submitted initial proposed language to address the eleven key topics identified in the initial survey.

Many open meetings were conducted to discuss this project. During these meetings, comment letters were discussed, and language was drafted (with some sections specifically assigned to interested parties or interested regulators to draft). Between May 2009 and June 2010, the Working Group conducted 15 public conference calls, five public meetings at NAIC National Meetings and one public interim hearing in June 2010. Financial Condition (E) Committee conducted three public conference calls.

Exposure drafts were released for public comment at multiple times. Public comment periods included December 2009, January 2010, March 2010, May 2010, June 2010 and July 2010.

All comment letters were considered and discussed by the Working Group in public sessions. In total, 27 comment letters were received from regulators and 36 comment letters were received from interested parties. Additionally, Financial Condition (E) Committee received and considered ten comment letters (one regulator and nine interested parties).

On June 18, 2010 the Working Group unanimously adopted revisions to Model #440 and #450 to be sent to Financial Condition (E) Committee for the Committee's consideration with the caveat that centralization data collection and confidentiality of enterprise risk supplemental filing should be addressed by Executive. E Committee met three times on August 5th adopted the revisions to the Models to be sent to Exec/Plenary.

Subsequent Discussions (Post Adoption by Financial Condition (E) Committee) – Director Ann Frohman and Danny Saenz, Chairs of GSIWG, and NAIC Legal and Executive Staff have engaged in numerous discussions with certain large industry trade organizations regarding the centralized filing of information at the NAIC. During these discussions these industry organizations were given significant time and opportunity to provide a compromise and to discuss these issues.

5. A Discussion of the Significant Issues

The following topics for revisions within the Models were discussed extensively with regulators and interested parties:

a. Model #440 Section 1—definitions of "enterprise risk".
   - Purpose of this change is to define a new term used in other revisions within the model.
   - This topic was addressed on GSIWG conference calls and the June 4th hearing. Interested party comments generally suggested replacing the definition of "contagion" with "enterprise risk', and voiced concerns with the phrase "has the potential" and with the term "contagion" being speculative. Comments were heard and discussed. Definitions of contagion was eliminated enterprise risk was incorporated in the model.

b. Model #440 Section 3A4—Notification of divestiture of controlling interests.
   - Purpose of this change is to allow for notification to the state of any divestiture of controlling interests. Regulators' have experienced divestitures that were not in the best interest of the policyholders and where regulators were not given prior notice.
   - This topic was introduced on the May 14th call with a separate exposure document released for comment. It was further discussed on the subsequent calls and the June 4th hearing. The GSIWG heard and discussed comments and made certain edits as a result.

c. Model #440 Sections 3B12, 3B13, 4B8, 11F and Model #450 Form A Item #13 & Form B Item #9—The filing of a report of the ultimate controlling person which identifies material risks within the insurance holding company system that could pose financial and/or reputational contagion to the insurer and potential sanctions.
   - This change is in response to recent economic downturns and worldwide discussions on contagion risk within the financial sector. It is also in response to regulators' experience regarding the financial impact that non-insurance entities within the group can have on an insurance company's financial solvency. The change is intended to provide regulators with more information about potential risks to the insurer.
   - This topic was discussed on multiple calls, revised and new draft language was re-released for public comment. Subsequent edits were also made. Interested party comments primarily focusing on this section being too broad, inconsistent, and creation of the presumption that insurers need to over-comply with the provision in order to cover all foreseeable circumstances in their reporting were heard and discussed on subsequent calls and the June 4th hearing.

d. Model #440 Section 4B5—Providing insurance holding company system financial statements.
   - This change is intended to provide regulators with access to more insurance holding company system information through the filing of holding company financial statements.
   - This topic was discussed on multiple GSIWG calls. Interested parties were heard and given the opportunity to submit optional draft language regarding SEC filings. Edits to the original draft language were made regarding the acceptance of SEC filings.

e. Revisions as they relate to corporate governance including 1) Model #440 section 4B7 —Statements of the Board of Directors; and 2) Model #440 Section 5C—Independence of Board of directors and committees no longer being optional language and the section edited so as not to conflict with the Model Audit Rule.
   - Section 4B7 requires the insurer's board of directors to make statements regarding the corporate governance and internal control responsibilities within the registration statement. Section 5C was changed to no longer be an "optional" section of the model by the Working Group but was revered by the E Committee. The section addresses board of director composition and committee responsibilities (which were edited to be in line with the Model Audit Rule). Additionally, a new paragraph with criteria for waiving the insurer from the requirements of the section was added.
   - These topics were discussed on multiple GSIWG calls and were referred to the Corporate Governance (EX) Working Group (CGWG). It was discussed by CGWG on two public conference calls where interested party comments were considered. Interested party concerns primarily related to suggestions to remove corporate governance language as it was felt is was not appropriate in these models or if not removed to modify the language to reflect that management was "responsible for" and that boards "oversee" rather than stating boards were "responsible for". CGWG made some edits, however retaining the "board is responsible for…" language and the no longer optional section 5C, and sent recommendations to GSIWG. GSIWG heard additional discussion at the June 4th hearing and made edits to section 5C waiver language.

f. Model #440 Section 4K—Disclaimer of affiliation.
   - The change includes language regarding disallowance of a disclaimer of affiliation and request for an administrative hearing.
   - GSIWG discussed this recommended change on the Feb. 26th call and the June 4th hearing. Comments regarding wording changes were heard and edits were made.

g. Model #440 Section 5A1b and Model #450 Section 19. Requirements of agreements for cost sharing services and management.
   - The intent of these changes is to provide minimum requirements for the agreements for cost sharing and management services in order to eliminate the potential for capital to flow out of the insurer through these types of agreements.
   - This topic was discussed on several GSIWG calls. Interested party comments were heard and considered. Numerous edits were made to the original draft language.

h. Model #440 Section 5A2—Amendments or modifications of affiliated agreements.
   - The change requires notification of amendments and modifications to affiliated transactions including requirements for the notification. Included in the change is the addition of notification of all reinsurance pooling agreements and agreements that are projected to be material to surplus.
   - This topic was discussed on several GSIWG calls and the June 4th hearing. Numerous edits were made to the original draft language.

i. Model #440 Section 6—Examination of affiliates, access to books and records and compelling production of information as it relates to examinations.
   - The changes to Section 6 are intended to give regulators power to examine the insurer and its affiliates, to provide better access to books and records of affiliated entities within the insurance holding company system and to compel the insurer to provide that access to those books and records in an effort to better ascertain the financial condition of the insurer and any contagion risk within the insurance holding company system.
   - The GSIWG addressed the topic on multiple conference calls including allowing interested parties to provide optional language. Interested parties expressed concerns about the potential for penalties and that the ability to examine an affiliate was overly broad and exceeded state jurisdictions. Proposed optional language was not accepted by GSIWG.

j. Model #440 Section 7—Supervisory Colleges.
   - As there is a world-wide push for more group-wide supervision of insurance holding company systems with international operations, this new section provides the regulators the authority to recoup expenses incurred for attending or conducting supervisory colleges from domestic insurers whose group is engaging in international activities.
   - The Supervisory Colleges and Methods of Cross-Border Communication (EX) Subgroup met in open session and drafted the language for this new section of Model #440.

- This topic was discussed on by the GSIWG and interested party comments were heard and considered. A few edits were made to the section by GSIWG.

6. Any Other Important Information

None

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

Table of Contents

Introduction

Be it Enacted by the General Assembly of the State of [insert state]:

Section 1. Applicability

Every person who is directly or indirectly the beneficial owner of more than ten percent (10%) of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the Commissioner [Superintendent, Director] on or before [January 31, 1965], or within ten (10) days after he becomes such beneficial owner, director or officer, a statement, in such form as the Commissioner may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the Commissioner a statement, in such form as the Commissioner may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

Note: It is recommended that the term "officer" be defined by regulation of the insurance commissioner which in effect adopts the definition set out in Schedule SIS as promulgated by the National Association of Insurance Commissioners, to wit:

The term "officer" means a president, vice president, treasurer, actuary, secretary, controller, and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

Section 2. Unfair Use of Information

For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six (6) months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty (60) days after request or shall fail to diligently prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not such, both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the Commissioner by rules and regulations may exempt as not comprehended within the purpose of this section.

Section 3. Sale of Equity Security

It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or his principal (i) does not own the security sold or (ii) if owning the security, does not deliver it against such sale within twenty (20) days thereafter or does not within five (5) days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

Section 4. Exceptions to Section 2 and 3

The provisions of Section 2 of this Act shall not apply to any purchase and sale, or sale and purchase, and the provisions of Section 3 of this Act shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The Commissioner may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Section 5. Exception - Foreign or Domestic Arbitrage Transaction

The provisions of Sections 1, 2, and 3 of this Act shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the Commissioner may adopt in order to carry out the purposes of this Act.

Section 6. Equity Security Defined

The term "equity security" when used in this Act means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the Commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

Section 7. Exceptions - Domestic Stock Insurers

The provisions of Sections 1, 2, and 3 of this Act shall not apply to equity securities of a domestic stock insurance company if:

A. Such securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended; or if

B. Such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of Sections 1, 2, and 3 of this Act except for the provisions of this Subsection B.

Section 8. Power of Commissioner

The Commissioner shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him by Sections 1 through 7 of this Act, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of Sections 1, 2 and 3 of this Act imposing any liability shall apply to any done or omitted in good faith in conformity with any rule or regulation of the Commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

Section 9. Forfeiture Provision

Any person that fails to file information, documents or reports required to be filed under this Act or any rule or regulation thereunder shall forfeit to the State of [insert state] the sum of $100 for each and every day such failure to file shall continue. Such forfeiture, which shall be in lieu of any criminal penalty for such failure to file which might be deemed to arise under this Act, shall be payable into the treasury of the State of [insert state] and shall be recoverable in a civil suit in the name of the State of [insert state].

Section 10. Effective Date

This act shall take effect [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1965 Proc. I 150, 153, 171-173, 191 (adopted).
1968 Proc. II 500, 564-565, 567 (amended).
1969 Proc. I 169, 246, 271 (technical amendments).

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-27-52 to 27-27-60 (1971).		
Alaska	ALASKA STAT. §§ 21.40.010 to 21.40.080 (1966).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-726.01 (1966).		
Arkansas	ARK. CODE ANN. §§ 23-69-201 to 23-69-208 (1965).		
California	CAL. INS. CODE §§ 1104.2 to 1107.1 (1965/1996).		
Colorado	COLO. REV. STAT. § 10-3-120 (1963/1996).		
Connecticut	CONN. GEN. STAT. §§ 38a-117 to 38a-124 (1965/1980).		
Delaware	DEL. CODE ANN. tit. 18, §§ 5101 to 5109 (1953/1995).		
District of Columbia	D.C. CODE § 31-603 (1966/1997).		
Florida	FLA. STAT. §§ 625.75 to 625.83 (1982/2000).		

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. §§ 33-14-91 to 33-14-97 (1965).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:4-208 to 431:4-214 (1988).		
Idaho	IDAHO CODE ANN. §§ 41-2860 to 41-2867 (1965).		
Illinois	215 ILL. COMP. STAT. 5/28.1 (1965).		
Indiana	IND. CODE §§ 27-2-10-1 to 27-2-10-9 (1965/1989).		760 IND. ADMIN. CODE 1-12-1 to 1-12-24 (2007/2013).
Iowa	IOWA CODE §§ 523.7 to 523.13 (1965).		
Kansas	KAN. STAT. ANN. §§ 40-264 to 40-271 (1965).		
Kentucky	KY. REV. STAT. ANN. §§ 304.26-010 to 304.26-090 (1970).		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 3413 (1969/1973).
Maryland			MD. CODE ANN., INS. § 3-119 (1965/1997).
Massachusetts	MASS. GEN. LAWS ch. 175, § 193I (1965).		
Michigan	MICH. COMP. LAWS §§ 500.5282 to 500.5290 (1966/1984).		
Minnesota	MINN. STAT. § 60A.22 (1967/1986).		
Mississippi	MISS. CODE ANN. §§ 83-19-81 to 83-19-97 (1966).		

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. REV. STAT. §§ 375.422 to 375.426 (1965).		
Montana	MONT. CODE ANN. §§ 33-3-441 to 33-3-447 (1965).		
Nebraska	NEB. REV. STAT. §§ 44-3,107.01 to 44-3,114 (1969/1993).		
Nevada	NEV. REV. STAT. §§ 694A.010 to 694A.080 (1971).		
New Hampshire	N.H. REV. STAT. ANN. §§ 402-A 1 to 402-A:9 (1965).		
New Jersey	N.J. REV. STAT. §§ 17:17B-1 to 17:17B-8 (1965).		
New Mexico	N.M. STAT. ANN. §§ 59A-36-1 to 59A-36-8 (1985).		
New York	N.Y. INS. LAW § 1221 (1984).		
North Carolina	N.C. GEN. STAT. § 58-7-145 (1965).		
North Dakota	N.D. CENT. CODE §§ 26.1-05-11 to 26.1-05-15 (1983).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3901.31 (1965/1997).		
Oklahoma	OKLA. STAT. tit. 36, § 2126.1 (1965/1984).		
Oregon	OR. REV. STAT. §§ 732.420 to 732.455 (1965).		
Pennsylvania	40 PA. STAT. ANN. § 422.1 (1965).		
Puerto Rico			P.R. LAWS ANN. tit. 26, § 2920 (1979).

AN ACT CONCERNING INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS §§ 27-1-29 to 27-1-37 (1965/1996).		
South Carolina	S.C. CODE ANN. §§ 38-23-10 to 38-23-100 (1988/1993).		
South Dakota	S.D. CODIFIED LAWS §§ 58-5-68 to 58-5-78 (1966/1996).		
Tennessee	TENN. CODE ANN. §§ 56-3-701 to 56-3-708 (1965/1967).		
Texas			TEX. INS. CODE ANN. §§ 548.001 to 548.203 (2005).
Utah	UTAH CODE ANN. § 31A-5-303 (1986).		
Vermont	VT. STAT. ANN. tit. 9, §§ 4301 to 4308 (1965/1996).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-214 (1986).		
Washington	WASH. REV. CODE §§ 48.08.100 to 48.08.190 (1965).		
West Virginia	W. VA. CODE § 33-5-30 (1966).		
Wisconsin	WIS. STAT. § 611.31(4) (1979).		
Wyoming	WYO. STAT. ANN. §§ 26-25-101 to 26-25-109 (1967/1983).		

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

Table of Contents

Section 1. Definition of Certain Terms

A. "Insurer" means any domestic stock insurance company with an equity security subject to the provisions of Act [insert applicable cite] of the [insert year] General Assembly and not exempt thereunder.

B. "Act" means Public Act [insert applicable citing] of the [insert year] General Assembly.

C. "Officer" means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

D. "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for such a security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right.

E. Securities "held of record"

(1) For the purpose of determining whether the equity securities of an insurer are held of record by 100 or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of the securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(a) In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as an owner on the records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

(b) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person.

(c) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person.

(d) Securities held by two or more persons as co-owners shall be included as held by one person.

(e) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if the securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons.

(f) Securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that the names represent the same person, may be included as held of record by one person.

(2) Notwithstanding Paragraph (1):

(a) Securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in the securities; provided however, that the insurer may rely in good faith on such information as is received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest.

(b) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the Act, the beneficial owners of the securities shall be deemed to be the record owners.

F. "Class" means all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

Section 2. Transactions Exempted From the Operation of Section 2 of the Act

Any acquisition or disposition of any equity security by a director or officer of an insurer within six (6) months prior to the date on which the Act shall first become applicable with respect to the equity securities of the insurer shall not be subject to the operation of Section 2 of the Act.

Section 3. Filing of Statements

A. Initial statements of beneficial ownership of equity securities required by Section 1 of the Act shall be filed on Form 3. Statements of changes in such beneficial ownership required by Section 1 shall be filed on Form 4. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

B. Any director or officer who is required to file a statement on Form 4 with respect to any change in his beneficial ownership of equity securities which occurs within six (6) months after he became a director or officer of the insurer or within six (6) months after equity securities of the insurer first became registered pursuant to Section 1 of the Act, shall include in the first such statement the information called for by Form 4 with respect to all changes in the beneficial ownership of equity securities of the insurer which occurred within six (6) months prior to the date of the changes which requires the filing of the statement.

C. Any person who has ceased to be a director or officer of an insurer which has equity securities registered pursuant to Section 1 of the Act, or who is a director or officer of an insurer at the time it ceased to have any equity securities so registered, shall file a statement on Form 4 with respect to any change in his or her beneficial ownership of equity securities of the insurer which shall occur on or after the date on which the person ceased to be a director or officer or the date on which the insurer ceased to have any equity securities so registered, as the case may be, if the change shall occur within six (6) months after any change in the beneficial ownership of the securities prior to that date. The statement on Form 4 shall be filed within ten (10) days after the end of the month in which the reported change in beneficial ownership occurs.

Section 4. Ownership of More Than Ten Percent of an Equity Security

A. In determining, for the purpose of Section 1 of the Act whether a person is the beneficial owner, directly or indirectly, of more than ten percent (10%) of any class of any equity security, the class shall be deemed to consist of the total amount of the class outstanding, exclusive of any securities of the class held by or for the account of the insurer or a subsidiary of the insurer; except that for the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall be deemed to consist of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of the outstanding securities have been so deposited. For the purpose of this section a person acting in good faith may rely on the information contained in the latest Annual Statement filed with the Commissioner with respect to the amount of securities of a class outstanding or in the case of voting trust certificates or certificates of deposit the amount issuable.

Editor's Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. In determining for the purpose of Section 1 of the Act whether a person is the beneficial owner, directly or indirectly, of more than ten percent (10%) of any class of equity securities, the person shall be deemed to be the beneficial owner of securities of any class which the person has the right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. The securities subject to such options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, in accordance with Subsection A, the percentage of outstanding securities of the class owned by that person, but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This subsection shall not be construed to relieve any person of any duty to comply with Section 1 of the Act with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section of the Act.

Section 5. Disclaimer of Beneficial Ownership

Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that the person is, for the purpose of the Act, the beneficial owner of any equity securities covered by the statement.

Section 6. Exemptions From Sections 1 and 2 of the Act

A. During the period of twelve (12) months following their appointment and qualification, securities held by the following persons shall be exempt from Sections 1 and 2 of the Act:

(1) Executors or administrators of the estate of a decedent;

(2) Guardians or committees for an incompetent; and

(3) Receivers, trustees in bankruptcy, assignors for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

B. After the 12-month period following their appointment or qualification the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under Section 1 of the Act and shall be liable for profits realized from trading in such securities pursuant to Section 2 of the Act only when the estate being administered is a beneficial owner of more than ten percent (10%) of any class of equity security of an insurer subject to the Act.

C. Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from Sections 1 and 2 during the time they are held by the insurer.

Section 7. Exemption From the Act of Securities Purchased or Sold by Odd-Lot Dealers

Securities purchased or sold by an odd-lot dealer in odd lots so far as reasonably necessary to carry on odd-lot transactions or in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the Act with respect to participation by the odd-lot dealer in such transactions.

Section 8. Certain Transactions Subject to Section 1 of the Act

The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed a change in the beneficial ownership of the security to which the privilege relates so as to require the filing of a statement reflecting the acquisition or disposition of the privilege. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of such an option, put, call, spread or straddle.

Section 9. Ownership of Securities Held in Trust

A. Beneficial ownership of a security for the purpose of Section 1 shall include:

(1) The ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust;

(2) The ownership of a vested beneficial interest in a trust; and

(3) The ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

B. Except as provided in Subsection C, beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 1 where less than twenty percent (20%) in market value of the securities having a readily ascertainable market value held by the trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from Section 1 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition or disposition of the securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to this subsection shall,however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of Section 1.

C. In the event that ten percent (10%) of any class of any equity security of an insurer is held in a trust, that trust and its trustees shall be deemed a person required to file the reports specified in Section 1 of the Act.

D. No more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten percent (10%) stockholders who are either trustees, settlors or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or ten percent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any report so long as he relies in good faith upon an understanding that the trustee of the trust will file whatever reports might otherwise be required of the beneficiary.

E. As used in this section the "immediate family" of a trustee means:

(1) A son or daughter of the trustee, or a descendant of either;

(2) A stepson or stepdaughter of the trustee;

(3) The father or mother of the trustee, or an ancestor of either;

(4) A stepfather or stepmother of the trustee;

(5) A spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of the person by blood.

F. In determining, for the purposes of Section 1 of the Act, whether a person is the beneficial owner, directly or indirectly, or more than ten percent (10%) of any class of any equity security, the interest of that person in the remainder of a trust shall be excluded from the computation.

G. No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under Section 1, with respect to his indirect interest in portfolio securities held by:

(1) A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(2) A business trust with over twenty-five (25) beneficiaries.

H. Nothing in this section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date.

Section 10. Exemption for Small Transactions

A. Any acquisition of securities shall be exempt from Section 1 where:

(1) The person effecting the acquisition does not within six (6) months thereafter effect any disposition, other than by way of gift, of securities of the same class; and

(2) The person effecting the acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six-month period during which the acquisition occurs.

B. Any acquisition or disposition of securities by way of gift, where the total amount of such gifts does not exceed $3,000 in market value for any six-month period, shall be exempt from Section 1 and may be excluded from the computations prescribed in Subsection A(2).

C. Any person exempted by Subsection A or B of this section shall include in the first report filed after a transaction within the exemption a statement showing his acquisitions and dispositions for each six-month period or portion thereof which has elapsed since the last filing.

Section 11. Exemption From Section 2 of the Act of Transactions Which Need Not be Reported Under Section 1

Any transaction which has been or shall be exempted from the requirements of Section 1 of the Act shall, insofar as it is otherwise subject to the provisions of Section 2, be likewise exempted from Section 2.

Section 12. Exemption from Section 2 of Certain Transactions Effected in Connection With a Distribution

A. Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Section 2 of the Act, to the extent specified in this section as not comprehended within the purpose of that section of the Act, upon the following conditions:

(1) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of business, in the distribution of the block of securities;

(2) The security involved in the transaction is;

(a) A part of a block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of the block of securities; or

(b) A security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with the distribution; and

(3) Other persons not within the purview of Section 2 of the Act are participating in the distribution of the block of securities on terms at least as favorable as those on which the person is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 2 of the Act by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

B. The exemption of a transaction pursuant to this section with respect to the participation therein of one party shall not render the transaction exempt with respect to participation of any other party unless the other party also meets the conditions of this section.

Section 13. Exemption From Section 2 of Acquisitions of Shares of Stock and Stock Options Under Certain Stock Bonus, Stock Option or Similar Plans

Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of Section 2 of the Act if the plan meets the following conditions:

A. The plan has been approved, directly or indirectly, by the affirmative votes of the holders of a majority of the securities of the insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the State of [insert state] or by the written consent of the holders of a majority of the securities of the insurer entitled to vote; provided however, that if the vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the National Association of Insurance Commissioners, if any, in effect at the time of the vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of the date the Act first applies to the insurer, or the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within thirty (30) days prior to the date of mailing. Four (4) copies of the written information shall be filed with, or mailed for filing to the Commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this subsection, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

B. If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows:

(1) With respect to the participation of directors:

(a) By the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

(b) By, or only in accordance with the recommendations of, a committee of three (3) or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

(c) Otherwise in accordance with the plan, if the plan (i) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or (ii) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(2) With respect to the participation of officers who are not directors:

(a) By the board of directors of the insurer or a committee of three (3) or more directors; or

(b) By, or only in accordance with the recommendations of, a committee of three (3) or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

For the purpose of this subsection, a director or committee member shall be deemed to be a disinterested person only if that person is not at the time discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(3) The provisions of this subsection shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Sections 1, 2 and 3 of the Act first become applicable with respect to any class of equity securities of any insurer.

C. As to each participant or as to all participants, the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted or employee stock purchase plan stock options granted pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. The limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

D. Unless the context otherwise requires, all terms used in this section shall have the same meaning as in the Act and in Section 1 of these regulations. In addition, the following definitions apply:

(1) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(2) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in Sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in Section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section; provided however, that for the purposes of this section an option which meets all of the conditions of that section, other than the date of issuance shall be deemed to be a "restricted stock option."

(3) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this section shall not include (a) the making of any election to receive under any plan an award of compensation in the form of stock or credits therefore; provided, that the election is made prior to the making of the award; and provided further that the election is irrevocable until at least six (6) months after termination of employment; (b) the subsequent crediting of such stock; (c) the making of any election as to a time for delivery of the stock after termination of employment, provided that the election is made at least six (6) months prior to delivery; (d) the fulfillment of any condition to the absolute right to receive stock; or (e) the acceptance of certificates for shares of stock.

Section 14. Exemption From Section 2 of Certain Transactions in Which Securities are Received by Redeeming Other Securities

Any acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of Section 2 of the Act upon condition that:

A. The equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or government bonds) consist of securities of the insurer issuing the equity security so acquired, and which

(1) Represented substantially and in practical effect a stated or readily ascertainable amount of equity security;

(2) Had a value which was substantially determined by the value of the equity security; and

(3) Conferred upon the holder the right to receive the equity security without the payment of any consideration other than the security redeemed;

B. No security of the same class as the security redeemed was acquired by the director or officer within six (6) months prior to the redemption or is acquired within six (6) months after the redemption;

C. The insurer issuing the equity security acquired has recognized the applicability of Subsection A of this section by appropriate corporate action.

Section 15. Exemption of Long Term Profits Incident to Sales Within Six Months of the Exercise of an Option

A. To the extent specified in Subsection B of this section, the Commissioner hereby exempts as not comprehended within the purposes of Section 2 of the Act any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where the purchase is pursuant to the exercise of an option or similar right either (1) acquired more than six (6) months before its exercise, or (2) acquired pursuant to the terms of an employment contract entered into more than six (6) months before its exercise.

B. In respect of transactions specified in Subsection A the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six (6) months before or after the date of sale. Nothing in this section shall be deemed to enlarge the amount of profit which would inure to the insurer in the absence of this section.

C. The Commissioner also hereby exempts, as not comprehended within the purposes of Section 2 of the Act, the disposition of a security, purchased in a transaction specified in Subsection A of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in Section 368(c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

D. The exemptions provided by this section shall not apply to any transaction made unlawful by Section 3 of the Act or by any rules and regulations thereunder.

E. The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption.

Section 16. Exemption From Section 2 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidations

A. The following transactions shall be exempt from the provisions of Section 2 of the Act as not comprehended within the purpose of the section:

(1) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to the merger or consolidation, owned eighty-five percent (85%) or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(2) The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to the merger or consolidation, owned eighty-five percent (85%) or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(3) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to the merger or consolidation, held over eighty-five percent (85%) of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation.

(4) The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to the merger or consolidation, held over eighty-five percent (85%) of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation.

B. A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

C. Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this section) of a security in any other company involved in the merger or consolidation within any period of less than six (6) months during which the merger or consolidation took place, the exemption provided by this section shall be unavailable to the officer, director or stockholder to the extent of the purchase and sale.

Section 17. Exemption From Section 2 of Transactions Involving the Deposit or Withdrawal of Equity Securities Under a Voting Trust or Deposit Agreement

Any acquisition or disposition of an equity security involved in the deposit of the security under, or the withdrawal of the security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing the security, shall be exempt from the operation of Section 2 of the Act if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn: provided, however, that this section shall not apply to the extent that there shall have been either (A) a purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or (B) a sale of an equity security of the class deposited and a purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction exempted by any other provision of the regulations under Section 2 of the Act) within a period of less than six (6) months which includes the date of the deposit or withdrawal.

Section 18. Exemption From Section 2 of Certain Transactions Involving the Conversion of Equity Securities

A. Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of Section 2 of the Act; provided however, that this section shall not apply to the extent that there shall have been either (1) a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or (2) a sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in the conversion or in a transaction exempted by any other provision of the regulations under Section 2 of the Act) within a period of less than six (6) months which includes the date of conversion.

B. For the purpose of this section, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with the conversion, of cash or other property in connection with the conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than fifteen percent (15%) of the value of the equity security issued upon conversion.

C. For the purpose of this section, an equity security shall be deemed convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

Section 19. Exemption From Section 2 of Certain Transactions Involving the Sale of Subscription Rights

A. Any sale of a subscription right to acquire any subject security of the same insurer shall be exempt from the provision of Section 2 of the Act, to the extent prescribed in this section, as not comprehended within the purpose of that section of the Act, if:

(1) The subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(2) The subscription right by its terms expires within forty-five (45) days after the issuance thereof;

(3) The subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(4) A registration statement under the Securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from registration have been met with respect to each subject security.

B. When used within this section the following terms shall have the meaning indicated:

(1) The term "subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(2) The term "beneficiary security" means a security registered pursuant to Section 12 of the Securities Exchange Act, to the holders of which a subscription right is granted;

(3) The term "subject security" means a security which is the subject of a subscription right.

C. Notwithstanding anything contained herein to the contrary, if a person purchases subscription rights for cash or other consideration, then a sale by such person of subscription rights otherwise exempted by this section will not be so exempted to the extent of such purchases within the six-month period preceding or following the sale.

Section 20. Exemption of Certain Securities From Section 3 of the Act

Any security shall be exempt from the operation of Section 3 of the Act to the extent necessary to render lawful under that section the execution by a broker of an order for an account in which he has no direct or indirect interest.

Section 21. Exemption From Section 3 of the Act of Certain Transactions Effected in Connection With a Distribution

Any security shall be exempt from the operation of Section 3 of the Act to the extent necessary to render lawful under the section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

A. The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

B. Other persons not within the purview of Section 3 of the Act are participating in the distribution of the block of securities on terms at least as favorable as those under which the dealer is participating and to an extent at least equal to the aggregate participation of persons exempted from the provisions of Section 3 of the Act by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing the functions shall not preclude an exemption which would otherwise be available under this section.

Section 22. Exemption From Section 3 of the Act of Sales of Securities to be Acquired

A. Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of Section 3, provided that:

(1) The sale is made subject to the same conditions as those attaching to the right of acquisition; and

(2) The person exercises reasonable diligence to deliver the security to the purchaser promptly after his right of acquisition matures; and

(3) The person reports the sale on the appropriate form for reporting transactions by persons subject to Section 1 of the Act.

B. This section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him or her pursuant to the right of acquisition.

Section 23. Arbitrage Transactions Under Section 5 of the Act

It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of the insurer, unless he shall include the transaction in the statements required by Section 1 of the Act and shall account to the insurer for the profits arising from the transaction, as provided in Section 2. The provisions of Section 3 shall not apply to such arbitrage transactions. The provisions of the Act shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than the director or officer of the insurer.

INSIDER TRADING REPORTING FORMS AND INSTRUCTIONS

Editor's Note: These forms are patterned substantially after Forms 3 and 4 of the Securities and Exchange Commission.

STATE OF [insert state]

Commissioner of Insurance

FORM 3
INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Filed Pursuant to:

_____
[Name of insurance company]

_____
[Name of person whose ownership is reported]

_____
[Business address of such person; street, city, zone, state]

Relationship of such person to company named above.

(See instruction 5)_____

Date of event which requires the filing of this state.

(See instruction 6)_____

SECURITIES BENEFICIALLY OWNED

TITLE OF SECURITY (See instruction 7)	NATURE OF OWNERSHIP (See instruction 8)	AMOUNT OWNED BENEFICIALLY (See instruction 9)

REMARKS: (See instruction 10)

I affirm under penalty of perjury that
the foregoing is full, true and correct.

_____
Signature

Date of statement:_____

FORM 3 - INSTRUCTIONS

1. PERSONS REQUIRED TO FILE STATEMENTS

A statement on this form is required to be filed by every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such a company.

2. WHEN STATEMENTS ARE TO BE FILED

A. Persons who hold any of the relationships specified in Instruction 1 are required to file a statement by _____, 1965, or within 10 days after assuming such relationship, whichever date is later.

B. Statements are not deemed to have been filed with the Commissioner until they have actually been received by the Commissioner.

3. WHERE STATEMENTS ARE TO BE FILED

One signed copy of each statement shall be filed with the Commissioner of Insurance, [address].

4. SEPARATE STATEMENT FOR EACH COMPANY

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY

Indicate clearly the relationship of the reporting person to the company; for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 percent of the company's common stock," etc.

6. DATE AS OF WHICH BENEFICIAL OWNERSHIP IS TO BE GIVEN

The information as to beneficial ownership of securities shall be given as of [insert month, day], 1965, or, in the case of persons who subsequently assume any of the relationships specified in Instruction 1, as of the date that relationship was assumed.

7. TITLE OF SECURITY

The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A Common Stock," "$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

8. NATURE OF OWNERSHIP

Under "nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate in a footnote or other appropriate manner the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

9. STATEMENT OF AMOUNT OWNED

In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he or she so desires, also indicate in a footnote or other appropriate manner the extent of his or her interest in the partnership, corporation, trust or other entity.

10. INCLUSION OF ADDITIONAL INFORMATION

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

11. SIGNATURE

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

STATE OF [insert state]

Commissioner of Insurance

FORM 4

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Filed Pursuant to:

_____

[Name of insurance company]

_____

[Name of person whose ownership is reported]

_____

[Business address of such person; street, city, zone, state]

Relationship of such person to company named above.

(See instruction 5)_____

Statement for Calendar Month of _____, 19_____

CHANGES DURING MONTH AND MONTH-END OWNERSHIP (See instruction 6)

TITLE OF SECURITY (See Instr. 7)	DATE OF TRANSACTION (See Instr. 8)	AMOUNT BOUGHT OR OTHERWISE ACQUIRED (See Instr. 9)	AMOUNT SOLD OR OTHERWISE DISPOSED OF (See Instr. 9)	NATURE OF OWNERSHIP (See Instr. 10)	AMOUNT OWNED BENEFICIALLY AT END OF MONTH (See Instr. 9)

REMARKS: (See instruction 11)

I affirm under penalty of perjury that the foregoing is full, true and correct.

_____

Signature

Date of statement:_____

FORM 4 - INSTRUCTIONS

1. PERSONS REQUIRED TO FILE STATEMENTS

Statements on this form are required to be filed by every person who at any time during any calendar month was directly or indirectly the beneficial owner of more than 10 percent of any class of equity security of a domestic stock insurance company, or a director or officer of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity security of such company.

2. WHEN STATEMENTS ARE TO BE FILED

Statements are required to be filed on or before the 10th day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the Commissioner until they have actually been received by him.

3. WHERE STATEMENTS ARE TO BE FILED

One signed copy of each statement shall be filed with the Commissioner of Insurance, [address].

4. SEPARATE STATEMENT FOR EACH COMPANY

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY

Indicate clearly the relationship of the reporting person to the company; for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 percent of the company's common stock," etc.

6. TRANSACTIONS AND HOLDINGS TO BE REPORTED

Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership; for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

7. TITLE OF SECURITY

The statement of the title of the security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A Common Stock," "$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

8. DATE OF TRANSACTION

The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

9. STATEMENT OF AMOUNTS OF SECURITIES

In stating the amount of the securities acquired, disposed of, or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, i.e., through a partnership, corporation, trust or other entity, the entire amount of securities involved in the transaction or owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote or other appropriate manner the extent of his interest in the transaction or holdings of the partnership, corporation, trust or other entity.

10. NATURE OF OWNERSHIP

Under "Nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate in a footnote, or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

11. CHARACTER OF TRANSACTION

If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character; for example, gift, 5% stock dividend, etc., as the case may be. The foregoing information may be appropriately set forth in the table or under "Remarks" at the end of the table.

12. INCLUSION OF ADDITIONAL INFORMATION

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

13. SIGNATURE

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1966 Proc. I 104, 105, 107-120, 127 (adopted).
1968 Proc. II 500, 561-564, 567 (amended).
1969 Proc I 169, 246, 247-257, 271 (amended and reprinted regulation).
1970 Proc. IIB 1046, 1066-1067, 1103 (amended).

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. ADMIN. CODE 054.00.3 (1966).		
California	CAL. CODE REGS. tit. 10, §§ 2682.1 to 2682.22 (1971).		
Colorado	3 COLO. CODE REGS. § 702-3:3-2-2 (1972/2014).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-124-1 to 38a-124-24 (1966/1992).		
Delaware	18 DEL. CODE REGS. § 402 (1970/2003).		
District of Columbia	D.C. MUN. REGS. tit. 26-A, §§ 1400 to 1499 (1966).		
Florida	FLA. ADMIN. CODE ANN. r. §§ 69O-143.001 to 69O-143.022 (1974/2003).		

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. COMP. R. & REGS. 120-2-9 (1965) (forms only).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 204.5 to 204.50 (1966).		
Indiana	760 IND. ADMIN. CODE 1-12 (2007).		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. ADMIN. REGS. §§ 40-13-1 to 40-13-26 (1967/1987).		
Kentucky	806 KY. ADMIN. REGS. 26:020 (1975).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.7501 to XIII.7563 (Regulation 27) (1966/1999).		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. 31.04.10.01 to 31.04.10.09 (1969).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. ADMIN. CODE r. 500.521 to 500.545 (1966/1970).		
Minnesota	MINN. R. 2715.4100 to 2715.6404 (1973).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE §§ 11:2-9.1 to 11:2-9.26 (1966/2000).		
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 8.0 to 8.3 (Regulation 45) (1969).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	31 PA. CODE §§ 21.1 to 21.61 (1971).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-45-5.1 to 20-45-5.23 (2001).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. ADMIN. R. 20:06:04:01 to 20:06:04:47 (1977/1986).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-14 (1974).		
Texas			TEX. ADMIN. CODE § 7.901 (1976/1982).
Utah	UTAH ADMIN. CODE r. 590-68 (1966/1994).		

REGULATIONS ADOPTED PURSUANT TO AN ACT CONCERNING THE INSIDER TRADING OF DOMESTIC STOCK INSURANCE COMPANY EQUITY SECURITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-250-10 to 5-250-240 (1970).		
Washington	WASH. ADMIN. CODE 284-26-010 to 284-26-230 (1969).		
West Virginia	W. VA. CODE R. §§ 114-4-1 to 114-4-6 (1968).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 6.41 to 6.43 (1966/1999).		
Wyoming	NO CURRENT ACTIVITY		

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

Table of Contents

Section 1. Application of Regulation

A. No domestic stock insurer that has any class of equity securities held of record by 300 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation. However, this regulation shall not apply to any insurer if ninety-five percent (95%) or more of its equity securities is owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than 500 persons. A domestic stock insurer which files with the Securities and Exchange Commission with respect to any class of securities forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and its applicable regulations, shall be exempt from the provisions of this regulation with respect to that class of securities.

B. Unless proxies, consents or authorizations in respect of any class of equity securities of a domestic insurer subject to Section 1A are solicited by or on behalf of the management of the insurer from the holders of record of the securities in accordance with this regulation and its schedules prior to any annual or other meeting of the security holders, the insurer shall file with the commissioner and transmit to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited a written information statement containing the information specified in Schedule C.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

Section 2. Definitions

The following definitions apply unless the context otherwise requires:

A. Affiliate. An "affiliate" of, or a person affiliated with a specified person is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. Associate. The term "associate" used to indicate a relationship with any person means:

(1) A corporation or organization (other than the issuer or a majority owned subsidiary of the issuer) of which the person is an officer or partner or is, directly or indirectly, the beneficial owner of ten percent (10%) or more of any class of equity securities;

(2) A trust or other estate in which the person has a substantial beneficial interest or as to which the person serves as trustee or in a similar fiduciary capacity; and

(3) A relative or spouse of that person, or any relative of the spouse, who has the same home as the person or who is a director or officer of the issuer or any of its parents or subsidiaries.

C. Beneficial owner. The term "beneficial owner" includes a person who, directly or indirectly, through a contract, arrangement, understanding, relationship, or otherwise, has or shares:

(1) Voting power including the power to vote, or the power to direct voting of, a security; or

(2) Investment power which includes the power to dispose of, or to direct the disposition of, the security.

D. Control. The term "control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

E. Issuer. The term "issuer" means the issuer of the securities in respect of which a proxy is solicited.

F. Last fiscal year. The "last fiscal year" of the issuer means the last fiscal year of the issuer ending prior to the date of the meeting for which proxies are to be solicited.

G. Officer. The term "officer" means the president, secretary, treasurer, any vice president in charge of a principal business function (such as sales, administration or finance) and any other person who performs similar policy-making functions for the insurer.

H. Parent. A "parent" of a specified person is an affiliate controlling the person directly or indirectly through one or more intermediaries.

I. Person. The term "person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, or a government or political subdivision thereof. As used in this subsection, the term "trust" shall include only a trust where the interest or interests of the beneficiary or beneficiaries are evidenced by a security.

J. Proxy statement. The term "proxy statement" means the statement required by Section 4, whether or not contained in a single document.

K. Solicitation.

(1) The terms "solicit" and "solicitation" include:

(a) A request for a proxy whether or not accompanied by or included in a form of proxy;

(b) A request to execute or not to execute, or to revoke, a proxy; or

(c) The furnishing of a form of proxy or other communication to security holders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(2) The terms do not apply, however, to the furnishing of a form of proxy to a security holder upon the unsolicited request of the security holder, the performance by the issuer of acts required by Section 8, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

Section 3. Solicitations to Which Regulation Applies

Section 10 of this regulation shall apply to every solicitation that is subject to Section 1. Sections 2 through 9 and Section 11 of this regulation shall apply to every solicitation that is subject to Section 1 except the following:

A. A solicitation made otherwise than on behalf of the issuer where the total number of persons solicited is not more than ten (10).

B. A solicitation by a person in respect of securities carried in his name or in the name of his nominee (otherwise than as voting trustee) or held in his custody, if the person:

(1) Receives no commission or remuneration for the solicitation, directly or indirectly, other than reimbursement of reasonable expenses;

(2) Furnishes promptly to the solicited person a copy of all soliciting material with respect to the same subject matter or meeting received from all persons who shall furnish copies thereof for that purpose and who shall, if requested, defray the reasonable expenses to be incurred in forwarding the material; and

(3) In addition, does no more than impartially instruct the person solicited to forward a proxy to the person, if any, to whom the person solicited desires to give a proxy, or impartially request from the person solicited instructions as to the authority to be conferred by the proxy and state that a proxy will be given if no instructions are received by a certain date.

C. A solicitation by a person in respect of securities of which it is the beneficial owner.

D. A solicitation through the medium of a newspaper advertisement which informs security holders of a source from which they may obtain copies of a proxy statement, form of proxy and any other soliciting material and does no more than:

(1) Name the issuer;

(2) State the reason for the advertisement; and

(3) Identify the proposal or proposals to be acted upon by security holders.

E. Any solicitation which the commissioner finds for good cause should be exempted from this regulation or any part thereof.

Section 4. Information to be Furnished Security Holders

A. No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

B. If the solicitation is made on behalf of the issuer and relates to an annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to Subsection A shall be accompanied or preceded by an annual report to security holders as follows:

(1) The report shall contain, in comparative columnar form, such financial statements for the last two (2) fiscal years, prepared on a consistent basis, as will in the opinion of the management adequately reflect the financial position of the issuer at the end of each year and the results of its operations for each year. Consolidated financial statements of the issuer and its subsidiaries shall be included in the report if they are necessary to reflect the financial position and results of operations of the issuer and its subsidiaries, but in that case the individual statements of the issuer may be omitted. The commissioner may, upon the request of the issuer, permit the omission of financial statements for the earlier of the two (2) fiscal years upon a showing of good cause.

(2) The financial statements for the last two (2) fiscal years required by Subsection A(1) shall be prepared in a manner acceptable to the commissioner.

(3) The report shall include, in comparative columnar form, a summary of issuer's operations, or the operations of the issuer and its subsidiaries consolidated, or both as appropriate, for each of the last five (5) fiscal years of the issuer (or the life of the issuer and its predecessors, if less).

Note: Paragraph 7 permits the information required by this subsection to be set forth in any form deemed suitable by management.

(4) The report shall contain a brief description of the business or businesses done by the issuer and its subsidiaries during the most recent fiscal year which will, in the opinion of management, indicate the general nature and scope of the business of the issuer and its subsidiaries.

(5) The report shall identify each of the issuer's directors and officers and shall indicate the principal occupation or employment of each person and the name and principal business of any organization by which the person is so employed.

(6) The report shall identify the principal market in which securities of any class entitled to vote at the meeting are traded, stating the range of bid and asked quotations for each quarterly period during the issuer's two most recent fiscal years, and shall set forth each dividend paid during the two (2) year period.

(7) Subject to the foregoing requirements, the report may be in any form deemed suitable by management and the information required by Subsections B(3) through B(6) may be presented in an appendix or other separate section of the report, provided that the attention of security holders is called to the presentation.

(8) This Subsection B shall not apply, however, to solicitations made on behalf of the management before the financial statements are available if solicitation is being made at the time in opposition to the management and if the management's proxy statement includes an undertaking in bold face type to furnish the annual report to all persons being solicited, at least twenty (20) days before the date of the meeting.

C. Two (2) copies of the report sent to security holders pursuant to this section shall be mailed to the commissioner, solely for the commissioner's information, not later than the date on which the report was first sent or given to security holders or the date on which preliminary copies of solicitation material are filed pursuant to Section 7, whichever date is later.

D. If the issuer knows that securities of any class entitled to vote at a meeting with respect to which the issuer intends to solicit proxies, consents or authorizations are held of record by a broker, dealer, bank or voting trustee, or their nominees, the issuer shall inquire of the record holder at least ten (10) days prior to the record date for the meeting of security holders whether other persons are the beneficial owners of the securities and, if so, the number of copies of the proxy and other soliciting material and, in the case of an annual meeting at which directors are to be elected, the number of copies of the annual report to security holders, necessary to supply these materials to beneficial owners. The issuer shall supply the record holder in a timely manner with additional copies assembled in a form and at a place the record holder may reasonably request, in order to address and send one copy to each beneficial owner of securities so held and

shall, upon the request of the record holder, pay its reasonable expenses for mailing the materials to security holders to whom the material is sent.

Section 5. Requirements as to Proxy

A. The form of proxy shall:

(1) Indicate in bold face type whether or not the proxy is solicited on behalf of the insurer's board of directors, and, if not, by whom it is solicited;

(2) Provide a specifically designated blank space for dating the proxy; and

(3) Identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the issuer or by security holders.

No reference need be made to proposals as to which discretionary authority is conferred pursuant to Subsection C.

B. (1) Means shall be provided in the form of proxy whereby the person solicited is afforded an opportunity to specify by ballot a choice between approval or disapproval of, or abstention with respect to, each matter or group of related matters referred to therein as intended to be acted upon, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not specified provided the form of proxy states in bold face type how it is intended to vote the shares represented by the proxy in each case.

(2) A form of proxy which provides both for the election of directors and for action on other specified matters shall be prepared clearly to provide, by a box or otherwise, a means by which the security holder may withhold authority to vote for any nominee for election as a director. The form of proxy which is executed by the security holder in a manner as not to withhold authority to vote for the election of all nominees shall be deemed to grant authority for all nominees for which a vote is not withheld, provided the form of proxy so states in bold face type.

C. A proxy may confer discretionary authority to vote with respect to any of the following matters:

(1) Matters which the persons making the solicitation do not know, a reasonable time before the solicitation, are to be presented at the meeting, if a specific statement to that effect is made in the proxy statement or form of proxy;

(2) Approval of the minutes of the prior meeting if the approval does not amount to ratification of the action taken at that meeting;

(3) The election of any person to any office for which a bona fide nominee is named in the proxy statement and the nominee is unable to serve or for good cause will not serve;

(4) Any proposal omitted from the proxy statement and form of proxy pursuant to Sections 9 or 10;

(5) Matters incident to the conduct of the meeting.

D. No proxy shall confer authority to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or to vote at any annual meeting, other than the next annual meeting (or any adjournment thereof), to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders. A person shall not be deemed to be a bona fide nominee and shall not be named as such unless the person has consented to being named in the proxy statement and to serve if elected.

E. The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the securities represented by the proxy will be voted and that where the person solicited specifies by means of a ballot provided pursuant to Subsection B a choice with respect to any matter to be acted upon, the securities will be voted in accordance with specifications so made.

Section 6. Presentation of Information in Proxy Statement

A. The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter and the various groups of statements shall be preceded by appropriate headings.

B. All proxy statements shall disclose, under an appropriate caption, the date by which proposals of security holders intended to be presented at the next annual meeting must be received by the issuer for inclusion in the issuer's proxy statement and form of proxy relating to that meeting, such date to be calculated in accordance with the provisions of Section 9A. If the date of the next annual meeting is subsequently advanced by more than thirty (30) calendar days or delayed by more than ninety (90) calendar days from the date of the annual meeting to which the proxy statement relates, the issuer shall, in a timely manner, inform security holders of the change, and the date by which proposals of security holders must be received, by any means reasonably calculated to so inform them.

Section 7. Material Required to be Filed

A. Two (2) preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to security holders with the proxy (or the information statement pursuant to Schedule C) shall be filed with the commissioner at least ten (10) days prior to the date final copies of the material are first sent or given to security holders, or a shorter period prior to that date as the commissioner may authorize upon a showing of good cause.

B. Two (2) preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders after the proxy statement shall be filed with the commissioner at least two (2) days (exclusive of Saturdays, Sundays and holidays) prior to the date copies of the material are first sent or given to security holders, or a shorter period prior to the date as the commissioner may authorize upon a showing of good cause.

C. Two (2) definitive copies of the proxy statement, form of proxy and all other soliciting material (or the information statement) in the form in which the material is furnished to security holders, shall be filed with, or mailed for filing to, the commissioner no later than the date the material is first sent or given to any security holder.

D. Copies of replies to inquiries from security holders requesting further information and copies of communications that do no more than request that forms of proxy previously solicited be signed and returned do not need to be filed pursuant to this section.

E. Despite the provisions of Subsections A and B of this section and of Section 12E, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the commissioner as required by Subsection C no later than the date the material is used or published. The provisions of Subsections A and B of this section and of Section 12E shall apply, however, to any reprints or reproductions of all or any part of such material.

F. Where any proxy statement, form of proxy or other material filed pursuant to this regulation is amended or revised, one of the copies of the amended or revised material filed pursuant to this regulation shall be marked to indicate clearly and precisely the changes.

Section 8. Mailing Communications for Security Holders

If the management of the issuer has made or intends to make any solicitation subject to this regulation, the issuer shall perform any of the following acts requested in writing with respect to the same subject matter or meeting by any security holder who is, or security holders who are, entitled to vote at least one percent of the votes entitled to be voted on the matter and who shall defray the reasonable expenses to be incurred by the issuer in the performance of the act or acts requested.

A. The issuer shall mail or otherwise furnish to a security holder, as promptly as practicable after the receipt of the request:

(1) A statement of the approximate number of record owners and, to the extent known to the issuer, the approximate number of beneficial owners of any class of securities, any of whom have been or are to be solicited on behalf of the management, or any group of whom the security holder shall designate:

(2) An estimate of the cost of mailing a specified proxy statement, form of proxy or other communication to the owners.

B. (1) Copies of any proxy statement, form of proxy or other communication furnished by the security holder shall be mailed by the issuer to any of the security owners specified in Subsection A(1) as the security holder shall designate.

(2) The material furnished by the security holder shall be mailed with reasonable promptness after receipt of the material to be mailed, envelopes or other containers therefor, and postage or payment for postage. The issuer need not, however, mail any material before the first day that solicitation is made on behalf of the issuer.

(3) The issuer shall not be responsible for the proxy statement, form of proxy or other communication.

C. In lieu of performing the acts specified above, the issuer may, at its option, furnish promptly to a security holder a reasonably current list of the names and addresses of the record owners and, to the extent known to the issuer, the beneficial owners the security holder shall designate and a schedule of the handling and mailing costs if the schedule has been supplied to the issuer.

Section 9. Proposals of Security Holders

A. If any holder or holders of an issuer's securities (hereafter referred to as the "proponent") notifies the issuer in writing not less than ninety (90) days before the issuer's annual meeting of his intention to present a lawful proposal for action at an upcoming meeting of the issuer's security holders and at the time of the notice the proponent is entitled to vote at least one percent of the votes entitled to be voted on the proposal, the issuer shall set forth the proposal in its proxy statement and identify it in its form of proxy and provide for the specification of approval or disapproval of the proposal. The proxy statement shall also include the name and address of the proponent.

B. If the issuer opposes any proposal received from a proponent, it shall also, at the request of the proponent, include in its proxy statement a statement of the proponent of not more than 200 words in support of the proposal.

C. The issuer may omit a proposal and any statement in support thereof from its proxy statement and form of proxy under any of the following circumstances:

(1) The proponent has submitted more than one proposal in connection with a particular meeting.

(2) The proposal is more than 300 words in length.

(3) The proposal or the supporting statement is contrary to any section of this regulation or the schedules attached, including Section 10 which prohibits false or misleading statements in proxy soliciting materials.

(4) The proposal relates to the enforcement of a personal claim or the redress of a personal grievance against the issuer, its management or any other person.

(5) The proposal deals with a matter not significantly related to the issuer's business, a matter beyond the issuer's power to effectuate, a matter relating to the conduct of the ordinary business operations of the issuer or an election to office.

(6) The proposal is counter to a proposal to be submitted by the issuer at the meeting, the proposal has been rendered moot or the proposal relates to specific amounts of cash or stock dividends.

(7) The proposal is substantially duplicative of a proposal previously submitted to the issuer by another proponent, which proposal will be included in the management's proxy material for the meeting.

(8) Substantially the same proposal has previously been submitted to security holders in the issuer's proxy statement and form of proxy relating to any annual or special meeting of security holders held within the preceding five (5) calendar years and received less than five percent (5%) of the total number of votes cast at the time of its most recent submission.

D. If the issuer intends to omit any proposal from its proxy statement or forms of proxy or both, it shall notify the proponent in writing of its intention at least ten (10) days before the issuer's preliminary proxy material is filed pursuant to Section 7A.

Section 10. False or Misleading Statements

No proxy statement, form of proxy, notice of meeting, information statement or other communication, written or oral, subject to this regulation shall contain any statement which, at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

Section 11. Prohibition of Certain Solicitations

No person making a solicitation that is subject to this regulation shall solicit any undated or postdated proxy or any proxy or any proxy that provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the security holder subject to this regulation.

Section 12. Special Provisions Applicable to Election Contests

A. Solicitations to which this section applies. This section applies to any solicitation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of security holders.

B. Participant or participant in a solicitation.

(1) For purposes of this section the terms "participant" and "participant in a solicitation" include:

(a) The issuer;

(b) Any director of the issuer and any nominee for whose election as a director proxies are solicited;

(c) Any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(2) For the purpose of this section the terms "participant" and "participant in a solicitation" do not include:

(a) A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of securities and who is not otherwise a participant;

(b) Any person or organization retained or employed by a participant to solicit security holders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

(c) Any person employed in the capacity of attorney, accountant or advertising, public relations or financial adviser, whose activities are limited to the performance of his duties in the course of such employment;

(d) Any person regularly employed as an officer or employee of the issuer or any of its subsidiaries or affiliates who is not otherwise a participant; or

(e) Any officer or director of, or any person regularly employed by any other participant, if the officer, director or employee is not otherwise a participant.

C. Filing of information required by Schedule B.

(1) No solicitation subject to this section shall be made by any person other than the issuer unless at least five (5) business days prior, or a shorter period as the commissioner may authorize upon a showing of good cause, there has been filed with the commissioner, by or on behalf of each participant in the solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to security holders in furtherance of the solicitation.

(2) Within five (5) business days after a solicitation subject to this section is made by the issuer, or a longer period the commissioner may authorize upon showing of good cause, there shall be filed with the commissioner, by or on behalf of each participant in the solicitation other than the issuer, a statement in duplicate containing the information specified by Schedule B.

(3) If any solicitation on behalf of the issuer or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition, a statement in duplicate containing the information specified in Schedule B shall be filed with the commissioner, by or on behalf of each participant in the prior solicitation, other than the issuer, as soon as reasonably practicable after the commencement of the solicitation in opposition.

(4) If after the filing of the statements required by Subsections A, B and C of this section additional persons become participants in a solicitation subject to this section, there shall be filed with the commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three (3) business days after the person becomes a participant, or a longer period the commissioner may authorize upon a showing of good cause.

(5) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to the statement shall be filed promptly with the commissioner.

(6) Each statement and amendment filed pursuant to this paragraph shall be part of the public files of the commissioner.

D. Solicitations prior to furnishing required written proxy statement.

Notwithstanding the provisions of Section 4A, a solicitation subject to this section may be made prior to furnishing security holders a written proxy statement containing the information specified in Schedule A with respect to the solicitation, provided that:

(1) The statements required by Subsection C are filed by or on behalf of each participant in the solicitation.

(2) No form of proxy is furnished to security holders prior to the time the written proxy statement required by Section 4A is furnished to these persons. However, this Paragraph (2) shall not apply where a proxy statement meeting the requirements of Schedule A has been furnished to security holders.

(3) At least the information specified in Paragraphs (2) and (3) of the statements required by Subsection C to be filed by each participant, or an appropriate summary, are included in each communication sent or given to security holders in connection with the solicitation.

(4) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given security holders at the earliest practicable date.

E. Solicitations prior to furnishing required written proxy statement—filing requirements.

Two (2) copies of any soliciting materials proposed to be sent or given to security holders prior to the furnishing of the written proxy statement required by Section 4A shall be filed with the commissioner in preliminary form at least five (5) business days prior to the date definitive copies of the material are first sent or given to the persons, or a shorter period the commissioner may authorize upon a showing of good cause.

F. Notwithstanding the provisions of Section 4B, two (2) copies of any portion of the annual report referred to in Section 4B which comments upon or refers to any solicitation subject to this section, or to any participant in any solicitation, other than the solicitation by the management, shall be filed with the commissioner as proxy material subject to this regulation. This portion of the report shall be filed with the commissioner, in preliminary form, at least five (5) business days prior to the date copies of the report are first sent or given to security holders.

Section 13. Solicitations and Materials Complying With NAIC Model Regulation and Schedules

Notwithstanding the foregoing sections, the commissioner may permit the solicitation of proxies, consents or authorizations, provided that the manner of solicitation and the form of proxy, proxy statement and other documents used in the solicitation comply with the National Association of Insurance Commissioners' (NAIC) model regulation and schedules.

SCHEDULE A

Item 1. Revocability of Proxy

State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited, or is subject to compliance with any formal procedure, briefly describe the limitation or procedure.

Item 2. Dissenters' Rights of Appraisal

Outline briefly any rights of appraisal or similar rights of dissenters with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by dissenting security holders in order to perfect their rights. Where these rights may be exercised only within a limited time after the proposal's date of adoption, the filing of a charter amendment or other similar act, indicate whether the person solicited will be notified of the date.

Item 3. Persons Making the Solicitation

A. Solicitations not subject to Section 12

(1) State if the solicitation is made by the issuer. Give the name of any director of the issue who has informed the issuer in writing that the director intends to oppose an action intended to be taken by the issuer and indicate the action which the director intends to oppose.

(2) If the solicitation is made by someone other than by the issuer, state the names of the persons by whom and on whose behalf it is made.

(3) If the solicitation is to be made by other than the use of the mails, describe the methods to be employed. If the solicitation is to be made by specially engaged employees or paid solicitors, state:

(a) The material features of any contract or agreement for the solicitation and identify the parties; and

(b) The cost or anticipated cost.

(4) State the names of the persons who will bear the cost of solicitation, directly or indirectly.

B. Solicitations subject to Section 12

(1) State who will make the solicitation and describe the methods employed a to solicit security holders.

(2) If regular employees of the issuer or any other participant in a solicitation have been or are to be employed to solicit security holders, describe the class or classes of employees to be so employed, and the manner and nature of their employment for this purpose.

(3) If specially engaged employees, representatives or other persons have been or are to be employed to solicit security holders, state:

(a) The material features of any contract or arrangement for the solicitation and identify the parties;

(b) The cost or anticipated cost; and

(c) The approximate number of employees or employees of another person (naming the other person) who will solicit security holders.

(4) State the total amount estimated to be spent and the total expenditures to date for or in connection with the solicitation of security holders.

(5) State who will bear the cost of the solicitation. If reimbursement will be sought from the issuer, state whether the question of reimbursement will be submitted to a vote of security holders.

(6) If a solicitation is terminated pursuant to a settlement between the issuer and an other participant in the solicitation, describe the terms of the settlement, including the cost or anticipated cost to the issuer.

Item 4. Interest of Certain Persons in Matters to be Acted Upon

A. Solicitations not subject to Section 12. Describe briefly any substantial interest, direct or indirect, of each of the following persons in a matter to be acted upon, other than elections to office:

(1) If the solicitation is made on behalf of the issuer, each current director or officer of the issuer;

(2) If the solicitation is made for other than on the issuer's behalf, any person who would be a participant in a solicitation (except the issuer or an officer, director or nominee of the issuer);

(3) Each nominee for election as a director of the issuer; and

(4) Each associate of the foregoing persons.

B. Solicitations subject to Section 12. Describe briefly any substantial interest, direct or indirect, of each participant (except the issuer) in any matter to be acted upon at the meeting. Include, with respect to each participant, the information required by Items 2A, 2D, 3, 4B, and 4C of Schedule B.

Item 5. Voting Securities and Principal Holders Thereof

A. State for each class of voting securities of the issuer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

B. Give the date that the record of security holders entitled to vote at the meeting will be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to vote.

C. If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights:

(1) Make a statement that they have these rights;

(2) Describe the rights;

(3) State the conditions precedent to the exercise of these rights; and

(4) Indicate if discretionary authority to cumulate votes is solicited.

D. Furnish the following information as of the most practicable date, in substantially the tabular form indicated, with respect to:

(1) A person or group of persons who is known to be the beneficial owner of more than five percent (5%) of any class of securities; and

(2) All directors and nominees, naming them, and directors and officers of the issuer as a group, without naming them.

(1) Title of Class	(2) Name of Beneficial Owner	(3) Amount and Nature of Beneficial Ownership	(4) Percent of Class

E. If, to the knowledge of the person on whose behalf the solicitation is made, a change in control of the issuer has occurred since the beginning of its last fiscal year, state: (1) The name of the person or persons who acquired control; (2) The amount and the source of the consideration used by the person or persons, (3) The basis of the control; (4) The date and a description of the transactions that resulted in the change of control; (5) The percentage of voting securities of the issuer now beneficially owned directly or indirectly by the person or persons who acquired control; and (6) The identity of the person or persons from whom control was assumed. Describe any arrangements which may at a later date result in a change of control of the issuer.

Item 6. Directors and Executive Officers

If action is to be taken with respect to election of directors, furnish the following information, in tabular form to the extent practicable, about each person nominated for election as a director and each person whose term of office will continue after the meeting. However, if the solicitation is made on behalf of persons other than the issuer, the information required should only be furnished as to nominees of the persons making the solicitation.

A. Identification of directors and officers. List the names and ages of all directors and officers of the issuer and all persons nominated or chosen to become directors or officers. Indicate all positions and offices with the issuer held by each person; state the term of office as director or officer or both and any period during which the person served. Briefly describe any arrangement or understanding between the person and any other person or persons (naming the persons) pursuant to which the person was or is to be selected as a director, officer or nominee. The information regarding officers does not need to be furnished in proxy or information statements provided that the information is furnished in a separate item in the issuer's annual report to stockholders.

B. Family relationships. State the nature of a family relationship not more remote than first cousin between a director, officer or person nominated or chosen by the issuer to become a director or officer. State the nature of any family relationship between any such person and an officer or director of any of the issuer's parent companies, subsidiaries or other affiliates.

C. Business experience. State the principal occupations and employment during the past five (5) years of each director and each person nominated or chosen to become a director or officer and the name and principal business of any corporation or other organization in which the occupations and employment were carried on.

D. Directorships. Indicate other directorships held by each director or person nominated or chosen to become a director.

E. Involvement in certain legal proceedings. Describe any legal proceedings that have occurred during the past five (5) years or which are pending that are material to an evaluation of the ability or integrity of any director or nominee for director or officer of the issuer.

F. Describe any of the following relationships that exist:

(1) If the nominee or director is, or has within the last two (2) full fiscal years been an officer, director or employee of, or owns, or has within the last two (2) fiscal years owned, directly or indirectly, an equity interest in any firm, corporation or other business in excess of a one percent:

(a) That has made payments to the issuer or its subsidiaries during the issuer's last full fiscal year or that proposes to make payments to the issuer or its subsidiaries during the current fiscal year in excess of one percent of the issuer's consolidated gross revenues for its last full fiscal year;

(b) To which the issuer or its subsidiaries were indebted at any time during the issuer's last fiscal year in an aggregate amount in excess of one percent of the issuer's total consolidated assets at the end of the fiscal year;

(c) To which the issuer or its subsidiaries have made payments during the entity's last fiscal year or to which the issuer or its subsidiaries propose to make payments during the entity's current fiscal year in excess of one percent of the entity's consolidated gross revenues for its last full fiscal year;

(d) In order to determine whether payments made or proposed to be made exceed one percent of the consolidated gross revenues of any entity other than the issuer for the entity's last full fiscal year, it is appropriate to rely on information provided by the nominee or director;

(e) In calculating payments for property and services the following may be excluded:

(i) Payments where the rates or charges involved in the transaction are determined by competitive bids, or the transaction involves the rendering of services as a public utility at rates or charges fixed in conformity with law or governmental authority;

(ii) Payments that arise solely from the ownership of securities of the issuer and no extra or special benefit not shared on a pro rata basis by all holders of the class of securities is received;

(f) In calculating indebtedness for purposes of Subparagraph (b) above, debt securities that have been publicly offered, admitted to trading on a national securities exchange or quoted on the automated quotation system of a registered securities association may be excluded.

(2) The nominee or director is a member or employee of, or is associated with, a law firm which the issuer has retained in the last two (2) full fiscal years or proposes to retain in the current fiscal year where fees paid or anticipated to be paid by the issuer are material to either the law firm, the issuer or both.

(3) The nominee or director is a director, partner, officer or employee of any investment banking firm that has performed services for the issuer other than as a participating underwriter in a syndicate in the last two (2) full fiscal years or which the issuer proposes to have perform services in the current year; or

(4) The nominee or director is a control person of the issuer (other than solely as a director of the issuer).

G. (1) State whether or not the issuer has standing audit, nominating and compensation committees of the board of directors, or committees performing similar functions. If the issuer has these committees, however designated, identify each committee member, state the number of committee meetings held by each committee during the last fiscal year and describe briefly the functions performed by the committees.

(2) If the issuer has a nominating or similar committee, state whether the committee will consider nominees recommended by shareholders. If so, describe the procedures to be followed by shareholders in submitting the recommendations.

H. State the total number of meetings of the board of directors (including regularly scheduled and special meetings) that were held during the last full fiscal year. Name each incumbent director who, during the last full fiscal year, attended fewer than seventy-five percent (75%) of the aggregate of:

(1) The total number of meetings of the board of directors (held during the period for which he has been a director); and

(2) The total number of meetings held by all committees of the board on which he served (during the periods that he served).

I. If a director has resigned or declined to stand for re-election to the board of directors since the date of the last annual meeting of shareholders because of a disagreement with the issuer on any matter relating to the issuer's operations, policies or practices, and if the director has furnished the issuer with a letter describing that disagreement and requesting that the matter be disclosed, the issuer shall state the date of resignation or declination to stand for re-election and summarize the director's description of the disagreement. If the issuer believes that the description provided by the director is incorrect or incomplete, it may include a brief statement presenting its views of the disagreement.

J. (1) With respect to those classes of voting stock that participated in the election of directors at the most recent meeting where directors were elected:

(a) State the percentage of shares present at the meeting and voting or withholding authority to vote in the election of directors; and

(b) Disclose in tabular format, the percentage of total shares cast for and withheld from the vote for or, where applicable, cast against, each nominee, which, respectively, were voted for and withheld from the vote for, or voted against, the nominee.

(2) When groups of classes or series of classes vote together in the election of a director or directors, they shall be treated as a single class for the purpose of Paragraph (1)(b).

Instructions:

1. Calculate the percentage of shares present at the meeting and voting or withholding authority to vote in the election of directors, referred to in Subsection J(1)(a), by dividing the total shares cast for and withheld from the vote for or, where applicable, voted against, the director for whom the highest aggregate number of shares was cast by the total number of shares outstanding that were eligible to vote as of the record date for the meeting.

2. No information need be given in response to Item 6J unless, with respect to any class of voting stock (or group of classes which voted together), five percent (5%) or more of the total shares cast for and withheld from the votes for or, where applicable, cast against any nominee were withheld from the vote for or cast against the nominee.

3. If an issuer elects less than the entire board of directors annually, disclosure is required for all directors if five percent (5%) or more of the total shares cast for and withheld from, the vote for or, where applicable, cast against an incumbent director were withheld from, or cast against, the vote for the director at the meeting where the person was most recently elected.

4. No information must be given in response to Item 6J if the issuer has previously furnished to its security holders a report of the results of the most recent meeting of security holders where directors were elected which includes:

(a) A description of each matter voted upon at the meeting and a statement of the percentage of the shares voting that were voted for and against each matter; and

(b) The information that would be called for by this Item 6J.

If an issuer has previously furnished the results to its security holders, this fact should be stated in a letter accompanying the filing of preliminary proxy materials with the commissioner.

Item 7. Remuneration of Directors and Officers

Furnish the following information if action is to be taken concerning (i) the election of directors; (ii) any bonus, profit sharing or other remuneration plan, contract or arrangement that a director, nominee for election as a director or officer of the issuer will participate; (iii) a pension or retirement plan where a person will participate; or (iv) the granting or extension to a person of any options, warrants or rights to purchase securities, other than warrants or rights issued to security holders on a pro rata bases. If the solicitation is made on behalf of persons other than the issuer, the information required need be furnished only as to nominees of the person making the solicitation and associates of the nominees.

A. Current remuneration. Furnish the information required in the table below, in substantially the tabular form specified, concerning all remuneration of the following persons and groups for services in all capacities to the issuer and its subsidiaries during the issuer's last fiscal year or, in specified instances, certain prior fiscal years:

(1) Five (5) officers or directors. Name each of the five (5) most highly compensated officers or directors of the issuer who have a total remuneration required to be disclosed in Columns C1 and C2 below that would exceed $50,000; and

(2) All officers or directors. All officers and directors of the issuer as a group, stating the number of persons in the group without naming them.

(3) Specified Tabular Format

(A) Name of individual or number of persons in groups	(B) Capacities in which served	(C) Cash and cash equivalent forms of remuneration		(D) Aggregate of contingent forms of remuneration
		(C1) Salaries, fees, directors' fees, commissions, and bonuses	(C2) Securities of property, insurance benefits or reimbursements, personal benefits	

(4) Information to be Included. Columns C-1, C-2, and D of the table should contain with respect to each person or group of persons specified in Subparagraphs A(1) and A(2) of this Item 7 a dollar amount that reflects the total of all items of remuneration described in the heading to that column including, but not necessarily limited to, those items set forth in the subparagraphs of that column.

COLUMN C

Include all cash and cash equivalent forms of remuneration received during the fiscal year and all amounts accrued during the fiscal year which, with reasonable certainty, will be distributed or vested in the future.

COLUMN C-1

Salaries, Bonuses, Fees and Commissions

1. All cash remuneration distributed or accrued in the form of salaries, commissions, bonuses and fees for services rendered.
2. Compensation earned for services performed in the latest fiscal year even if it is deferred for future payment.
3. Payments received in the latest fiscal year but earned in prior years that were deferred until the latest year, if the amounts were not shown in an earlier proxy statement or annual report to stockholders.

COLUMN C-2

Securities, Property Insurance Benefits or Reimbursements, Personal Benefits

1. Spread between the acquisition price, if any, and fair market price of securities or property acquired under any contract, plan or arrangement.
2. Cost of any life insurance premiums, health insurance premiums and medical reimbursement plans. Premiums for non-discriminatory plans generally available to all salaried employees are excluded.
3. Personal benefits (perquisites) not directly related to job performance, ex-cluding benefits provided on a non-discriminatory basis, valued on the basis of cost to the issuer of providing the benefits.
    a. If unreasonable effort or expense is required to determine the amounts of personal benefits, they may be omitted if their aggregate value does not exceed $10,000 for each officer.

COLUMN D

Include all contingent forms of remuneration, vesting and measurement of which is subject to future events. Report only amounts relating to the latest fiscal year, not amounts accrued in previous periods.

1. Amount expensed for financial reporting pur-poses representing non-vested contributions, pay-ments or accruals under any pension or retirement plans, annuities, employ-ment contracts deferred compensation plans in-cluding IRS qualified plans, unless the amount for the individual cannot be separated, in which case a footnote is re-quired indicating the percentage that contri-butions to the plan bear to participants' total remuneration.
2. The amount expensed for financial reporting pur-poses under any incentive plans (long-term income plans), such as stock appreciation rights, stock options, performance share plans, where payout is based on objective standards or stock values. In subsequent years, if the corporation credits

	b. If the amount of personal benefits exceed ten percent (10%) of the total remuneration or $25,000, whichever is less, the amount and a brief description of the benefits must be disclosed in a footnote.	compensation expense for financial reporting purposes as a result of a decline in the value of contingent compensation, Column D may be reduced by a corresponding amount. A footnote explaining the action should be included
4.	Vested company contributions to thrift, profit, sharing, pension stock purchase and similar plans.	3. The amount expensed for financial reporting purposes for any non-vested contribution payment or accrual to stock purchase plans, profit sharing, and thrift plans whether or not they are qualified under the Internal Revenue Code.

(5) Transactions with third parties. Item 7A, among other things, includes transactions between the issuer and a third party when the primary purpose of the transaction is to furnish remuneration to the persons specified in Item 7A. Other transactions between the issuer and third parties in which persons specified in Item 7A have an interest, or may realize a benefit, generally are addressed by other disclosure requirements concerning the interest of management and others in certain transactions. Item 7A does not require disclosure of remuneration paid to a partnership in which any officer or director was a partner; these transactions should be disclosed pursuant to these other disclosure requirements, and not as a note to the remuneration table presented pursuant to Item 7A.

(6) Other permitted disclosure. The issuer may provide additional disclosure through a footnote to the table, through additional columns or otherwise, describing the components of aggregate remuneration in greater detail as is appropriate.

B. Proposed remuneration.

(1) Briefly describe all remuneration payments proposed to be made in the future, pursuant to any existing plan or arrangement to the persons and groups specified in Item 7A. As to defined benefit or actuarial plans with respect to amounts not included in the table, include a separate table showing the estimated annual benefits payable upon retirement to persons in specified remuneration and years-of-service classifications.

(2) Information does not need to be furnished with respect to any group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of officers or directors of the issuer and that are available generally to all salaried employees.

C. Remuneration of directors. Describe any standard or special arrangements, stating amounts, by which directors of the issuer are compensated for services as a director.

D. Options, warrants or rights.

(1) Furnish the information required by the following table for all options to purchase securities from the issuer or its subsidiaries that were granted to or exercised by the persons and groups specified in Item 7A since the beginning of the issuer's last fiscal year and as to all options held by these persons as of the latest practicable date:

The following tabulation shows as to certain directors and officers and as to all directors and officers as a group:

(a) The amount of options granted since the beginning of the issuer's last full fiscal year;

(b) The amount of shares acquired since that date through the exercise of options;

(c) The amount of shares of the same class sold during the period; and

(d) The amount of shares subject to all unexercised options held as of the most recent practicable date.

Title of Securities	Name	Name	Name	All directors and officers as a group
Granted-19[ ] to date:				
Number of shares				
Average per share option price	$	$	$	$
Exercised-19[ ] to date:				
Number of shares				
Aggregate option price of options exercised	$	$	$	$
Aggregate market value of shares on date options exercised	$	$	$	$
Sales-19[ ] to date:				
Number of shares				
Unexercised at 19[ ]:				
Number of shares				**
Average per share option price	$	$	$	$

In addition, during the period employees were granted options for ____ shares at an average price per share of $____.

**Sales by directors and officers who exercised options during the period 19[ ] to date.

Instructions:

1. All figures should be adjusted, where applicable, in accordance with the terms of the options to reflect stock splits and to give effect to share dividends.

2. Other tabular presentations are acceptable if they include the necessary data. Tabular presentation may not be needed if only a very few options have been granted

3. (a) Where the total market value on the granting dates of the securities called for by all options granted during the period specified does not exceed $10,000 for any officer or director named in answer to Item 7A, or $40,000 for all officers and directors as a group, this Item need not be answered with respect to options granted to a person or group.

   (b) Where the total market value on the dates of purchase of all securities purchased through the exercise of options during the period specified does not exceed $10,000 for a person or $40,000 for a group, this item does not need to be answered with respect to options exercised by a person or group.

   (c) Where the total market value as of the latest practicable date of the securities called for by all options held at the time does not exceed $10,000 for a person or $40,000 for a group, this item does not need to be answered with respect to options held as of the specified date by a person or group.

      (i) The term "options" as used in Subsection D includes all options, warrants or rights, other than those issued to security holders as such on a pro rata basis. Where the average option price per share is called for, the weighted average price per share shall be given.

      (ii) The extension, regranting or material amendment of options shall be deemed the granting of options within the meaning of this paragraph.

      (iii) If the options relate to more than one class of securities, the information shall be given separately for each class.

   E. Indebtedness of management.

      (1) State for each director or officer of the issuer, each nominee for election as a director, and each associate of a director, officer or nominee who was indebted to the issuer or its subsidiaries at any time since the beginning of the last fiscal year of the registrant:

         (a) The largest aggregate amount of indebtedness outstanding at any time during the period,

         (b) The nature of the indebtedness outstanding and the transaction in which it was incurred,

         (c) The amount outstanding as of the latest practicable date; and

         (d) The rate of interest paid or charged.

      (2) Subsection E does not apply to:

         (a) Any person whose aggregate indebtedness did not exceed $10,000 or one percent of the issuer's total assets, whichever is less, at any time during the period specified; or

         (b) Indebtedness under an insurance policy.

F. Transactions with management.

(1) Describe briefly any transaction since the beginning of the issuer's last fiscal year or any presently proposed transactions, to which the issuer or any of its subsidiaries was or is to be a party, in which any of the following persons had or is to have a direct or indirect material interest, naming the person and stating the relationship to the issuer, the nature of the interest in the transaction and, where practicable, the amount of the interest.

(a) A director of officer of the issuer;

(b) A nominee for election as a director;

(c) A security holder who is known to the issuer to own of record or beneficially more than ten percent (10%) of any class of the issuer's voting securities; and

(d) A relative or spouse of any of the foregoing persons, or any relative of the spouse, who has the same home as the person or who is a director or officer of a parent or subsidiary of the issuer.

(2) Also, describe briefly any material legal proceedings in which a person is an adverse party to the issuer or any of its subsidiaries or has an adverse material interest to the issuer or any of its subsidiaries.

(3) Information does not need to be given in response to this Item 7F as to any remuneration or other transaction reported in response to Item 7A, B, C, D or E, or as to any transaction with respect to which information may be omitted pursuant to these items.

(4) Information does not need to be given in answer to this Item 7F for any transaction where:

(a) The rates or charges involved in the transaction are determined by competitive bids, or at rates or charges fixed in conformity with law or governmental authority;

(b) The transaction involves services as a bank depository of funds, transfer agent, registrar, trustee under a trust indenture, or similar services;

(c) The amount involved in the transaction or series of similar transactions, including all periodic installments in the case of any lease or other agreement providing for periodic payments or installments, does not exceed $40,000; or

(d) The interest of the specified person arises solely from the ownership of securities of the issuer and the specified person receives no extra or special benefit not shared on a pro rata basis by all holders of securities of the class.

(5) It should be noted that this item calls for disclosure of indirect, as well as direct, material interests in transactions. A person who has a position or relationship with a firm, corporation or other entity, that engages in a transaction with the issuer or its subsidiaries may have an indirect interest in the transaction by reason of the position or relationship. However, a person shall be deemed not to have a material indirect interest in a transaction within the meaning of this Item 7F where:

(a) The interest arises only (i) from the person's position as a director of another corporation or organization (other than a partnership) which is a party to the transaction, or (ii) from the direct or indirect ownership by the person and all other persons specified in Item 7F of less than a ten percent (10%) equity interest in another person (other than a partnership) which is a party to the transaction, or (iii) from both the position and ownership;

(b) The interest arises only from the person's position as a limited partner in a partnership in which he and all other persons specified in Item 7F had an interest of less than ten percent (10%); or

(c) The interest of the person arises solely from the holding of an equity interest (including a limited partnership interest but excluding a general partnership interest) or a creditor interest in another person which is a party to the transaction with the issuer or any of its subsidiaries and the transaction is not material to the other person.

Instructions:

1. In describing any transaction involving the purchase or sale of assets by or to the issuer or any of its subsidiaries, other than in the ordinary course of business, state the cost of the assets to the purchaser and, if acquired by the seller within two (2) years prior to the transaction, the cost to the seller. Indicate the principle followed in determining the issuer's purchase or sale price and the name of the person making the determination.

2. Information shall be furnished in answer to this Item with respect to transactions not excluded above which involve remuneration from the issuer or its subsidiaries, directly or indirectly, to any of the specified persons for services in any capacity unless the interest of these persons arises solely from the ownership individually and in the aggregate of less than ten percent (10%) of any class of equity securities of another corporation furnishing the services to the issuer or its subsidiaries.

G. Transactions with pension or similar plans.

(1) Describe briefly any transactions since the beginning of the issuer's last fiscal year, or any presently proposed transactions, to which any pension, retirement, savings or similar plan provided by the issuer, or any of its parents or subsidiaries was or is to be a part, in which any of the persons specified in Item 7F or the issuer or any of its subsidiaries had or is to have a direct or indirect material interest naming the person and stating his relationship to the issuer, the nature of his interest in the transaction and, where practicable, the amount of the interest.

(2) Information does not need to be given in answer to Subsection G with respect to:

(a) Payments to the plan, or payments to beneficiaries, pursuant to the terms of the plan;

(b) Payment of remuneration for services not in excess of five percent (5%) of the aggregate remuneration received by the specified person during the issuer's last fiscal year from the issuer and its subsidiaries; or

(c) Any interest of the issuer or any of its subsidiaries that arises solely from its general interest in the success of the plan.

Instructions:

1. Subparagraph 3 to Item 7F shall apply to this Item 7G.

2. Without limiting the general meaning of the term "transaction" there shall be included in the answer to this item any remuneration received or any loans received or outstanding during the period, or proposed to be received.

Item 8. Matters Related to Accounting

If the solicitation is made on behalf of the issuer and relates to an annual meeting of security holders at which directors are to be elected, or financial statements are included, furnish the following information:

A. State if the issuer's financial statements are not certified by independent public or certified accountants.

B. State if the board of directors has no audit or similar committee.

C. If the issuer's financial statements are certified by independent public or certified accountants, state that fact and provide the following information:

(1) The name of the principal accountant selected or being recommended to shareholders for election, approval or ratification for the current year. If no accountant has been elected or recommended, so state and briefly describe the reasons.

(2) The name of the principal accountant for the fiscal year most recently completed if different from the accountant selected or recommended for the current year or if no accountant has been elected or recommended for the current year.

(3) State if a change or changes in accountants have taken place since the date of the proxy statement for the most recent annual meeting of shareholders. If, in connection with the change, a material disagreement in connection with financial disclosure between the accountant and issuer has occurred, the disagreement shall be described. Prior to filing the preliminary proxy materials with the commissioner that contain or amend the description, the issuer shall furnish the description of the disagreement to an accountant with whom the disagreement has occurred. If that accountant believes that the description of the disagreement is incorrect or incomplete, the accountant may include a brief statement, not to exceed 200 words, in the proxy statement presenting his or her view of the disagreement. This statement shall be submitted to the issuer within ten (10) business days of the date the accountant receives the issuer's descriptions.

(4) The proxy statement shall indicate whether or not representative of the principal accountants for the current year and for the most recently completed fiscal year are expected to be present at the stockholders' meeting with the opportunity to make a statement if they desire to do so and whether or not the representatives are expected to be available to respond to appropriate questions.

(5) If a change in accountants has taken place since the date of the proxy statement for the most recent annual meeting of shareholders, state whether the change was recommended or approved by:

(a) An audit or similar committee of the board of directors, if the issuer has this committee; or

(b) The board of directors, if the issuer has no committee.

D. For the fiscal year most recently completed, describe each professional service provided by the principal accountant and state the percentage relationship that the aggregate of the fees for all nonaudit services bear to the audit fees and, except as provided below, state the percentage relationship that the fee for each nonaudit service bears to the audit fees. Indicate whether, before each professional service provided by the principal accountant was rendered, it was approved by, and the possible effect on the independence of the accountant was considered by:

(1) An audit or similar committee of the board of directors; and

(2) The board of directors for a service not approved by an audit or similar committee.

Instructions:

1. For purposes of this subsection, all fees for services provided in connection with the audit function (e.g. reviews of quarterly reports) may be computed as part of the audit fees. Indicate which services are reflected in the audit fees computation.

2. If the fee for any non-audit service is less than three percent (3%) of the audit fees, the percentage relationship does not need to be disclosed.

3. Each service should be specifically described. Broad general categories such as "tax matters" or "management advisory services" are not sufficiently specific.

4. Describe the circumstances and give details of any services provided by the issuer's independent accountant during the latest fiscal year that were furnished at rates or terms that were not customary.

5. Describe any existing direct or indirect understanding or agreement that places a limit on current or future years' audit fees, including fee arrangements that provide fixed limits on fees that are not subject to reconsideration if unexpected issues involving accounting or auditing are encountered. Disclosure of fee estimates is not required.

Item 9. Bonus, Profit Sharing and Other Remuneration Plans: Pension and Retirement Plans

If action is to be taken with respect to any bonus, profit sharing or other remuneration plan or any pension or retirement plan, furnish the following information:

A. Describe briefly the material features of the plan, identify each class of persons who will participate, indicate the approximate number of persons in each class and state the basis of the participation.

B. Furnish the information, in addition to that required by this item and Item 7, as may be necessary to describe adequately the provisions already made pursuant to all bonus, profit sharing, pension, retirement, stock option, stock purchase, deferred compensation or other remuneration or incentive plans, now in effect or in effect within the past five (5) years, for:

(1) Each director or officer named in answer to Item 7A who may participate in the plan to be acted upon;

(2) All present directors and officers of the issuer as a group, if any director or officer may participate in the plan; and

(3) All employees, if employees may participate in the plan.

C. If the plan to be acted upon can be amended otherwise than by a vote of stockholders, to increase the cost thereof to the issuer or to alter the allocation of the benefits as between the directors and officers on the one hand and employees on the other, state the nature of the amendments which can be made.

D. With regard to any bonus, profit sharing or other remuneration plan, on which action is to be taken, furnish the following information:

(1) State separately the amounts which would have been distributable under the plan during the last fiscal year of the issuer:

(a) To directors and officer, and

(b) To employees if the plan had been in effect.

(2) State the name and position with the issuer of each person specified in Item 7A who will participate in the plan and the amount each person would have received under the plan for the last fiscal year of the issuer if the plan had been in effect.

E. With regard to any pension or retirement plan on which action is to be taken, furnish the following information:

(1) State:

(a) The approximate total amount necessary to fund the plan with respect to past services, the period over which the amount is to be paid and the estimated annual payments necessary to pay the total amount over the period;

(b) The estimated annual payment to be made with respect to current services; and

(c) The amount of the annual payments to be made for the benefit of

(i) directors and officers, and

(ii) employees.

(2) State:

(a) The name and position with the issuer of each person specified in Item 7A who will be entitled to participate in the plan;

(b) The amount which would have been paid or set aside by the issuer and its subsidiaries for the benefit of the person for the last fiscal year of the issuer if the plan had been in effect; and

(c) The amount of the annual benefits estimated to be payable to the person in the event of retirement at normal retirement date.

Instructions:

1. If action is to be taken with respect to the amendment or modification of an existing plan, the item shall be answered with respect to the plan as proposed to be amended or modified ad shall indicate any material differences from the existing plan.

2. The following instruction shall apply to Subsection B:

(a) Information need only be given with respect to benefits received or set aside within the past five (5) years.

(b) Information does not need to be included as to payments made for, or benefits to be received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

(c) If action is to be taken with respect to any plan in which directors or officers may participate, the information called for by Item 7D shall be furnished for the last five (5) fiscal years of the issuer and any period after the end of the latest fiscal year, in aggregate amounts for the entire period for each person and group. If any named person, or any other director or officer, purchased securities through the exercise of options during period, state the aggregate amount of securities of that class sold during the period by the named person and by the named person and other directors and officers as a group. The information called for by this instruction is in lieu of the information since the beginning of the issuer's last fiscal year called for by Item 7D. If employees may participate in the plan to be acted upon, state the aggregate amount of securities called for by all options granted to employees during the five (5) year period and, if the options were other than "restricted" or "qualified" stock options or options granted pursuant to an "employee stock

purchase plan," as the quoted terms are defined in Sections 422 through 424 of the Internal Revenue Code, state that fact and the weighted average option price per share. The information called for by this instruction may be furnished in the form of the table set forth in Item 7D.

3. If the plan to be acted upon is set forth in a written document, three (3) copies shall be filed with the commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

4. The information called for by Subsection E(1)(c) or E(2)(b) of this Item 9 does not need to be given as to payments made on an actuarial basis pursuant to any group pension plan that provides for fixed benefits in the event of retirement at a specified age or after a specified number of years of service.

Item 10. Options, Warrants or Rights

If action is to be taken with respect to the granting or extension of any options to purchase securities of the issuer or any subsidiary, furnish the following information:

A. State:

(1) The title and amount of securities called for or to be called for by the options;

(2) The prices, expiration dates and other material conditions upon which the options may be exercised;

(3) The consideration received or to be received by the issuer or subsidiary for the granting or extension of the options;

(4) The market value of the securities called for or to be called for by the options as of the latest practicable date; and

(5) In the case of options, the federal income tax consequences of the issuance and exercise of the option to the recipient and to the issuer.

B. (1) State separately the amount of options received or to be received by the following persons, naming each person:

(a) Each director or officer named in answer to Item 7A;

(b) Each nominee for election as a director of the issuer;

(c) Each associate of the directors, officers, or nominees; and

(d) Each other person who received or is to receive ten percent (10%) or more of the options.

(2) State the total amount of the options received or to be received by all directors and officers of the issuer as a group, without naming them.

C. Furnish the information, in addition to that required by this item and Item 7, necessary to describe adequately the provisions already made pursuant to all bonus, profit sharing, pension, retirement, stock option, stock purchase, deferred compensation, or other remuneration or incentive plans, now in effect or in effect within the past five (5) years, for:

(1) Each director or officer named in answer to Item 7A who may participate in the plan to be acted upon;

(2) All present directors and officers of the issuer as a group, if any director or officer may participate in the plan; and

(3) All employees, if employees may participate in the plan.

Instructions:

1. For the purpose of this Item 10 the term option includes any option, warrant or right.

2. Paragraphs B and C do not apply to warrants or rights to be issued to security holders on a pro rata basis.

3. Instruction 2 to Item 9 shall also apply to Paragraph C of this item.

4. If the options described in answer to this item are issued pursuant to a plan which is set forth in a written document, three (3) copies shall be filed with the commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

Item 11. Authorization or Issuance of Securities Otherwise than for Exchange

If action is to be taken with respect to the authorization or issuance of any securities otherwise than for exchange for outstanding securities of the issuer, furnish the following information:

A. State the title and amount of securities to be authorized or issued.

B. If the securities are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

C. Describe briefly the transaction in which the securities are to be issued, including a statement as to:

(1) The nature and approximate amount of consideration received or to be received by the issuer, and

(2) The approximate amount devoted to each purpose, as far as is determinable, for which the net proceeds have been or are to be used.

If it is impracticable to describe the transaction in which the securities are to be issued, state the reason, indicate the purpose of the authorization of the securities, and state whether further authorization for the issuance of the securities by a vote of security holders will be solicited prior to issuance.

D. If the securities are to be issued otherwise than in a general public offering for cash, state the reasons for the proposed authorization or issuance and the general effect upon the rights of existing security holders.

Item 12. Modification or Exchange of Securities

If action is to be taken with respect to the modification of any class of securities of the issuer, or the issuance or authorization for issuance of securities of the issuer in exchange for outstanding securities of the issuer, furnish the following information:

A. If outstanding securities are to be modified, state the title and amount thereof. If securities are to be issued in exchange for outstanding securities, state the title and amount of securities to be so issued, the title and amount of outstanding securities to be exchanged therefor and the basis of the exchange.

B. Describe any material differences between the outstanding securities and the modified or new securities.

C. State the reasons for the proposed modification or exchange and the general effect upon the rights of existing security holders.

D. Furnish a brief statement as to arrears in dividends or as to defaults in principal or interest in respect to the outstanding securities which are to be modified or exchanged and other information appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

E. Outline briefly any other material features of the proposed modification or exchange. If the plan of proposed action is set forth in a written document, file copies thereof with the commissioner at the time the preliminary proxy material is filed.

Item 13. Mergers, Consolidations, Acquisitions and Similar Matters

Furnish the following information if action is to be taken with respect to any plan for (i) the merger or consolidation of the issuer into or with an other person or of an other person into or with the issuer; (ii) the acquisition by the issuer or any of its security holders of securities of another issuer; (iii) the acquisition by the issuer of an other going business or of the assets thereof; (iv) the sale or other transfer of all or any substantial part of the assets of the issuer; or (v) the liquidation or dissolution of the issuer:

A. Outline briefly the material features of the plan. State the reasons therefor and the general effect thereof upon the rights of existing security holders. If the plan is set forth in a written document, file three (3) copies thereof with the commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

B. Furnish the following information as to the issuer and each person which is to be merged into the issuer or into or with which the issuer is to be merged or consolidated or the business or assets that are to be acquired or which is the issuer of securities to be acquired by the issuer in exchange for all or a substantial part of its assets or to be acquired by security holders of the issuer. What is required is information essential to an investor's appraisal of the action proposed to be taken.

(1) Describe briefly the business of the person.

(2) State the location and describe the general character of the plants and other important physical properties of the person. The description is to be given from an economic and business standpoint, as distinguished from a legal standpoint. Portfolio or investment assets of an insurer do not need to be disclosed.

(3) Furnish a brief statement as to dividends in arrears or defaults in principal or interest in respect of any securities of the issuer or of the person, and as to the effect of the plan thereon and other information as may be appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

(4) Furnish a tabulation in columnar form showing the existing and the pro forma capitalization.

(5) Furnish in columnar form for each of the last five (5) fiscal years a historical summary of earnings and show per share amounts of net earnings, dividends declared for each year and book value per share at the end of the latest period.

(6) Furnish in columnar form for each of the last five (5) fiscal years a combined pro forma summary of earnings, as appropriate in the circumstances, indicating the aggregate and pre-share earnings for each year and the pro forma book value per share at the end of the latest period. If the transaction establishes a new basis of accounting for assets of any of the persons included, the pro forma summary of earnings shall be furnished only for the most recent fiscal year and interim period and shall reflect appropriate pro forma adjustments resulting from the new basis of accounting.

(7) To the extent material for the exercise of prudent judgment in regard to the matter to be acted upon, furnish the historical and pro forma earnings data specified in (5) and (6) above for interim periods of the current and prior fiscal years, if available.

Instructions: Subparagraph B of this Item 13 shall not apply if the plan described in answer to Paragraph A involves only the issuer and one or more of its totally-held subsidiaries.

C. As to each class of securities of the issuer, or of any person specified in Paragraph B, which is admitted to dealing on a national securities exchange or with respect to which a market otherwise exists, and that will be materially affected by the plan, state the high and low sale prices (or, in the absence of trading in a particular period, the range of the bid and asked prices) for each quarterly period within two (2) years. This information may be omitted if the plan involves merely the liquidation or dissolution of the issuer.

Item 14. Financial Statements

A. If action is to be taken with respect to any matter specified in Items 11, 12, or 13, furnish financial statements of the issuer and its subsidiaries complying with the requirements of Section 4B(1), (2) and (3) of the regulation including schedules of supplementary profit and loss information. The statements may be omitted with respect to a plan described in answer to Item 13 if the plan involves only the issuer and one or more of its totally-held subsidiaries.

B. If action is to be taken with respect to any matter specified in Item 13B, furnish for each person specified, other than the issuer, financial statements complying with the requirements of Section 4B(1), (2) and (3) of the regulation.

C. The commissioner may, upon the request of the issuer, permit the omission of any of the statements herein required where the statements are not necessary for the exercise of prudent judgment in regard to any matter to be acted upon, or may permit the filing in substitution of appropriate statements of comparable character. The commissioner may also require the filing of other statements in addition to, or in substitution for, the statements required in any case where the statements are necessary or appropriate for an adequate presentation of the financial condition of any person whose financial statements are required, or whose statements are otherwise material for the exercise of prudent judgment in regard to any matter to be acted upon. In the usual case, financial statements are deemed material to the exercise of prudent judgment where the matter to be acted upon is authorization or issuance of a material amount of senior securities, but are not deemed material where the matter to be acted upon is the authorization or issuance of common stock, otherwise than in an exchange, merger or consolidation, acquisition or similar transaction.

D. The proxy statement may incorporate by reference any financial statements contained in an annual report sent to security holders with respect to the same meeting as that to which the proxy statement relates, provided the financial statements substantially meet the requirements of this item.

Item 15. Acquisition or Disposition of Property

If action is to be taken with respect to the acquisition or disposition of any property, furnish the following information:

A. Describe briefly the general character and location of the property.

B. State the nature and amount of consideration to be paid or received by the issuer or any subsidiary. To the extent practicable outline briefly the facts bearing upon the question of the fairness of the consideration.

C. State the name and address of the transferor or transferee, as the case may be, and the nature of any material relationship of the person to the issuer or an affiliate of the issuer.

D. Outline briefly any other material features of the contract or transaction.

Item 16. Restatement of Accounts

If action is to be taken with respect to the restatement of any asset, capital or surplus account of the issuer, furnish the following information:

A. State the nature of the restatement and the date as of which it is to be effective.

B. Outline briefly the reasons for the restatement and for the selection of the particular effective date.

C. State the name and amount of each account (including any reserve accounts) affected by the restatement and the effect of the restatement thereon. Tabular presentation of the amounts shall be made when appropriate, particularly in the case of recapitalizations.

D. To the extent practicable, state whether and the extent, if any, to which the restatement will, as of the date thereof, alter the amount available for distribution to the holders of equity securities.

Item 17. Action with Respect to Reports

If action is to be taken with respect to any report of the issuer or of its directors, officers or committees or any minutes of meetings of its stockholders, furnish the following information:

A. State whether or not the action is to constitute approval or disapproval of any of the matters referred to in the reports or minutes.

B. Identify each of the matters which it is intended will be approved or disapproved and furnish the information required by the appropriate item or items of this schedule with respect to each matter.

Item 18. Matters Not Required to be Submitted

If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state the nature of the matter, the reasons for submitting it to a vote of security holders and what action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

Item 19. Amendment of Charter, Bylaws or Other Documents

If action is to be taken with respect to any amendment of the issuer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of the amendment.

Drafting Note: Where the matter to be acted upon is the classification of directors, state whether vacancies which occur during the year may be filled by the board of directors to serve only until the next annual meeting or may be so filled for the remainder of the full term.

Item 20. Other Proposed Action

If action is to be taken with respect to any matter not specifically referred to above describe briefly the substance of each matter in substantially the same degree of detail as is required by Items 5 to 19.

Item 21. Vote Required for Approval

As to each matter that is to be submitted to a vote of security holders, other than elections to office or the selection or approval of auditors, state the vote required for its approval.

SCHEDULE B

INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE ISSUER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST

Item 1. Issuer

State the name and address of the Issuer.

Item 2. Identity and Background

A. State the following:

(1) Your name and business address,

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which the employment is carried on.

B. State the following:

(1) Your residence address,

(2) Information as to all material occupations, positions, offices or employments during the last ten (10) years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each occupation, position, office or employment was carried on.

C. State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten (10) years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

D. State whether or not, during the past ten (10) years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item does not need to be included in the proxy statement or other proxy soliciting material.

Item 3. Interest in Securities of the Issuer

A. State the amount of each class of securities of the issuer that you own beneficially, directly or indirectly.

B. State the amount of each class of securities of the issuer that you own of record but not beneficially.

C. State with respect to all securities of the issuer purchased or sold within the past two (2) years, the dates when they were purchased or sold and the amount purchased or sold on each date.

D. State if any part of the purchase price or market value of any of the securities specified in Subsection C is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding securities. Indicate the amount of the indebtedness as of the latest practicable date. If funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction and state the names of the parties.

E. State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any securities of the issuer including but not limited to joint ventures, loan or option arrangements, puts or calls guarantees against losses or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom some contracts, arrangements or understandings exist and give the details thereof.

F. State the amount of securities of the issuer owned beneficially, directly or indirectly, by each of your associates and the name and address of each associate.

G. State the amount of each class of securities of any parent, subsidiary or affiliate of the issuer that you own beneficially, directly or indirectly.

Item 4. Further Matters

A. Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

B. Describe briefly, and where practicable state the approximate amount of any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

C. State whether or not you or any of your associates have any arrangement or understanding with any person:

(1) With respect to any future employment by the issuer or its subsidiaries or affiliates; or

(2) With respect to any future transactions to which the issuer or any of its subsidiaries or affiliates will or may be a party.

If so, describe the arrangement or understanding and state the names of the parties.

Item 5. Signature

The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete and correct to the best of my knowledge and belief.

_____ _____

(Date) (Signature of participant or authorized representative)

SCHEDULE C

INFORMATION REQUIRED IN INFORMATION STATEMENT

Note: Where any item, other than Item 5, calls for information with respect to any matter to be acted upon at the meeting, the item need be answered only with respect to proposals to be made by the issuer.

Item 1. Information Required by Items of Schedule 14A

Furnish the information called for by all of the items of Schedule A of the Regulation Regarding Proxies, Consents and Authorizations (other than Items 1, 3 and 4) that would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting.

Item 2. Statement That Proxies Are Not Solicited

The following statement shall be set forth on the first page of the information statement in bold face type:

WE ARE NOT ASKING YOU FOR A PROXY AND YOU ARE REQUESTED NOT TO SEND US A PROXY.

Item 3. Date, Time and Place of Meeting

State the date, time and place of the meeting of security holders, unless the information is otherwise disclosed in material furnished to security holders with the information statement.

Item 4. Interest of Certain Persons in or Opposition to Matters to Be Acted Upon

A. Describe briefly any substantial interest, direct or indirect, by security holdings or otherwise, of each of the following persons in any matter to be acted upon, other than elections to office:

(1) Each person who has been a director or officer of the issuer at any time since the beginning of the last fiscal year;

(2) Each nominee for election as a director of the issuer;

(3) Each associate of the foregoing persons.

B. Give the name of any director of the issuer who has informed the management in writing that he intends to oppose any action to be taken by the management at the meeting and indicate the action that he intends to oppose.

Item 5. Proposals by Security Holders

If any security holder entitled to vote at the meeting has submitted to the issuer, not less than 90 days before the issuer's annual meeting, a proposal that is accompanied by notice of the security holder's intention to present the proposal "for action at the meeting, make a statement to that effect, identify the proposal" and indicate the disposition proposed to be made of the proposal by the management at the meeting.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1965 Proc. I 150, 153, 155-170, 191 (adopted).
1969 Proc. I 168-169, 243-247, 257-267 (amended and reprinted).
1980 Proc. II 22, 25, 300, 309-338 (adopted new regulation).

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-042 (1981).		
Alaska	NO CURRENT ACTIVTY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R. 20-6-401 (2003).		
Arkansas	ARK. ADMIN. CODE 054.00.2 (1966).		
California	CAL. CODE REGS. tit. 10, §§ 2680.1 to 2680.13 (1965).		
Colorado	3 COLO. CODE REGS. § 702-3:3-2-1 (1972/2014).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-147-1 to 38a-147-10 (1966/1992).		
Delaware	18 DEL. CODE REGS § 401 (1970/2003).		
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 1500 to 1599 (1966).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-143.026 to 69O-143.037 (1974).		

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. COMP. R. & REGS. 120-2-7 (1965/1970).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:4-231 to 431:4-247 (2000); HAW. CODE R. §§ 16-1-1 to 16-1-15 (1966/1981).		
Idaho			IDAHO CODE ANN. § 41-2868 (1969).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 203.10 to 203.110 (1970/1978).		
Indiana	760 IND. ADMIN. CODE 1-11-3 to 1-11-13 (1966/1970).		
Iowa	IOWA ADMIN. CODE r. 191-7.1 to 191-7.10 (1966/1985).		
Kansas	KAN. ADMIN. REGS. § 40-11-12 (1981/1986) (adopted by reference).		
Kentucky	806 KY. ADMIN. REGS 26:010 (1975).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.7101 to XIII.7125 (Regulation 24) (1965/1999).		
Maine	NO CURRENT ACTIVITY		
Maryland	MD. CODE REGS. 31.04.07.01 to 31.04.07.16 (1969/1970).		
Massachusetts	211 MASS. CODE REGS. 13.01 to 13.12 (1970).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. R. 2715.7100 to 2715.7390 (1983).		

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-11.200 (1965/1974).		
Montana			MONT. ADMIN. R. §§ 6.6.1301 to 6.6.1326 (1975).
Nebraska	210 NEB. ADMIN. CODE ch. 9 (1994).		
Nevada	NEV. ADMIN. CODE §§ 693A.010 to 693A.560 (1972/1996).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE §§ 11:2-5.1 to 11:2-7.10 (1965/1996).		
New Mexico	N.M. ADMIN. CODE 13.3.4 (1978).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 10.1 to 10.11 (Regulation 48) (1965).		
North Carolina	NO CURRENT ACTIVTY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE §§ 3901-2-01 to 3901-2-15 (1987/2014).		
Oklahoma			OKLA. STAT. tit. 36, § 2126.4 (1965/1979).
Oregon	OR. ADMIN. R. §§ 836-024-0003 to 836-24-0220 (1976).		

REGULATION REGARDING PROXIES, CONSENTS AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	31 PA. CODE §§ 23.1 to 23.96 (1971).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-45-4.1 to 20-45-4.12 (2001).		
South Carolina	S.C. CODE ANN. REGS. 69-9 (1966).		
South Dakota	S.D. ADMIN. R. 20:06:03:01 to 20:06:03:40 (1975/1986).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-13-.01 to 0780-1-13-.12 (1974).		
Texas			TEX. ADMIN. CODE § 7.901 (1976/1982).
Utah	UTAH ADMIN. CODE r. 590-67 (1965/1989).		
Vermont			VT. STAT. ANN. tit. 8, § 3313 (1967).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-240-10 to 5-240-100 (1970).		
Washington	WASH. ADMIN. CODE 284-28-010 to 284-28-110 (1965/1969).		
West Virginia	W. VA. CODE R. §§ 114-1-1 to 114-1-4 (1966).		
Wisconsin	WIS. ADMIN. CODE INS. § 6.40 (1965/2002).		
Wyoming	NO CURRENT ACTIVTY		

STOCKHOLDERS INFORMATION SUPPLEMENT
SCHEDULE SIS

Table of Contents

Section 1. General Instructions

The Stockholder Information Supplement shall be completed by all stock companies incorporated in the United States that have 100 or more stockholders. The supplement shall be filed with the insurance commissioner of the company's domiciliary state as a part of its annual statement. The information required to be contained in this supplement is to be furnished to the best of the knowledge of the company. Where appropriate, the company should obtain the required information, in writing, from its directors or officers and from any person known to the company to be the beneficial owner of more than ten percent (10%) of any class of its equity securities.

The term "officer" means a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

Section 2. Financial Reporting to Stockholder

A. Did the company distribute to its stockholders prior to the [insert current year] annual meeting an annual report for the year [insert preceding year]?

Answer _____.

If answer is "Yes" attach copy. If answer is "No" explain in detail below. Attach separate sheet if necessary.

B. Will the company distribute to its stockholders prior to the [insert following year] annual meeting an annual report for the year [insert current year]?

Answer _____.

If answer is "Yes" a copy of the report shall be forwarded to the insurance commissioner of the company's domiciliary state at the same time as it is distributed to stockholders. If answer is "No" explain in detail below. Attach separate sheet if necessary.

C. If an annual report to stockholders was distributed for the year [insert preceding year];

(1) Was the distribution prior to or contemporaneous with the solicitation of proxies in respect of the annual meeting?

Answer _____.

If the answer is "No" explain in detail below. Attach separate sheet if necessary.

(2) Did it contain the following financial statements (indicate answer in Column A) and were the financial statements prepared substantially on the basis (individual or consolidated) as required to be presented in the company's annual statement (indicate answer in Column B)?

	Column A		Column B	
	Yes	No	Yes	No
To be answered by Life and A & H Companies:				
a. Statement of Assets, Liabilities, Surplus and Other Funds.				
b. Summary of Operations.				
c. Surplus Account.				
To be answered by Fire and Casualty Companies:				
a. Statement of Assets, Liabilities, Surplus and Other Funds.				
b. Statement of Income—Operations and Investment Exhibit				
c. Capital and Surplus Account.				
To be answered by Title Insurance Companies:				
a. Statement of Assets, Liabilities, Surplus and Other Funds.				
b. Statement of Income—Operations and Investment Exhibit				
c. Capital and Surplus Account.				

Section 3. Information Regarding Management and Directors

A. Furnish the following information for each director, and for each of the three highest paid officers, whose aggregate direct remuneration exceeded $20,000 during the year, naming each such person.

Name and Title (1)	Principal Occupation or Employment (2)	Served As Director From (3)	Aggregate Direct Remuneration (4)	Benefits Accrued or Set Aside During Current Year		Estimated Annual Benefits Upon Retirement	
				Retirement Plan (5)	Other Emp. Benefits (6)	Retirement Plan (7)	Other Emp. Benefits (8)

Furnish on a separate sheet the following information as to each of the individuals named above or state below that the information is not present:

(1) Information as to any material interest, direct or indirect, on the part of the individual during [insert current year] in any material transaction or any material proposed transaction as to which the company, or any of its subsidiaries, was or is to be a party.

(2) Information as to all options to purchase securities of the company granted to or exercised by each such individual during the current year.

B. Answer "yes" or "no" in each column as to whether or not the information in Item 1 above has been, or will be, furnished to stockholders in any proxy statement relating to (i) the election of directors, (ii) any bonus, profit sharing or other remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the company will participate, (iii) any pension or retirement plan in which any such person will participate, or (iv) the granting or extension to any such person of any options, warrants or rights to purchase any securities, other than warrants or rights issued to security holders, as such, on a pro rata basis. If any answer is "no" explain in detail on separate sheet.

Name and Title (1)	Principal Occupation or Employment (2)	Served As Director From (3)	Aggregate Direct Remuneration (4)	Benefits Accrued or Set Aside During Current Year: Retirement Plan (5)	Benefits Accrued or Set Aside During Current Year: Other Emp. Benefits (6)	Estimated Annual Benefits Upon Retirement: Retirement Plan (7)	Estimated Annual Benefits Upon Retirement: Other Emp. Benefits (8)

C. Furnish the information specified in Item 1 for all directors and officers of the Company, as a group, without naming them.

Name and Title (1)	Principal Occupation or Employment (2)	Served As Director From (3)	Aggregate Direct Remuneration (4)	Benefits Accrued or Set Aside During Current Year: Retirement Plan (5)	Benefits Accrued or Set Aside During Current Year: Other Emp. Benefits (6)	Estimated Annual Benefits Upon Retirement: Retirement Plan (7)	Estimated Annual Benefits Upon Retirement: Other Emp. Benefits (8)
XXXX	XXXX						

D. Did the stockholders have an opportunity to vote for or against the election of directors and also other matters to be presented at any stockholders' meeting?

Answer _____. If answer is "no" explain on separate sheet.

E. Will the company solicit proxies from its stockholders during [insert following year] and will such solicitation(s) precede any shareholders' meeting or meetings by at least 10 days?

Answer _____. If answer is "yes" and proxies are to be solicited, copies of the proxy statement and form of proxy and other soliciting material to be furnished stockholders shall be submitted to the Insurance Commissioner of the company's domiciliary state at least 10 days prior to the date such material is first sent or given to stockholders. If answer is "no" and proxies are not to be solicited from stockholders, explain in detail below. Attach separate sheet if necessary.

Section 4. Instructions for Information Regarding Management and Directors

A. This information applies to any person who was a director or officer of the company at any time during the year. However, information need not be given for any portion of the year during which such person was not a director or officer of the company.

B. Include under "Other Employee Benefits" information for such items as savings plans, deferred compensation plans, thrift plans, profit sharing plans, etc., or other contracts, authorizations or arrangements, whether or not set forth in any formal document. Briefly describe such "plans" and the basis upon which directors or officers participate therein, if not previously described in a prior "Stockholder Information Supplement" indicating date thereof. Company cost of benefits accrued or set aside need not be stated with respect to payments computed on an actuarial basis under any plan which provides for fixed benefits on retirement at a specified age or after a specified number of years of service.

C. Information need not be included as to payments made for, or benefits received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

D. If it is impractical to state the amount of the estimated annual benefits proposed to be made upon retirement, the aggregate amount set aside or accrued to date in respect of such payment should be stated, together with an explanation of the basis for future payments.

E. Attach separate sheets if necessary to fully answer any questions.

Section 5. Instructions for Statement of Beneficial Ownership of Securities

			Number of Shares				
					Disposed of During (insert current year)		
Name and Title of Each Director, Officer or Owner of More than 10%	Title of Security	Nature of Ownership	Owned at 12-31- [insert preceding yr]	Acquired During [insert cur yr]	Held less than 6 mos.	Held 6 mos. or more	Owned at 12-31- [insert cur yr]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Answer "yes" or "no" as to whether the information concerning the number of shares owned at end of year (as shown in Column 8) by each director and the three highest paid officers whose aggregate direct remuneration exceeded $20,000 during the year, has been or will be furnished to stockholders in a proxy statement or otherwise.

Answer _____. If answer is "no" explain in detail on separate sheet.

State the number of stockholders of record of the company at the end of [insert current year].

Answer _____.

Column 1
Indicate relationship of the person to the company, for example: "director," "director and vice-president," "beneficial owner of more than 10% of the company's common stock," etc.

Column 2

The statement of the title of a security should be such as to clearly identify the security, even though there may be only one class, for example: "common stock," "4% convertible preferred stock," etc.

Column 3

Under "Nature of Ownership" state whether ownership of securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate in a footnote or other appropriate manner the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

Columns 4 to 8

In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. There may also be indicated in a footnote or other appropriate manner the extent of the security holder's interest in the partnership, corporation, trust or other entity.

If a transaction in securities of the company was with the company or one of its subsidiaries, so state. If it involved the purchase of securities through the exercise of options, so state. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character; for example, gift, stock dividend, etc., as the case may be. The foregoing information may be indicated in a footnote or other appropriate manner.

Any additional information or explanation deemed relevant by the company should be included as a footnote or in other appropriate manner.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1964 Proc. I 158, 203, 205-209, 210 (adopted).
1964 Proc. II 301, 313, 315, 324-327, 343 (adopted as part of annual statement).
1965 Proc. I 150, 151, 175-178, 191 (reaffirmed and reprinted).

STOCKHOLDERS INFORMATION SUPPLEMENT SCHEDULE SIS

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. AGENCIES REGS. § 38a-147-10 (1966/1992).		
Delaware	18 DEL. CODE REGS. § 401-4.0 (1970/2003).		
District of Columbia	D.C. MUN. REGS. tit. 26-A, § 1599 (1966).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-143.029 (1974).		
Georgia	GA. COMP. R. & REGS. 120-2-7 (1965/1970).		
Guam	NO CURRENT ACTIVITY		

STOCKHOLDERS INFORMATION SUPPLEMENT SCHEDULE SIS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	HAW. CODE R. § 16-1-15 (1981).		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, § 203.50 (1970/1978).		
Indiana	760 IND. ADMIN. CODE § 1-11-5 (1966); § 1-11-12 (1966/2013).		
Iowa	IOWA ADMIN. CODE r. § 191-7.4 (1966/1985).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	806 KY. ADMIN. REGS. 26:010 (1975/1994).		
Louisiana	LA. ADMIN. CODE tit. 37, § XIII.7109 (1965); § XIII.7123 (1965/1999).		
Maine	NO CURRENT ACTIVITY		
Maryland	MD. CODE REGS. 31.04.07.05 (1968/1970).		
Massachusetts	211 MASS. CODE REGS. 13.04 (1969); 13.11(1969).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-11.200(4) (1965); App. A (1965/1974).		
Montana	MONT. ADMIN. R. § 6.6.1311 (1975).		

STOCKHOLDERS INFORMATION SUPPLEMENT SCHEDULE SIS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NEB. ADMIN. R. & REGS. tit. 210, Ch. 9, § 005 (1994).		
Nevada	NEV. ADMIN. CODE § 693A.120 (1972); § 693A.380 (1972).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE § 11:2-5.4 (1965).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, § 10.4. (1965).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. STAT. tit. 36, § 2126.4 D&E, Item 7 (1965/1979).		
Oregon	OR. ADMIN. R. § 836-024-0006 (1976); § 836-24-026(2) (1976).		
Pennsylvania	31 PA. CODE § 23.1 (1969); § 23.77 (1971).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-45-4.11 (2001); 20-45-4.4 to 20-45-4.5 (2001).		
South Carolina	S.C. CODE REGS. 69-9 (1966).		

STOCKHOLDERS INFORMATION SUPPLEMENT SCHEDULE SIS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	S.D. ADMIN. R. 20:06:03:28 (1975/1986).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-13-.04 (1974); 0780-1-13-.11 (1974).		
Texas	TEX. ADMIN. CODE 7.901 (1976/1982).		
Utah	UTAH ADMIN. CODE R. 590-67-5 (1965/1989).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-240-40 to 5-240-50 (1970); Schedule A, Item 7 (1970).		
Washington	WASH. ADMIN. CODE 284-28-040 (1969); 284-28-100 (1961); Schedule A, Item 7 (1961/1969).		
West Virginia	W. VA. CODE R. §§ 114-1-2 to 114-1-3 (1966).		
Wisconsin	WIS. ADMIN. CODE INS. § 6.40(4) (1965); § 7.01 (1965/1999).		
Wyoming	NO CURRENT ACTIVITY		

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

Table of Contents

Section 1. Purpose and Scope.

The purpose of this Act is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance commissioner of this state.

The requirements of this Act shall apply to all insurers domiciled in this state unless exempt pursuant to Section 6.

The Legislature finds and declares that the ORSA Summary Report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of this Legislature that the ORSA Summary Report shall be a confidential document filed with the commissioner, that the ORSA Summary Report will be shared only as stated herein and to assist the commissioner in the performance of his or her duties, and that in no event shall the ORSA Summary Report be subject to public disclosure.

Section 2. Definitions.

A. "Insurance group." For the purpose of conducting an ORSA, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in [insert state law equivalent of the model Insurance Holding Company System Regulatory Act].

B. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

C. "Own Risk and Solvency Assessment" or "ORSA." An "Own Risk and Solvency Assessment" or "ORSA" shall mean a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

D. "ORSA Guidance Manual." The term "ORSA Guidance Manual" shall mean the current version of the *Own Risk and Solvency Assessment Guidance Manual* developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

E. "ORSA Summary Report." An "ORSA Summary Report" shall mean a confidential high-level summary of an insurer or insurance group's ORSA.

Section 3. Risk Management Framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Section 4. ORSA Requirement.

Subject to Section 6, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Section 5. ORSA Summary Report.

A. Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

Drafting Note: In order to ensure that the commissioner is receiving the most current information from an insurer, Section 5.A. recognizes that the time for filing the ORSA Summary Report during the calendar year may vary from insurer to insurer depending on when an insurer or insurance group conducts its internal strategic planning process. In any event, the report shall be filed once each year, with the insurer apprising the commissioner as to the anticipated time of filing.

B. The report(s) shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his/her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer may comply with subsection A by providing the most recent and substantially similar report(s) provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

Section 6. Exemption.

A. An insurer shall be exempt from the requirements of this Act, if

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and,

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

B. If an insurer qualifies for exemption pursuant to paragraph (1) of subsection A, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (2) of subsection A, then the ORSA Summary Report that may be required pursuant to Section 5 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

C. If an insurer does not qualify for exemption pursuant to paragraph (1) of subsection A, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (2) of subsection A, then the only ORSA Summary Report that may be required pursuant Section 5 shall be the report applicable to that insurer.

D. An insurer that does not qualify for exemption pursuant to subsection A may apply to the commissioner for a waiver from the requirements of this Act based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

E. Notwithstanding the exemptions stated in this section,

(1) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if the insurer has Risk-Based Capital for company action level event as set forth in [insert cross-reference to appropriate section of Risk-Based Capital (RBC) Model Act], meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [insert cross-reference to appropriate section of Model Regulation to define standards and commissioner's authority over companies deemed to be in hazardous financial condition], or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

F. If an insurer that qualifies for an exemption pursuant to subsection A subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this Act.

Section 7. Contents of ORSA Summary Report.

A. The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection B of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

B. The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers and insurance groups.

Section 8. Confidentiality.

A. Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Department of Insurance that are obtained by, created by or disclosed to the commissioner or any other person under this Act, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

B. Neither the commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A.

C. In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(1) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection A, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], with the NAIC and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this Act, consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this Act remains with the commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner;

(iii) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(v) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Act; and

(vi) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

D. The sharing of information and documents by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this Act.

F. Documents, materials or other information in the possession or control of the NAIC or third-party consultants pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Section 9. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Section 10. Severability Clause.

If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act are severable.

Section 11. Effective Date.

The requirements of this Act shall become effective on January 1, 2015. The first filing of the ORSA Summary Report shall be in 2015 pursuant to section 5 of this Act.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2012 Proc. 3rd Quarter, Vol. I 95, 99, 112, 123 (adopted).

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-29A-1 to 27-29A-10 (2016).		
Alaska	ALASKA STAT. §§ 21.23.010 to 21.23.090 (2015).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-491 to 20-490.07 (2016).		
Arkansas	ARK. CODE ANN. §§ 23-69-401 to 23-69-410 (2015).		
California	CAL. INS. CODE §§ 935.1 to 935.11 (2013).		
Colorado	COLO. REV. STAT. §§ 10-3-1501 to 10-3-1511 (2016).		
Connecticut	CONN. GEN. STAT. § 38a-142 (2015).		BULLETIN FS-29-2014 (2014).
DELAWARE	DEL. CODE ANN. tit. 18, §§ 8401 to 8412 (2014).		
District of Columbia	D.C. CODE §§ 31-4121.01 to 31-4121.09 (2019).		
Florida	FLA. STAT. § 624.4212 (2016); § 628.8015 (2018).		

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. §§ 33-13-30 to 33-13-41 (2015/2019).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3D-101 to 431:3D-110 (2016).		
Idaho	IDAHO CODE ANN. §§ 41-6301 to 41-6308 (2017).		
Illinois	215 ILL. COMP. STAT. 5/129.1 to 5/129.9 (2014).		
Indiana	IND. CODE §§ 27-1-23.5-1 to 27-1-23.5-14 (2014/2018).		
Iowa	IOWA CODE §§ 522.1 to 522.10 (2013/2015).		
Kansas	KAN. STAT. ANN. §§ 40-6001 to 40-6011 (2015).		
Kentucky	KY. REV. STAT. ANN. §§ 304.3-600 to 304.3-635 (2014); § 304.99-055 (2014).		
Louisiana	LA. REV. STAT. ANN. §§ 22:691.31 to 22:691.39 (2015).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 222 (1969/2017) (portions of model).		
Maryland	MD. CODE ANN. INS. §§ 32-101 to 32-110 (2017).		
Massachusetts	MASS. GEN. LAWS ch. 176V, § 1 to 9 (2017).		
Michigan	MICH. COMP. LAWS §§ 500.1701 to 500.1715 (2015).		
Minnesota	MINN. STAT. §§ 60D.50 to 60D.58 (2014).		
Mississippi	MISS. CODE ANN. §§ 83-85-1 to 83-85-21 (2017).		

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. REV. STAT. §§ 382.500 to 382.550 (2015).		
Montana	MONT. CODE ANN. §§ 33-2-1130 to 33-2-1138 (2015).		
Nebraska	NEB. REV. STAT. §§ 44-9001 to 44-9011 (2014/2016).		
Nevada	NEV. REV. STAT. §§ 692C.351 to 692C.3548 (2015).		
New Hampshire	N.H. REV. STAT. ANN. §§ 401-C:1 to 401-C:10 (2013/2017).		
New Jersey	N.J. STAT. ANN. §§ 17:23-27 to 17:23-37 (2014).		
New Mexico	N.M. ADMIN. CODE 13.2.11 (2021).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 82.1 to 82.5 (2014) (portions of model).		
North Carolina	N.C. GEN. STAT. §§ 58-10-700 to 58-10-745 (2017).		
North Dakota	N.D. CENT. CODE §§ 26.1-10.2-01 to 26.1-10.2-08 (2015).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3901.371 to 3901.378 (2014).		
Oklahoma	OKLA. STAT. tit. 36, §§ 3301 to 3309 (2015).		
Oregon	OR. REV. STAT. §§ 732.650 to 732.672 (2015/2017).		
Pennsylvania	40 PA. CONS. STAT. §§ 991.2601 to 991.2610 (2013).		

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	26 P.R. LAWS §§ 4531 to 4539 (2020).		
Rhode Island	R.I. GEN. LAWS §§ 27-77-1 to 27-77-10 (2013).		
South Carolina	S.C. CODE ANN. §§ 38-13-810 to 38-13-900 (2017).		
South Dakota	S.D. CODIFIED LAWS § 58-5a-1 (2017); §§ 58-5A-81 to 58-5a-93 (2017).		
Tennessee	TENN. CODE ANN. §§ 56-11-201 to 56-11-210 (2014).		
Texas	TEXAS CODE ANN. §§ 830.001 to 830.012 (2015).		
Utah	UTAH CODE ANN. §§ 31A-16a-101 to 31A-16a-110 (2017).		
Vermont	VT. STAT. ANN. tit. 8, §§ 3581 to 3589 (2013).		
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 485 to 496 (2019).		
Virginia	VA. CODE ANN. §§ 38.2-1334.3 to 38.2-1334.10 (2014).		
Washington	WASH. REV. CODE §§ 48.05A.005 to 48.05A.901 (2015).		
West Virginia	W.VA. CODE §§ 33-40B-1 to 33-40B-11 (2017).		
Wisconsin	WIS. STAT. §§ 622.03 to 622.17 (2014).		
Wyoming	WYO. STAT. ANN. §§ 26-51-101 to 26-51-110 (2014).		

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the [State] Life and Health Insurance Guaranty Association Act.

Section 2. Purpose

A. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3A against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in Section 3B, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

B. To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited by this Act, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Act.

Drafting Note: The primary purpose of this model act is to protect policy or contract owners, insureds, beneficiaries, health care providers, annuitants, payees and assignees against losses (both in terms of paying claims and continuing coverage) which might otherwise occur due to an impairment or insolvency of an insurer. Unlike the property and liability lines of business, life and annuity contracts in particular are long-term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus it is essential that coverage be continued. It is also essential that the guaranty association assesses insurers in a fair and reasonable manner and that the guaranty association has sufficient assessment capacity for all insolvencies.

Section 3. Coverage and Limitations

A. This Act shall provide coverage for the policies and contracts specified in Subsection B:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under Paragraph (2);

(2) To persons who are owners of or certificate holders or enrollees under the policies or contracts (other than unallocated annuity contracts, and structured settlement annuities) and in each case who:

(a) Are residents; or

(b) Are not residents, but only under all of the following conditions:

(i) The member insurer that issued the policies or contracts is domiciled in this State;

(ii) The States in which the persons reside have associations similar to the association created by this Act;

(iii) The persons are not eligible for coverage by an association in any other State due to the fact that the insurer or the health maintenance organization was not licensed in the State at the time specified in the State's guaranty association law.

(3) For unallocated annuity contracts specified in Subsection B; Paragraphs (1) and (2) of this subsection shall not apply, and this Act shall (except as provided in Paragraphs (5) and (6) of this subsection) provide coverage to:

(a) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State; and

(b) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

Drafting Note: It is believed that coverage of unallocated annuities is a policy decision that should be made by each individual State. Attached as an Appendix are alternative Sections 3, 5 and 6, which specifically exclude all unallocated annuities from coverage.

(4) For structured settlement annuities specified in Subsection B; Paragraphs (1) and (2) of this subsection shall not apply, and this Act shall (except as provided in Paragraphs (5) and (6) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following conditions:

(i) (I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident; but

a. The insurer that issued the structured settlement annuity is domiciled in this State; and

b. The State in which the contract owner resides has an association similar to the association created by this Act; and

(ii) Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the State in which the payee or contract owner resides.

(5) This Act shall not provide coverage to:

(a) A person who is a payee (or beneficiary) of a contract owner resident of this State, if the payee (or beneficiary) is afforded any coverage by the association of another State; or

(b) A person covered under Paragraph (3) of this subsection, if any coverage is provided by the association of another State to the person; or

(c) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(6) This Act is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Act is provided coverage under the laws of any other State, the person shall not be provided coverage under this Act. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one State, whether as an owner, payee, enrollee, beneficiary or assignee, this Act shall be construed in conjunction with other State laws to result in coverage by only one association.

Drafting Note: The exclusion from coverage in Section 3A(5)(c) of any person who has purchased from an original structured settlement annuity payee his or her rights to receive structured settlement annuity benefits and the exclusion of such benefits from covered benefits under Section 3B(2)(n) recognize that the protections afforded by guaranty associations are intended for insurance consumers, such as the original payees of structured settlement annuities. Guaranty association protection does not extend to sophisticated investors who acquire rights to receive structured settlement annuity benefits in the secondary market. These exclusions, however, do not apply to structured settlement annuity benefits that are transferred to children, present or former spouses or other dependents as part of domestic relations settlements or orders, or to other transferees (including donees) who acquire rights to receive structured settlement annuity benefits without providing any monetary consideration. Thus, Section 3A(5)(c) and Section 3B(2)(n) clarify that guaranty association coverage protects structured settlement annuity benefits to which the original payee and his or her family members retain the rights.

B. (1) This Act shall provide coverage to the persons specified in Subsection A for policies or contracts of direct, non-group life insurance, health insurance (which for the purposes of this Act includes health maintenance organization subscriber contracts and certificates), or annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in Paragraph (3) of this subsection, this Act shall not provide coverage for:

(a) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(c) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value;

(i) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier; and

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(d) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under;

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(e) A portion of a policy or contract to the extent that it provides for

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(f) A policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this State;

(g) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(h) A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(i) A portion of a policy or contract to the extent that the assessments required by Section 9 with respect to the policy or contract are preempted by federal or State law;

(j) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(iii) Misrepresentations of or regarding policy or contract benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(k) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(l) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under Section 3B(2)(l), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(m) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C& D), or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto; or

(n) Structured settlement annuity benefits to which a payee (or beneficiary) has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(3) The exclusion from coverage referenced in Paragraph (2)(c) of this subsection shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

Drafting Note: Some life insurance policies and annuity contracts covered by this Act provide for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract. Sections 3B(2)(c) and 3B(2)(l) clarify the treatment of such policies or contracts in order to limit increases in interest in a manner that parallels the treatment provided other policies and contracts under this Act. Section 3B(2)(c) explicitly states that the application of the limit on "rate of interest" includes returns and changes in value determined by equity index or other reference. Section 3B(2)(l) excludes from coverage any interest or change in value that, as of the date the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier, has not been credited to the policy or contract. It excludes from coverage any interest or change in value as to which the right of the policy or contract owner is subject to forfeiture on the date the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier. However, for policies or contracts that credit interest or changes in value less than annually, Section 3B(2)(1) clarifies that crediting will be done according to the procedures set forth in the policy or contract except that the date of impairment or insolvency under this Act, whichever is earlier, will be deemed the final date for crediting interest of changes in value. Section 3B(3) is added to clarify that the interest limitation in Section 3B(2)(c) does not apply to long-term care or any other health insurance benefits.

C. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) (a) With respect to one life, regardless of the number of policies or contracts:

(i) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) For health insurance benefits:

(I) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance as defined in [section of State law dealing with health insurance/disability income insurance/long-term care insurance] including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability income insurance as defined in [section of State law dealing with health insurance/ disability income insurance], and $300,000 for long-term care insurance as defined in [section of State law dealing with health insurance/ long-term care insurance];

(III) $500,000 for health benefit plans;

(iii) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(b) With respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(c) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(d) However, in no event shall the Association be obligated to cover more than (i) an aggregate of $300,000 in benefits with respect to any one life under Paragraphs 2(a), 2(b) and 2(c) of this subsection except with respect to benefits for health benefit plans under Paragraph 2(a)(ii) of this subsection, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual, or (ii) with respect to one owner of multiple non-group policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(e) With respect to either (i) one contract owner provided coverage under Subsection A(3)(b) of this section; or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Paragraph (2)(b) of this subsection, $5,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this Act and are owned by a trust or other entity for the benefit of two (2) or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this State and in no event shall the Association be obligated to cover more than $5,000,000 in benefits with respect to all these unallocated contracts.

(f) The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this Act may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

(g) For purposes of this Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

D. In performing its obligations to provide coverage under Section 8 of this Act, the Association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, or reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Drafting Note: This section and Section 8 are key sections of the Act. Section 3 identifies who and what are covered and not covered by the Act. Section 8 specifies the responsibilities of the Association toward covered persons with covered policies.

Protection of this Act is primarily extended to resident persons but certain nonresidents under specific circumstances will be protected by this Act if the insolvent insurer was domiciled in this State.

This model does not apply to reinsurance unless assumption certificates were issued to the direct insureds or enrollees. Furthermore, it applies only to direct individual or group certificate insurance issued or written by member insurers licensed to transact business in this State at any time.

Persons to whom coverage is typically provided are resident enrollees, policy or contract owners, or their beneficiaries, assignees or payees. For group contracts or policies, coverage is provided to resident enrollees, and certificate holders and not to the owners of the group contracts or policies; this avoids the possibility of double coverage and indirect coverage of nonresident enrollees, and certificate holders through resident group policy or contract owners. However, for unallocated annuities, coverage is provided under Subsection A(3) to plan sponsors whose principal place of business is in this State, rather than to contract owners. No coverage is provided to individuals who have or might have an interest in the plan or unallocated annuity contract because there is no contractual guaranty by the insurer to individuals under those contracts. Subsection A(4) provides coverage for structured settlement annuities to resident payees rather than to the contract owners.

Subsection A(3) providing unallocated annuity contract coverage to plan sponsors whose principal place of business is in the State and Subsection A(4) providing structured settlement annuity coverage to resident payees are significant changes from previous versions of this Model Act intended to place the coverage in the State of the resident persons to be protected rather than in the State where the nominal owner of the contract resides. Subsections A(5) and (6) avoid the possibility of double coverage due to differing approaches for determining the covered persons in different State statutes and provide mechanisms for resolving which State's statutes will be used to determine the existence and limits of coverage.

Policies and contracts covered by the model act are life insurance, health insurance and annuity policies and contracts, and policies or contracts supplemental thereto. The use of the term health insurance is intended to include "accident and health" insurance, "sickness and accident" insurance, "disability income" insurance, health maintenance organization contracts, etc. The use of the term disability income insurance is intended to include insurance policies and contracts that cover the loss of income due to a disability. The individual State may want to adjust this language to fit its particular terminology.

Subsection B(2) identifies certain types of contracts or policies or portions of contracts or policies that are specifically not covered by this Act. If a portion of a contract or policy is not covered, the remainder of the contract or policy is covered unless excluded otherwise. Subsection B(2) also provides a ready means by which an individual State can exempt from the Act those policies and contracts issued by member insurers or similar organizations deemed appropriate for exemption by the State.

Subsection B(2)(h) excludes coverage for any unallocated annuity contract not used to fund a benefit plan for natural persons or governmental lottery. Subsection B(2)(k) is intended to exclude from coverage those products commonly referred to as "financial guaranty" products.

Subsection C provides the maximum limitations of the Association's liability by type of contract or policy or line of business and overall per one life, plan sponsor or owner. The limits may be reached through cash surrender payments, benefit payments, or continuing coverage or a combination thereof. The maximum limits for each type of coverage should be set at an appropriate level after review by each State.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2.

Section 5. Definitions

As used in this Act:

A. "Account" means either of the two accounts created under Section 6.

B. "Association" means the [State] Life and Health Insurance Guaranty Association created under Section 6.

C. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board of Directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

D. "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

E. "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

F. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Insert the title of the chief insurance regulatory official whenever the term "commissioner" appears.

G. "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3.

H. "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 3.

I. "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

J. "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(1) Accident only insurance:

(2) Credit insurance;

(3) Dental only insurance;

(4) Vision only insurance;

(5) Medicare Supplement insurance;

(6) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(7) Disability income insurance;

(8) Coverage for on-site medical clinics; or

(9) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

K. "Impaired insurer" means a member insurer which, after the effective date of this Act, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

L. "Insolvent insurer" means a member insurer which after the effective date of this Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

M. "Member insurer" means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) A hospital or medical service organization, whether profit or non-profit;

(2) A fraternal benefit society;

(3) A mandatory State pooling plan;

(4) A mutual assessment company or other person that operates on an assessment basis;

(5) An insurance exchange;

(6) An organization that has a certificate or license limited to the issuance of charitable gift annuities under [insert the appropriate section of the State code]; or

(7) An entity similar to any of the above.

Drafting Note: States that license Health Care Service Corporations or similar organizations that undertake to provide basic health care services may want to address these entities in this Act.

N. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

O. "Owner" of a policy or contract and "policyholder," "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder and policy owner do not include persons with a mere beneficial interest in a policy or contract.

P. "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

Q. "Plan sponsor" means:

(1) The employer in the case of a benefit plan established or maintained by a single employer;

(2) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

R. "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 3B except that assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one policy or contract owner. "Premiums" shall not include:

(1) Premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, or

(2) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

S. (1) "Principal place of business" of a plan sponsor or a person other than a natural person means the single State in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

(a) The State in which the primary executive and administrative headquarters of the entity is located;

(b) The State in which the principal office of the chief executive officer of the entity is located;

(c) The State in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(d) The State in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(e) The State from which the management of the overall operations of the entity is directed; and

(f) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the State in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single State, that State shall be deemed to be the principal place of business of the plan sponsor.

(2) The principal place of business of a plan sponsor of a benefit plan described in Subsection Q(3) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

T. "Receivership court" means the court in the insolvent or impaired insurer's State having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

U. "Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one State, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the Association created by this Act, shall be deemed residents of the State of domicile of the member insurer that issued the policies or contracts.

V. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

W "State" means a State, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

X. "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

Y. "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Drafting Note: Each State will wish to examine its own statutes to determine whether these definitions are applicable and to determine whether some should be deleted and others added.

Section 6. Creation of the Association

A. There is created a nonprofit legal entity to be known as the [State] Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or a health maintenance organization business in this State. The Association shall perform its functions under the plan of operation established and approved under Section 10 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the Association shall maintain two (2) accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(a) Life insurance account;

(b) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(c) Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(2) The health account.

B. The Association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

Section 7. Board of Directors

A. The board of directors of the Association shall consist of not less than seven (7) nor more than eleven (11) member insurers serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. In addition, two (2) persons who must be public representatives shall be appointed by the commissioner to the board of directors. A "public representative" may not be an officer, director or employee of an insurance company or a health maintenance organization or any person engaged in the business of insurance.

Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, for member insurers subject to the approval of the commissioner, and by the commissioner for public representatives. To select the initial board of directors, and initially organize the Association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial insurer members in addition to the public representatives.

B. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the Association for their services.

Drafting Note: Subsection A provides that the number and term of the members of the board of directors shall be determined in the plan of operation. To avoid problems in initially selecting the board, this section includes a provision for a start-up meeting which will be called by the commissioner. To determine voting rights at the organizational meeting each member would have one vote. Thereafter the plan of operation will establish the voting procedures, by-laws, etc. governing the conduct of the Association. States that are amending an existing statute should provide for a continuation of the board.

States may consider including language in Subsection B to effectuate the fair representation of guaranty association members.

Section 8. Powers and Duties of the Association

A. If a member insurer is an impaired insurer, the Association may, in its discretion, and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) Provide such monies, pledges, loans, notes, guarantees or other means as are proper to effectuate Paragraph (1) and assure payment of the contractual obligations of the impaired insurer pending action under Paragraph (1).

B. If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

(1) (a) (i) Guaranty, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

(ii) Assure payment of the contractual obligations of the insolvent insurer; and

(b) Provide monies, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the Association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(a) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the Association becomes obligated with respect to the policies and contracts;

(ii) With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date (if any) under the policies or contracts or one year, but in no event less than thirty (30) days, from the date on which the Association becomes obligated with respect to the policies or contracts;

(b) Make diligent efforts to provide all known insureds, enrollees or annuitants (for non-group policies and contracts), or group policy or contract owners with respect to group policies and contracts, thirty (30) days notice of the termination (pursuant to Subparagraph (a) of this paragraph) of the benefits provided;

(c) With respect to non-group policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of Subparagraph (d), if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class:

(d) (i) In providing the substitute coverage required under Subparagraph (c), the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates[, subject to the prior approval of the commissioner];

(ii) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;

(iii) The Association may reinsure any alternative or reissued policy or contract.

(e) (i) Alternative policies or contracts adopted by the Association shall be subject to the approval of the commissioner. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(iii) Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the Association.

(f) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk[, subject to prior approval of the commissioner];

(g) The Association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association;

(h) When proceeding under this Subsection B(2) with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with Section 3B(2)(c).

C. Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy, contract, or coverage under this Act with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by this Act shall not apply where any guaranty protection is provided to residents of this State by the laws of the domiciliary State or jurisdiction of the impaired or insolvent insurer other than this State.

F. In carrying out its duties under Subsection B, the Association may:

(1) Subject to approval by a court in this State, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the Association finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the Association's duties under this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(2) Subject to approval by a court in this State, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this State, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this State or in a reciprocal State, pursuant to [insert citation to this State's law dealing with the handling of special deposits] shall be promptly paid to the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this State related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets pursuant to applicable State receivership law dealing with early access disbursements.

H. If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in Subsection B of this section, the commissioner shall have the powers and duties of the Association under this Act with respect to the insolvent insurer.

I. The Association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The Association shall have standing to appear or intervene before a court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this Act or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another State with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise.

K. (1) A person receiving benefits under this Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition

precedent to the receipt of any right or benefits conferred by this Act upon the person.

(2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

(3) In addition to Paragraphs (1) and (2) above, the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts (including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this Act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore), excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130).

(4) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts (or portion thereof) covered by the Association.

(5) If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the Association.

L. In addition to the rights and powers elsewhere in this Act, the Association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this Act; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Act;

(5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the Association issue policies or contracts other than those issued to perform its obligations under this Act;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the State;

(8) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this Act with respect to the person, and the person shall promptly comply with the request;

(9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this Act; and

(10) Take other necessary or appropriate action to discharge its duties and obligations under this Act or to exercise its powers under this Act.

M. The Association may join an organization of one or more other State associations of similar purposes, to further the purposes and administer the powers and duties of the Association.

N. (1) (a) At any time within one hundred eighty (180) days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(b) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings (i) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and (ii) notices of any defaults under the reinsurance contacts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(c) The following Subparagraphs (i) through (iv) shall apply to reinsurance contracts so assumed by the Association:

(i) The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts, or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator;

(ii) The Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary under the policy, contracts, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(I) The amount received by the Association; and

(II) The excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contracts, or annuity less the retention of the insurer applicable to the loss or event.

(iii) Within thirty (30) days following the Association's election (the "election date"), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to Subparagraph (c)(ii) of this Paragraph (1), the receiver shall remit the same to the Association as promptly as practicable.

(iv) If the Association or receiver, on the Association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

(2) During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation),

(a) (i) Neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under Subsection (1), whether for periods prior to or after the date of the order of liquidation; and

(ii) The reinsurer, the receiver and the Association shall, to the extent practicable, provide each other data and records reasonably requested;

(b) Provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by Subsection (1).

(3) If the Association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (1), the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(4) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under Subsection (1), subject to the following:

(a) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(b) The obligations described in Subsection (1) of this Section shall no longer apply with respect to matters arising after the effective date of the transfer; and

(c) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

(5) The provisions of this Section N shall supersede the provisions of any State law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(6) Except as otherwise provided in this section, nothing in this Section N shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the Association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

O. The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this Act in an economical and efficient manner.

P. Where the Association has arranged or offered to provide the benefits of this Act to a covered person under a plan or arrangement that fulfills the Association's obligations under this Act, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the Association arising under the Act shall be in [insert name of county] County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this Act.

Drafting Note: Along with Section 3, this section is a key to the specific responsibilities of the Association toward covered persons. That responsibility varies by type of policy or contract involved.

The Association is primarily intended to act after the entry of an order of liquidation with the finding of insolvency against a member insurer. However, the Association may act (Section 8A) in the case of an impaired insurer to guarantee, assume, reissue, or reinsure any or all policies or contracts or otherwise provide money to the member insurer.

Subsection B details the main role of the Association in the instance of an order of liquidation against an insolvent insurer. The responsibilities of the Association vary depending on the kind of coverage and type of policy or contract—group or individual. The Association may offer alternative policies or contracts or change the premiums or benefits of existing policies or contracts. "New contracts or policies" shall be offered without new underwriting and with coverage for existing conditions. This subsection also details that any rate changes, including rates for new or replacement contracts or policies, must be actuarially justified and, if specified by the State, the commissioner must approve the rates prior to the rates becoming effective. In order to facilitate the sale of blocks of business for which the Association is responsible, the cooperation of the domestic receiver may be necessary.

Subsection F relates to the imposition of policy and contract liens, moratoriums, etc. These are devices which have been used in the past in connection with continuation of the insolvent insurer's coverage. Since, by definition, the assets of the insolvent insurer were not adequate to support its contractual obligations, liens were used to reduce those obligations to a level where the assets would be adequate. However, in the past there was no means to infuse additional funds where needed to make whole policy or contract owners, insureds, enrollees, and beneficiaries. The purpose of the model act is to provide timely payment and protect against losses due to an insolvency, by providing prompt fulfillment of insurance or health maintenance organization benefits to the extent of the Association's obligations under this Act. To the extent that liens and moratoriums are sanctioned, the model act retreats from this principle.

On the one hand, it can be argued that if liens and moratoriums cannot be used, there will be a run on the assets of the impaired or insolvent company. In the past this seems to have been true. However, unlike the past, the performance of the member insurer's contractual obligations would be guaranteed.

Also, the standard nonforfeiture laws provide that an insurer in its policies shall reserve the right to defer the payment of cash values for a period of six months after demand therefor with surrender of the policy. Similarly, it is common to require an insurer to reserve for a period of six months the right to defer the granting of any policy loan (other than to pay premiums). For those various reasons, the model act does not encourage the use of liens and moratoriums in ordinary situations.

On the other hand, in periods of severe liquidity problems and economic stress, perhaps of even catastrophic proportions, such devices may become essential. While the model act concentrates on the protection of those to whom the impaired or insolvent insurer has a contractual obligation, the impact of assessments on the policyholders, contract owners, certificate holders, or enrollees of assessed companies is also an important consideration (e.g., significant sales of depressed value assets in a tight money market). Consequently Subsection F(1) authorizes the Association to cause to be imposed liens and moratoriums (or other similar means):

1. If the Court finds that the amounts assessable are less than what is needed, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the use of such tools in the public interest; and

2. The Court approves the use of the specific lien, moratorium, etc.

This provides a highly flexible mechanism while at the same time it avoids impairing the contractual obligations of the impaired or insolvent insurer as a routine matter under ordinary economic and financial conditions. The provision also recognizes that while contractual rights of policy owners, contract owners, certificate holders, or enrollees may not constitutionally be impaired, when the impaired or insolvent insurer's obligation under the contract is assumed by another insurer the policy owner, contract owners, certificate holders, or enrollees has two options. The policy owner, contract owners, certificate holders, or enrollees may accept the new contract with such liens or moratoriums as permitted by the court, or accept such pro rata payment as is available from the estate of the insolvent insurer.

Furthermore, to provide added flexibility in a temporary situation (e.g., run on assets), Subsection F(2) provides for temporary moratoriums or liens on payment of cash values and policy loans, but not on the payment of other benefits, with the Court's approval.

Subsection J, to enable the Association to protect its interest and the best interests of the policyholders, contract owners, certificate holders, or enrollees in the handling of an impairment or insolvency, provides that the Association shall have standing to appear in courts with jurisdiction over an insolvent insurer and such standing will extend to any matters concerning the duties of the Association.

Subsection L(9) was added to clarify that the Association has the authority to request rate increases under Section 8 in accordance with the terms of the policies or contracts, unless prohibited by law. States should determine whether it would be consistent with other provisions of State law to make this power of the Association subject to prior approval of the commissioner. States that have adopted long-term care insurance laws and regulations similar to the NAIC's Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation should consider whether this language should be changed to conform to any applicable notice and approval requirements for premium rate schedule increases for long-term care insurance policies.

Subsection M explicitly recognizes that prompt and efficient discharge of the Association's obligations will be greatly facilitated, especially in multistate insolvencies by acting in concert through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) to develop and, where appropriate, carry out coordinated plans.

Subsection N has been revised to conform to the provisions of Section 612 of the Insurer Receivership Model Act. Section 612 represents a compromise among receivers, reinsurers and guaranty associations regarding reinsurance of life and health insurance contracts. The revisions of Section 8N are intended to preserve that compromise in this Act insofar as the Association is concerned.

R. In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under Subsections A or B, the Association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract, and;

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms

Section 9. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.

B. There shall be two (2) classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(3) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology shall provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

Drafting Note: The purpose of Subsection C(3) is to allocate the responsibility for an insolvency of a long-term care member insurer evenly between member insurers in the health industry and member insurers in the life and annuity industries. As it is likely that life and annuity member insurers will be subject to assessments from the health account, and accident and health member insurers will be subject to assessments from the life account, the formula below should be utilized by guaranty associations so that member insurers in the health industry pay 50% of the assessment and member insurers in the life and annuity industries pay 50% of the assessment.

In determining the shares that shall be allocated to the life and annuity account pursuant to Subsection C(3), guaranty associations should use the following formula:

(.50 - Life and annuity member insurers' share of HA) / (Life and annuity member insurers' share of LIAA - Life and annuity member insurers' share of HA)

For the purposes of the formula above and Subsection C(3) only, a "life and annuity member insurer" means a member insurer for which (i) the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to (ii) its assessable health insurance premiums, which shall include its assessable health maintenance organization premiums but shall exclude its assessable premiums written for disability income and long-term care insurance. For purposes of this definition, assessable premiums shall be measured within the state. An "accident and health member insurer" means any member insurer not defined as a "life and annuity member insurer." HA represents the guaranty association Health Account and LIAA represents the guaranty association Life Insurance and Annuity Account.

(4) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired) bears to premiums received on business in this State for those calendar years by all assessed member insurers.

(5) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

E. (1) (a) Subject to the provisions of Subparagraph (b) of this paragraph, the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one calendar year exceed two percent (2%) of that member insurer's average annual premiums received in this State on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(b) If two (2) or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Subparagraph (a) of this paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(c) If the maximum assessment, together with the other assets of the Association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to Subsection C(2), the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in Paragraph (1) above.

F. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses claims.

G. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this Act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.

H. The Association shall issue to each member insurer paying an assessment under this Act, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

I. (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the Association shall notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty (30) days after a final decision has been made, the Association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the Association may refer protests to the commissioner for a final decision, with or without a recommendation from the Association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

J. The Association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

Drafting Note: The Association is authorized to raise funds to fulfill its obligations under this Model Act with respect to an impaired or insolvent insurer by assessing the member insurers on the basis of the premiums they write in the State. This corresponds to the Association's liability which, in most cases, is limited to covered policies of residents. This assessment system provides a base broad enough to meet fairly large demands on the Association. Equally important, since it reflects the market share of each member insurer in the State including health maintenance organizations, it is an equitable method of apportioning the burden of the assessments.

Subsection E provides some limitations on the amounts that can be assessed in a given year. The maximum assessment per year may be varied from State to State depending on the size of the base and the concentration of the business. The two percent (2%) maximum assessment per year should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed member insurers and their policy owners, contract owners, certificate holders, or enrollees. The maximum is applied to the amount of assessments authorized in a given year, and not the amount called; this allows the Association the flexibility to utilize current capacity for future obligations without collecting assessments from the member insurers until required. The Model Act provides additional discretion and flexibility for the Association in fulfilling its responsibilities by authorizing it to borrow funds that later can be paid out of future assessments.

Subsection G provides that a member insurer may consider in its premium rates and dividend scale an amount reasonably necessary to meet its assessment obligations. This makes it clear that the cost can be ultimately passed on to the policy owners, contract owners, certificate holders, or enrollees—i.e., to persons who enjoy the protection provided by the Act. Subsection H provides that the Association shall issue to assessed member insurers certificates of contribution in the amount levied. The certificates may be carried by a member insurer in its annual statement as an asset in such form, amount and period as may be approved by the commissioner. By permitting the member insurers to carry these certificates as an asset, to the extent of their estimated value, the impact on member insurers will be lessened.

States may consider establishing a pre-funding arrangement for both insurance companies and health maintenance organizations that write health benefit plans to meet their assessment obligations to the Association. To pre-fund, member insurers writing health benefit plans would collect a set amount per member or per certificate per month and remit that amount directly to the Association. The pre-funded amounts would be utilized by the member insurers to satisfy Class B assessment obligations for future insolvencies. When the fund reaches a statutory cap, the pre-funding would stop. In the event of a depletion of the fund below the statutory cap, the pre-funding assessment would be reinstated.

Establishing a pre-funding arrangement allows for the use of interest and investment income to lessen the impact of insolvencies on State taxpayers. Pre-funding also spreads the assessment obligations amongst policyholders prior to an insolvency and does not require the member health insurers or health maintenance organizations to look to the State taxpayers for recoupment. In addition, member insurers in the health industry that do not pay income or premium taxes would be offered a recoupment methodology that is the same as other member insurers in their markets. If a pre-funding arrangement is established, the funds should be legally insulated to avoid diversion for any other purposes, and ensure that they are held exclusively for the Association's obligations.

Section 10. Plan of Operation

A. (1) The Association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless it has not been disapproved within thirty (30) days.

(2) If the Association fails to submit a suitable plan of operation within 120 days following the effective date of this Act or if at any time thereafter the Association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the Association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

(1) Establish procedures for handling the assets of the Association;

(2) Establish the amount and method of reimbursing members of the board of directors under Section 7;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments under Section 9;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association;

(8) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer;

(9) Require the Board of Directors to establish a policy and procedures for addressing conflicts of interests.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 8L(3) and Section 9, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two (2) or more States. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 11. Duties and Powers of the Commissioner

In addition to the duties and powers enumerated elsewhere in this Act,

A. The commissioner shall:

(1) Upon request of the board of directors, provide the Association with a statement of the premiums in this and any other appropriate States for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this Act.

B. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

C. A final action of the board of directors or the Association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this State that apply to the actions or orders of the commissioner.

D. The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this Act.

Drafting Note: Subsection A(2) requires that the commissioner give notice of an impairment to the impaired insurer, and hence to its stockholders, and serve a demand that the impairment be made good. If the company and stockholders fail to raise the necessary funds, this will be a factor bearing upon the stockholder's ownership rights under Section 14E.

State Proceedings for the liquidation, rehabilitation or conservation of member insurers present several difficulties that both acts seek to solve. Briefly, the difficulties have two sources. First, in some States the liquidator, rehabilitator or ancillary receiver may be a person unfamiliar with insurance or health benefit plan regulation. Inefficient administration of the proceedings may result.

Second, the laws of more than one State may be applied to the proceedings, particularly regarding ownership of assets and preferences for payment. The result is confusion and inequity in the collection and distribution of the assets. The Insurers Rehabilitation and Liquidation Model Act and the Uniform Insurers Liquidation Act meet the first source of problems by designating the insurance commissioner as the receiver of a domestic insurer or the ancillary receiver of a foreign insurer. To solve the problem of multiple laws and marshaling of assets, both acts give the receiver title to the assets. The ancillary receiver is then required to forward all assets to the receiver. Both acts also detail the laws under which preferences in the distribution of assets will be determined.

In drafting this model guaranty act, particular effort was made to avoid (to the extent possible) disrupting existing State liquidation and rehabilitation laws. However, each individual State may want to consider adopting the Insurers Rehabilitation and Liquidation Model Act or the Uniform Insurers Liquidation Act, if it has not already done so.

Section 12. Prevention of Insolvencies

To aid in the detection and prevention of member insurer insolvencies or impairments,

A. It shall be the duty of the commissioner:

(1) To notify the commissioners of all the other States, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(a) Revocation of license;

(b) Suspension of license; or

(c) Makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors.

(2) To report to the board of directors when the commissioner has taken any of the actions set forth in Paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another State. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

B. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this State.

C. The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this State. The reports and recommendations shall not be considered public documents.

D. The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

[**Section 13. Credits for Assessments Paid (Tax Offsets)—OPTIONAL**

A. A member insurer may offset against its [premium, franchise or income] tax liability to this State an assessment described in Section 9H to the extent of twenty percent (20%) of the amount of the assessment for each of the five (5) calendar years following the year in which the assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its [premium, franchise, or income] tax liability for the year it ceases doing business.

B. A member insurer that is exempt from taxes referenced in Subsection A above may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

C. Any sums that are acquired by refund, pursuant to Section 9F, from the Association by member insurers, and that have been offset against [premium, franchise or income] taxes as provided in Subsection A above, shall be paid by the member insurers to this State in such manner as the tax authorities may require. The Association shall notify the commissioner that refunds have been made.]

Drafting Note: Subsection A provides an offset against future premium, franchise or income taxes of assessments, over a five-year period. The timing of the credit is dependent on the year the assessment is paid. It also allows the member insurer to select the applicable tax (premium, franchise or income) against which the credit may be applied and it permits member insurers going out of business to make use of the credit in their final year of operations.

Life insurance premiums, and premiums for certain forms of health insurance, cannot be changed on existing policyholders. Thus, a suitable and practical method of recoupment available to companies writing life and health insurance lies in offsets against premium or other taxes on such companies. The method suggested in this section is not only equitable to the companies involved but also reduces the impact on State revenue by the partial offset over a period of years. To the extent the recovery from the insolvent company exceeds the tax credit received, the State would be the ultimate beneficiary. The equitable treatment of assessments for tax purposes would have additional positive effects: (1) the State legislature would have an additional incentive for providing adequate funds for insurance department personnel and administration, and (2) participation in the economic loss would be shared, to some degree, by the general public rather than solely by insureds, thus minimizing what might otherwise be a penalty on thrift and savings. It may be advisable in some jurisdictions to provide a cross-reference to the premium or other tax statutes to avoid questions of conflicting statutory provisions.

Subsection B provides an alternative mechanism for tax-exempt member insurers to recoup funds paid for assessments, and is intended to avoid disadvantaging tax-exempt or non-profit member insurers that are not subject to a [premium, franchise or income] tax liability, and thus would not benefit from a premium tax offset. The amount and duration of a surcharge is subject to approval by the commissioner, and any such surcharge cannot be considered premium for any purpose. Building assessments into surcharges for future policyholders or contract owners has proven to be an effective way for insurers to recoup funds, and a surcharge mechanism is necessary to provide tax-exempt and non-profit member insurers with a meaningful opportunity to recoup funds paid for assessments.

This section is optional, and the NAIC neither endorses nor rejects the tax credit or the surcharge concept. Each State will wish to consider this provision in the light of its own regulatory experience.

Section 14. Miscellaneous Provisions

A. This Act shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board of directors to discuss the activities of the Association in carrying out its powers and duties under Section 8. The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except (i) upon the termination of the impairment or insolvency of the member insurer, or (ii) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under Section 15.

C. For the purpose of carrying out its obligations under this Act, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to Section 8K. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer as established in Subsection C of this section and consistent with [insert cite of applicable State receivership law provision dealing with early access disbursements], the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this Act. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

E. (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association with interest thereon for funds expended in carrying out its powers and duties under Section 8 with respect to the member insurer have been fully recovered by the Association.

[F. (1) If an order for liquidation or rehabilitation of a member insurer domiciled in this State has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of Paragraphs (2) to (4).

(2) No such distribution shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person, who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under Paragraph (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.]

Drafting Note: Subsection A is intended to preserve the assessment liability of the insureds of assessment mutuals.

Subsection B addresses record-keeping by the Association. The Association should be held publicly accountable for its actions. On the other hand, effective handling of the rehabilitation or liquidation effort requires minimum publicity. Thus, such records will be made public only after the liquidation, rehabilitation or conservation proceeding is terminated, the impairment or insolvency is terminated or there is a prior order by a court of competent jurisdiction.

Since this Act imposes the obligation upon the Association to continue coverage for policyholders, contract owners, certificate holders, or enrollees of insolvent insurers, the assets of the insolvent insurer ought to be used, to the extent available, for the purpose of continuing such coverage. Subsections C and D are designed to accomplish this purpose.

Subsection E, in conjunction with Section 11A(2), is intended to prevent the shareholders of an impaired or insolvent insurer from sitting back and doing nothing and then reaping the benefits of funds put up by the Association. These stockholders should not obtain a more advantageous position than they would have occupied in the absence of this Act. The court is empowered to modify and distribute the ownership rights of an impaired or insolvent insurer in order to do equity as between the interested parties.

Subsection F, which should be deleted if the State has adopted Section 602 of the NAIC Insurers Receivership Model Act dealing with affiliated transactions, is designed to recapture excessive dividend payments to affiliates that exercised control over the impaired or insolvent insurer. The NAIC Insurance Holding Company System Regulatory Model Act in large measure prevents improper distribution of dividends by an insurer to its holding company since extraordinary dividends are subject to the prior approval of the commissioner, and ordinary dividends are required to be reported to the commissioner. If, however, dividends are paid under circumstances that the member insurer should have reasonably known that such payment could reasonably be expected to affect its ability to perform its contractual obligation to its policyholders, contract owners, certificate holders, or enrollees the holding company and affiliates should be required to repay such dividends subject to certain reasonable limitations.

If a State has the NAIC Insurance Holding Company System Regulatory Model Act, the definitions therein could be referred to by this subsection. States without the Model Act could incorporate the relevant definitions in this subsection.

Section 15. Examination of the Association; Annual Report

The Association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the Association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the Association shall provide the member insurer with a copy of the report.

Section 16. Tax Exemptions

The Association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property.

Section 17. Immunity

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this Act. This immunity shall extend to the participation in any organization of one or more other State associations of similar purposes and to any such organization and its agents or employees.

Drafting Note: This drafting note is for the purpose of clarifying the intent of the drafters of Section 17. As the courts have indicated, this provision was never intended to protect the Association from actions seeking to enforce its statutory obligations to pay covered claims. See, e.g., Mendes v. Hawaii Insurance Guaranty Association, 950 P.2d 1214, 1218 (Haw. Sup. Ct. 1998), ("HIGA is amenable to suit for the limited purpose of compelling it to perform its statutory duty to deal with the covered claims of insolvent insurers"); PIE Mutual Insurance Company v. Ohio Insurance Guaranty Association, 611 N.E. 2d. 313, 317 (Ohio Sup. Ct. 1993) (" … insured or third-party claimant is entitled to judicial relief to force OIGA to perform its statutory duties").

Nor was the provision ever intended to protect the Association from contract actions to enforce express obligations of the Association under contracts entered into by the Association.

Each State may wish to review its own statutes to determine whether its Tort Claims Act, if it has one, could be used as an alternative to this section insofar as it applies to the commissioner or his representative.

Section 18. Stay of Proceedings; Reopening Default Judgments

All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Section 19. Prohibited Advertisement of Insurance Guaranty Association Act in Insurance Sales; Notice to Policy Owners

A. No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this State for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the [State] Life and Health Insurance Guaranty Association Act. However, this section shall not apply to the [State] Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

B. Within one hundred eighty (180) days of the effective date of this Act, the Association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with Subsection C of this section. This document shall be submitted to the commissioner for approval. At the expiration of the sixtieth day after the date on which the commissioner approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to the Act may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this Act.

C. The document prepared under Subsection B shall contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(2) Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(3) State the types of policies or contracts for which guaranty funds will provide coverage;

(4) State that the member insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

(5) State that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization;

(6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this Act; and

(7) Provide other information as directed by the commissioner including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that State's public records law.

D. A member insurer shall retain evidence of compliance with Subsection B for so long as the policy or contract for which the notice is given remains in effect.

Drafting Note: Subsection A continues the prohibition of using the existence of the Association in the inducement of sale of insurance or health maintenance organization coverage. However, Subsection B requires notification to new policyholders concerning the general parameters of the association law and responsibility thereunder.

The following form for the disclaimer notice is suggested:

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The [insert name of the Life and Health Insurance Guaranty Association] provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this State. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer or a health maintenance organization.

[Insert addresses of the Association and department.]

Insurers, health maintenance organizations and agents should be required to deliver the document and disclaimer described under Subsections B and C when a customer is solicited if a "free look" period is not required by State law.

Computer programs or other evidence of established procedures for including the notice required under Subsection 19B in the policy or contract in the printing, assembly or issue process would be considered evidence of the compliance required under Subsection 19D.

Section 20. Prospective Application

This Act shall not apply to any member insurer that is insolvent or unable to fulfill its contractual obligations on the effective date of this Act.

APPENDIX
ALTERNATIVE PROVISIONS

Drafting Note: The underlining and overstrikes in the following provisions show the necessary changes from the model if a State decides to eliminate coverage for unallocated annuities.

Alternative Section 3. Coverage and Limitations

A. This Act shall provide coverage for the policies and contracts specified in Subsection B:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under Paragraph (2);

(2) To persons who are owners of or certificate holders or enrollees under the policies or contracts (other than structured settlement annuities) and in each case who

(a) Are residents; or

(b) Are not residents, but only under all of the following conditions:

(i) The member insurer that issued the policies or contracts is domiciled in this State;

(ii) The States in which the persons reside have associations similar to the association created by this Act;

(iii) The persons are not eligible for coverage by an association in any other State due to the fact that the insurer or the health maintenance organization was not licensed in the State at the time specified in the State's guaranty association law.

(3) For structured settlement annuities specified in Subsection B; Paragraphs (1) and (2) of this subsection shall not apply, and this Act shall (except as provided in Paragraphs (5) and (6) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following conditions;

(i) (I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident; but

a. The insurer that issued the structured settlement annuity is domiciled in this State; and

b. The State in which the contract owner resides has an association similar to the association created by this Act; and

(ii) Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the State in which the payee or contract owner resides.

(4) This Act shall not provide coverage to a person who is a payee (or beneficiary) of a contract owner resident of this State, if the payee (or beneficiary) is afforded any coverage by the association of another State.

(5) This Act is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Act is provided coverage under the laws of any other State, the person shall not be provided coverage under this Act. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one State, whether as an owner, payee, enrollee, beneficiary or assignee, this Act shall be construed in conjunction with other State laws to result in coverage by only one association.

B. (1) This Act shall provide coverage to the persons specified in Subsection A for policies or contracts of direct, non-group life insurance, health insurance (which for the purposes of this Act includes health maintenance organization subscriber contracts and certificates), or annuities and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in Paragraph (3) of this subsection, this Act shall not provide coverage for:

(a) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(c) A portion of a policy or contract to the extent that the rate of interest on which it is based

(i) Averaged over the period of four (4) years prior to the date on which the Association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the Association became obligated; and

(ii) On and after the date on which the Association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(d) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(e) A portion of a policy or contract to the extent that it provides for

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(f) A policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this State;

(g) A portion of a policy or contract to the extent that the assessments required by Section 9 with respect to the policy or contract are preempted by federal or State law;

(h) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, contract holder, contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(iii) Misrepresentations of or regarding policy or contract benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(i) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(j) An unallocated annuity contract; and

(k) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D), or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto.

(3) The exclusion from coverage referenced in Paragraph (2)(c) of this subsection shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

C. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(2) (a) With respect to one life, regardless of the number of policies or contracts:

(i) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) For health insurance benefits:

(I) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance as defined in [section of State law dealing with health insurance/disability income insurance/long-term care insurance] including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability income insurance as defined in [section of State law dealing with health insurance/disability income insurance] and $300,000 for long-term care insurance as defined in [section of State law dealing with health insurance/long-term care insurance];

(III) $500,000 for health benefit plans;

(iii) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(b) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event shall the Association be obligated to cover more than (i) an aggregate of $300,000 in benefits with respect to any one life under Paragraphs 2(a), 2(b) and 2(c) of this subsection except with respect to benefits for health benefit plans under Paragraph 2(a)(ii) of this subsection, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual, or (ii) with respect to one owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(d) The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this Act may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

(e) For purposes of this Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

D. In performing its obligations to provide coverage under Section 8 of this Act, the Association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Drafting Note: This section and Section 8 are key sections of the Act. Section 3 identifies who and what are covered and not covered by the Act. Section 8 specifies the responsibilities of the Association toward covered persons with covered policies.

Protection of this Act is primarily extended to resident persons but certain nonresidents under specific circumstances will be protected by this Act if the insolvent insurer was domiciled in this State.

This model does not apply to reinsurance unless assumption certificates were issued to the direct insureds or enrollees. Furthermore, it applies only to direct individual or group certificate insurance issued or written by member insurers licensed to transact business in this State at any time.

Persons to whom coverage is typically provided are resident enrollees, policy or contract owners, or their beneficiaries, assignees or payees. For group contracts or policies, coverage is provided to resident enrollees, and certificate holders and not to the owners of the group contracts or policies; this avoids the possibility of double coverage and indirect coverage of nonresident enrollees, and certificate holders through resident group policy or contract owners. Subsection A(3) provides coverage for structured settlement annuities to resident payees rather than to the contract owners.

Subsection A(3) providing structured settlement annuity coverage to resident payees is a significant change from previous versions of this Model Act intended to place the coverage in the State of the resident persons to be protected rather than in the State where the nominal owner of the contract resides. Subsections A(4) and (5) avoid the possibility of double coverage due to differing approaches for determining the covered persons in different State statutes and provide mechanisms for resolving which State's statutes will be used to determine the existence and limits of coverage.

Policies and contracts covered by the model act are life insurance, health insurance and annuity policies and contracts and policies or contracts supplemental thereto. The use of the term health insurance is intended to include "accident and health" insurance, "sickness and accident" insurance, "disability income" insurance, health maintenance organization contracts, etc. The use of the term disability income insurance is intended to include insurance policies and contracts that cover the loss of income due to a disability. The individual State may want to adjust this language to fit its particular terminology.

Subsection B(2) identifies certain types of contracts or policies or portions of contracts or policies that are specifically not covered by this Act. If a portion of a contract or policy is not covered, the remainder of the contract or policy is covered unless excluded otherwise. Subsection B(2) also provides a ready means by which an individual State can exempt from the Act those policies and contracts issued by member insurers or similar organizations deemed appropriate for exemption by the State.

Subsection B(2)(i) is intended to exclude from coverage those products commonly referred to as "financial guaranty" products.

Subsection C provides the maximum limitations of the Association's liability by type of contract or policy or line of business and overall per one life, plan sponsor or owner. The limits may be reached through cash surrender payments, benefit payments, or continuing coverage or a combination thereof. The maximum limits for each type of coverage should be set at an appropriate level after review by each State.

Alternative Section 5. Definitions

As used in this Act:

A. "Account" means either of the two accounts created under Section 6.

B. "Association" means the [State] Life and Health Insurance Guaranty Association created under Section 6.

C. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board of Directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

D. "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

E. "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

F. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Insert the title of the chief insurance regulatory official whenever the term "commissioner" appears.

G. "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3.

H. "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 3.

I. "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

J. "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(1) Accident only insurance:

(2) Credit insurance;

(3) Dental only insurance;

(4) Vision only insurance;

(5) Medicare Supplement insurance;

(6) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(7) Disability income insurance;

(8) Coverage for on-site medical clinics; or

(9) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

K. "Impaired insurer" means a member insurer which, after the effective date of this Act, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

L. "Insolvent insurer" means a member insurer which after the effective date of this Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

M. "Member insurer" means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under Section 3, and includes an insurer or health maintenance organization whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) A hospital or medical service organization, whether profit or non-profit;

(2) A fraternal benefit society;

(3) A mandatory State pooling plan;

(4) A mutual assessment company or other person that operates on an assessment basis;

(5) An insurance exchange;

(6) An organization that has a certificate or license limited to the issuance of charitable gift annuities under [insert the appropriate section of the State code]; or

(7) An entity similar to any of the above.

Drafting Note: States that license Health Care Service Corporations or similar organizations that undertake to provide basic health care services may want to address these entities in this Act.

N. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

O. "Owner" of a policy or contract and "policyholder, "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholders and policy owner do not include persons with a mere beneficial interest in a policy or contract.

P. "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

Q. "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 3B except that assessable premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to one individual, one participant and one policy or contract owner. "Premiums" shall not include:

(1) Premiums on an unallocated annuity contract State; or

(2) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

R. (1) "Principal place of business" of a plan sponsor or a person other than a natural person means the single State in which the natural persons who establish policy or contract for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

(a) The State in which the primary executive and administrative headquarters of the entity is located;

(b) The State in which the principal office of the chief executive officer of the entity is located;

(c) The State in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(d) The State in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(e) The State from which the management of the overall operations of the entity is directed; and

(f) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the State in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single State, that State shall be deemed to be the principal place of business of the plan sponsor.

(2) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

S. "Receivership court" means the court in the insolvent or impaired insurer's State having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

T. "Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one State, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the Association created by this Act, shall be deemed residents of the State of domicile of the member insurer that issued the policies or contracts.

U. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

V. "State" means a State, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

W. "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

X. "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Drafting Note: Each State will wish to examine its own statutes to determine whether these definitions are applicable and to determine whether some should be deleted and others added.

Alternative Section 6. Creation of the Association

A. There is created a nonprofit legal entity to be known as the [State] Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or a health maintenance organization business in this State. The Association shall perform its functions under the plan of operation established and approved under Section 10 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the Association shall maintain two (2) accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(a) Life insurance account; and

(b) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(2) The health account.

B. The Association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1971 Proc. I 54, 58, 134, 159, 160-173 (adopted).
1976 Proc. I 2, 9, 270, 296-297, 298-312 (amended and reprinted).
1977 Proc. II 19, 21, 355, 363 (amended).
1978 Proc. I 13, 15, 211, 241 (corrected).
1986 Proc. I 9-10, 22, 149, 294-295, 306-322 (amended and reprinted).
1987 Proc. II 15, 22, 160, 320 (decertification of 4-account approach).
1988 Proc. I 9, 18-19, 157-159, 337-338, 339-354 (amended to create 2 accounts and reprinted).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 620-621 (amended).
1993 Proc. 3rd Quarter 7, 30, 333-334, 341-343, 350-352 (amended).
1995 Proc. 1st Quarter 7, 10, 461, 466 (amended).
1995 Proc. 3rd Quarter 4, 18, 582, 585-586 (amended).
1996 Proc. 4th Quarter 11, 45-46, 938, 956, 959-981 (amended and reprinted).
1997 Proc. 4th Quarter 25, 27-28, 645, 646-647 (amended).
1998 Proc. 1st Quarter 15, 17, 598, 602, 603-616 (amended to add appendix).
1999 Proc. 1st Quarter 8, 9, 443, 445-446 (amended).
1999 Proc. 2nd Quarter 10, 11, 435, 436-438 (amended).
2009 Proc. 1st Quarter, Vol. I 111, 135, 139, 188, 240-287, 293, 821-835 (amended).
2016 Proc. 4th Quarter (amended).
2017 Proc. 4th Quarter (amended)

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-44-1 to 27-44-21 (1982/2014) (3 accounts).	
Alaska	ALASKA STAT. §§ 21.79.010 to 21.79.990 (1990/2018).		BULLETIN 2006-14 (2006); ORDER R2018-3 (2018).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-681 to 20-695 (1977/2018).		BULLETIN 2013-02 (2013); BULLETIN 2018-02 (2018).
Arkansas	ARK. CODE ANN. §§ 23-96-101 to 23-96-121 (1989/2019).		054.00.49 ARK. CODE R. §§ 1 to 6 (1992/1999) (notice to policyholders); BULLETIN 16-2013 (2013).
California		CAL. INS. CODE §§ 1067 to 1067.19 (1993/2019) (3 accounts).	
Colorado	COLO. REV. STAT. §§ 10-20-101 to 10-20-120 (1991/2023).		
Connecticut	CONN. GEN. STAT. §§ 38a-858 to 38a-879 (1972/2019).		
Delaware	DEL. CODE ANN. tit. 18, §§ 4401 to 4419 (1982/2019).		SURPLUS LINES BULLETIN 16 (2014).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia		D.C. CODE §§ 31-5401 to 31-5416 (1992/2015).	BULLETIN 04-003-IB (2006).
Florida	FLA. STAT. §§ 631.711 to 631.735 (1979/2019).		
Georgia	GA. CODE ANN. §§ 33-38-1 to 33-38-22 (1981/2020) (2 accounts with subaccounts).		
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:16-201 to 431:16-219 (1987/2012) (3 accounts).	HAW. CODE R. §§ 16-18-1 to 16-18-4 (1992) (notice to policyholders).
Idaho	IDAHO CODE ANN. §§ 41-4301 to 41-4320 (1977/2018).		
Illinois	215 ILL. COMP. STAT. 5/531.01 to 5/531.20 (1981/2018) (2 accounts with subaccounts).		ILL. ADMIN. CODE tit. 50, §§ 3401.10 to 3401.40; Illus. A (2014/2019); BULLETIN 2010-7 (2010).
Indiana	IND. CODE §§ 27-8-8-2 to 27-8-8-18 (1978/2019).		BULLETIN 249 (2019).
Iowa	IOWA CODE §§ 508C.1 to 508C.19 (1987/2019).		BULLETIN 2012-2 (2012); BULLETIN 2012-3 (2012); BULLETIN 2021-5 (2021).
Kansas		KAN. STAT. ANN. §§ 40-3001 to 40-3018 (1972/2011) (3 accounts).	
Kentucky	KY. REV. STAT. ANN. §§ 304.42-010 to 304.42-190 (1978/2019).		
Louisiana	LA. REV. STAT. ANN. §§ 22:2081 to 22:2099 (2008/2018).		LA. ADMIN. CODE tit. 37, §§ XIII.901 to XIII.909 (Regulation 40) (4 accounts) (1992/2016) (notice to policyholders); ADVISORY LETTER No. 2018-03 (2018).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 4601 to 4621 (1984/2018) (3 accounts).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland	MD. ANN. CODE INS. §§ 9-401 to 9-419 (1971/2020) (3 accounts).		MD. CODE REGS. 31.04.14.03 (2010/2015); BULLETIN 2012-13 (2012).
Massachusetts		MASS. GEN. LAWS ch. 175, § 146B (1985/2014)	
Michigan		MICH. COMP. LAWS §§ 500.7701 to 500.7780 (1982/2016) (2 accounts with subaccounts).	BULLETIN 2013-13-INS (2013).
Minnesota	MINN. STAT. ANN. §§ 61B.18 to 61B.33 (2020).	MINN. STAT. §§ 61B.18 to 61B.32 (1993/2009) (2 accounts with subaccounts).	MINN. STAT. § 60C.21 (2012).
Mississippi	MISS. CODE ANN. §§ 83-23-201 to 83-23-239 (2020).		
Missouri	MO. REV. STAT. §§ 376.715 to 376.758 (1988/2018).		MO. CODE REGS. ANN. tit. 20, § 400-5.600 (1988/2016).
Montana	MONT. CODE ANN. §§ 33-10-201 to 33-10-236 (1974/2019).		
Nebraska	NEB. REV. STAT. §§ 44-2701 to 44-2720 (1975/2019).		
Nevada	NEV. REV. STAT. §§ 686C.010 to 686C.390 (1973/2019).		BULLETIN 2011-009 (2011); BULLETIN 2019-006 (2019).
New Hampshire	N.H. REV. STAT. §§ 408-F:1 to 408-F:20 (2019).	N.H. REV. STAT. ANN. §§ 408-B:1 to 408-B:20 (1995/2015) (2 accounts with subaccounts).	
New Jersey	N.J. STAT. ANN. §§ 17B:32A-1 to 17B-32A-19 (1991/2022).		
New Mexico		N.M. STAT. ANN. §§ 59A-42-1 to 59A-42-17 (1985/2014) (2 accounts).	
New York	N.Y. INS. LAW §§ 7701 to 7720 (1985/2023).		N.Y. INS. LAW §§ 7501 to 7507 (1984/2014).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	N.C. GEN. STAT. §§ 58-62-2 to 58-62-86 (1991/2018).		BULLETIN 2009-B-3 (2009); BULLETIN 2010-B-5 (2010).
North Dakota	N.D. CENT. CODE §§ 26.1-38.1-01 to 26.1-38.1-16 (1989/2019).		N.D. ADMIN. CODE § 45-11-01-01 (1990/2012) (advertising rules).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3956.01 to 3956.20 (1989/2022) (2 accounts with subaccounts).		
Oklahoma	OKLA. STAT. tit. 36, §§ 2021 to 2044 (1981/2019).		OKLA. ADMIN. CODE § 365:10-1-6 (2011); BULLETIN 2010-03 (#2) (2010).
Oregon		OR. REV. STAT. §§ 734.750 to 734.890 (1975/2011) (3 accounts).	
Pennsylvania	40 PA. STAT. ANN. §§ 991.1701 to 991.1718 (1992/2020).		
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3901 to 3918 (1974/2009) (3 accounts).	
Rhode Island		R.I. GEN. LAWS §§ 27-34.3-1 to 27-34.3-20 (1995/2012).	
South Carolina	S.C. CODE ANN. §§ 38-29-10 to 38-29-210 (1988/2020).		BULLETIN 2020-11 (2020).
South Dakota	S.D. CODIFIED LAWS §§ 58-29C-44 to 58-29C-62 (1989/2020) (portions of model).		
Tennessee	TENN. CODE ANN. §§ 56-12-201 to 56-12-220 (1989/2019).		BULLETIN 6-7-2010 (2010).
Texas	TEX. INS. CODE ANN. §§ 463.001 to 463.206 (1985/2019).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah	UTAH CODE ANN. §§ 31A-28-101 to 31A-28-120 (1986/2018) (2 accounts with subaccounts).		UTAH ADMIN. CODE R590-155 (2010/2019).
Vermont	VT. STAT. ANN. tit. 8, §§ 4171 to 4190 (2023).	VT. STAT. ANN. tit. 8, §§ 4151 to 4169 (1972/2015) (3 accounts).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-1700 to 38.2-1721 (1986/2018) (2 accounts).		ADMIN. LETTER 2018-2 (2018).
Washington	WASH. REV. CODE §§ 48.32A.005 to 48.32A.901 (2001/2022) (2 accounts with subaccounts).		
West Virginia	W. VA. CODE §§ 33-26A-1 to 33-26A-19 (1977/2018) (2 accounts).		INFORMATIONAL LETTER 204 (2019).
Wisconsin			WIS. STAT. §§ 646.01 to 646.61 (1979/2017) ("Insurance Security Fund").
Wyoming	WYO. STAT. ANN. §§ 26-42-101 to 26-42-118 (1990/2019).		

PROJECT HISTORY - 2017

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT (#520)

1. Description of the Project, Issues Addressed, etc.

On December 13, 2016, Executive (EX) Committee and Plenary adopted two new charges for the Receivership Model Law (E) Working Group of the Receivership and Insolvency (E) Task Force:

- Evaluate and consider the changing marketplace of long-term care (LTC) products and the potential guaranty fund impact.
- Evaluate the need for amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) to address issues arising in connection with the insolvency of LTC insurers.

The charges were adopted in response to issues arising out of the Penn Treaty Network of America Insurance Company insolvency and other potential insolvencies involving LTC insurance.

On December 15, 2016, the Working Group requested comments regarding the new charges. Eleven comments were received by the February 7, 2017, deadline. The primary concerns raised by the comments involved guaranty association assessments on LTC insurance insolvencies and guaranty association coverage of LTC insurance. Specific issues that were identified included:

- The need to expand the assessment base.
- Whether to include health maintenance organizations (HMOs) as guaranty association members.
- Guaranty associations' ability to modify LTC insurance benefits and provide alternative policies.
- Clarifying the application of the "Moody's Limitation" to LTC insurance.
- Premium rate increases by guaranty associations.
- The allocation of premiums between the guaranty association and liquidator.

In addition, the National Organization of Life and Health Guaranty Associations (NOLHGA) gave a presentation of background information on LTC insurance on March 30, 2017.

The Working Group discussed the comments at the April 2017 NAIC Spring National Meeting in Denver, and on four conference calls held in May 2017 and June, 2017. The Working Group determined that changes were needed to Model #520 and submitted a Request for NAIC Model Law Development on June 21, 2017. The request proposed amendments to Model #520 to address guaranty association assessments, coverage issues, and the potential inclusion of HMOs as guaranty association members.

On its July 10, 2017, conference call, the Working Group supported the concepts of aggregating the life/annuity and health insurance accounts and including HMOs as members of the guaranty association, subject to the NAIC's approval of the Request for NAIC Model Law Development. At the 2017 Summer National Meeting, the Executive (EX) Committee approved the request to revise Model #520. The Working Group formed a drafting group, which included regulators, receivers and the industry representatives.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force is responsible for Model #520. The 2017 members of the Task Force include: New Jersey (Chair); Texas (Vice Chair), Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Mexico, New York, Oklahoma, Pennsylvania, Rhode Island, Utah, Washington and Wisconsin.

The Receivership Model Law (E) Working Group evaluated the issues and completed the amendments to Model #520. The 2017 members of the Working Group include: Texas (Chair), Washington (Vice Chair); Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, Pennsylvania, Utah, and Wyoming.

The amendments to Model #520 were drafted by an informal drafting group of the Receivership Model Law (E) Working Group. The conference calls and interim meeting participation included attendees representing 12 state insurance departments and 35 interested parties including life and health industry trade groups, life insurers, health insurers, HMOs, guaranty associations, receivers, consumer representatives, health care provider trade groups and academics. The attendees were as follows:

- State Insurance Regulators: Arkansas; Colorado; Connecticut; Florida; Maine; Michigan; Missouri; New Jersey; Pennsylvania; Texas; Utah; and Washington.
- Interested Parties: Aetna Inc.; American Council of Life Insurers (ACLI); American Hospital Association (AHA); American Medical Association (AMA); America's Health Insurance Plans (AHIP); Anthem Blue Cross and Blue Shield of Connecticut; Arbor Strategies LLC; Blue Cross and Blue Shield Association (BSBCA); California Health Advocates; Cantilo & Bennett LLP; Center for Insurance Research; Cigna; Delaware Life and Health Insurance Guaranty Association; Delta Dental Plans Association; Faegre Baker Daniels LLP; GHR Consulting, LLC; Health Care Services Corporation (HCSC); Kaiser Permanente; Katten Muchin Rosenman LLP; Lewis Roca Rothgerber Christie LLP; Life Insurance Guaranty Corp of New York; Mark Pratt Consulting LLC; Maryland Life and Health Guaranty Association; Michigan Life and Health Guaranty Association; Morgan Lewis & Brockius LLP; Mutual of Omaha; National Organization of Life and Health Guaranty Association (NOLHGA); New York Life Insurance Company; Northwestern Mutual Life Insurance Company; Priority Health; Protective Life Corp.; Risk Regulatory Consulting LLC (RRC); RPGLTC Services, LLC; Sonya Larkin-Thorne (Consumer Advocate); United American Insurance Company; United Health Group; and the University of Connecticut School of Law.

3. Project Authorized by What Charge and Date First Given to the Group

The Receivership and Insolvency (E) Task Force is charged with addressing any issues that affect receivership law.

In 2017, the Receivership Model Law (E) Working Group of the Receivership and Insolvency (E) Task Force was charged to:

- Evaluate and consider the changing marketplace of LTC products and the potential guaranty fund impact.
- Evaluate the need for amendments to Model #520, to address issues arising in connection with the insolvency of LTC insurers.

4. A General Description of the Drafting Process and Due Process

a. The Working Group held eight conference calls between February 2017 and August 2017 and meetings at the NAIC Spring National Meeting and Summer National Meeting, during which the issues were evaluated, and the plan was decided for drafting amendments to Model #520. On July 10, 2017, the Receivership Model Law (E) Working Group formed a drafting group to draft the amendments to Model #520, contingent upon the approval of the Request for NAIC Model Law Development. The Executive (EX) Committee approved the request at the 2017 Summer National Meeting.

b. The drafting group held 12 conference calls and an interim meeting between September 2017 and October 2017 to draft the amendments to Model #520. Written comments were received during the drafting process from ACLI, AHIP, AMA, Arbor Strategies, LLC, Cantilo and Bennett, LLP, Kaiser Permanente, Morgan Lewis Brockius LLP, NOLHGA, Colorado Division of Insurance, Maine Bureau of Insurance, and the Washington Office of the Insurance Commissioner.

c. The Working Group held a conference call on Oct. 27, 2017, at which time it received a report of the drafting group and exposed the draft amendments for a 30-day public comment period ending Nov. 27, 2017. Written comments on the exposure draft were received from Alliance for Community Health Plans (ACHP), AHA, joint comment letter from ACLI and Arbor Strategies LLC, BCBSA, Cantilo & Bennett LLP, Health Partners, and Kaiser Permanente. Technical edits were received from NAIC legal staff, BCBSA and NOLHGA.

d. The Working Group and the Receivership and Insolvency (E) Task Force held a joint conference call on Nov. 29, 2017. During the call, discussion on the amendments was heard from interested parties and interested regulators. The Working Group agreed to make certain non-substantive technical edits. No substantive changes were made to the amendments. The Working Group and the Task Force adopted the amendments to Model #520 on Nov. 29, 2017.

e. The Financial Condition (E) Committee received one comment letter from Kaiser Permanente. No changes were made to the amendments. The Financial Condition (E) Committee adopted the amendments to Model #520 on December 4, 2017.

f. The Executive (EX) Committee and Plenary adopted the amendments to Model #520 in December 2017.

5. A Discussion of the Significant Issues

a. Timeline: Members of the Receivership Model Law (E) Working Group and numerous interested parties urged that amendments to Model #520 be developed and adopted by the NAIC as expeditiously as possible. It was noted that legislation to amend life and health insurance guaranty acts was anticipated in some states as early as January 2018, regardless of whether the NAIC revised Model #520. Some interested parties suggested that the Working Group take more time to draft the amendments to fully consider all of the potential ramifications of the proposed changes.

The Working Group concluded that it was imperative that it complete its amendments before the end of 2017, so the revised Model could be considered in the 2018 legislative sessions.

b. Adding HMOs as Member Insurers: The Working Group considered comments favoring and opposing the inclusion of HMOs as members of the guaranty association. See *NAIC Proceedings – Summer 2017, Receivership and Insolvency (E) Task Force, Attachment Three*. The following summarizes some of the key arguments.

Arguments in support of HMO membership in guaranty associations included, but were not limited to the following:

- Some states already include HMOs in their life and health guaranty association.
- The marketplace for HMOs and major medical carriers is similar, both types of carriers now largely write network-based managed care policies, and the distinctions between them have diminished or in many markets are non-existent. As HMOs compete with major medical carriers, there is no compelling public policy to exclude HMOs. There are concerns that large health insurance groups could move business to their HMOs to avoid assessments.
- As illustrated by health cooperative insolvencies, consumers and providers are at risk without guaranty association coverage. When HMOs become insolvent, claims of medical providers and are often unpaid, and consumers have been improperly billed for unpaid medical services, despite hold-harmless provisions. Some states have even enacted emergency legislation – similar to traditional guaranty association coverage and often partially funded by health insurers - upon the insolvency of state HMOs to ensure continued care of members and payment of providers.
- If only LTC insurance writers are assessed, there might not be enough capacity to absorb future LTC insurance insolvencies. Broadening the assessment base would simplify the guaranty association system by providing more uniformity and enhance the overall stability of the system.

Arguments opposing HMO membership in guaranty associations included, but were not limited to the following:

- There is no nexus between HMOs and LTC insurance; HMOs do not write LTC insurance policies and should not be assessed for a line of business they do not write.
- HMOs have a significant non-profit sector, and it is not good public policy for non-profits to subsidize for-profit enterprises;
- HMO enrollees are already protected through hold harmless provisions with contracted providers or other regulatory provisions.
- Other NAIC models treat HMOs differently than insurance. There are complexities surrounding tax treatment and insolvency protections in state laws.

After considering the comments, the Working Group concluded that HMOs should be included as members largely for the reasons discussed above and because it was believed that distinctions regarding HMOs tax and non-profit status could be addressed through alternate provisions depending upon each state's market and existing laws.

c. Assessment Split: The Working Group considered alternative methodologies for Class B (claims payment) assessments for LTC insurance insolvencies. The options included different approaches for aggregating the

life/annuity and health insurance accounts for LTC insurance insolvencies and including HMOs as members of the guaranty association.

- The ACLI and certain large health insurers/groups proposed a compromise assessment methodology for LTC insurance insolvency assessments that would: increase the assessment base across the board by adding life and annuity premiums to the assessment base; and create a statutory 50% / 50% split of any needed assessment between life and health insurer members with the inclusion of HMOs as member health insurers.

- Kaiser Permanente proposed an assessment methodology based on the proportion of LTC insurance premium written in the state, similar to the calculation in Model #520 for other lines.

As the 50%/50% proposal with the inclusion of life and annuity premiums and HMOs would provide a broader and more predictable assessment base on a nationwide basis, would more equitably align assessments by reducing the current burden that is disproportionately on health insurers, and was widely supported by life and large health insurers, the Working Group adopted this methodology.

6. Any Other Important Information

The material changes to Model #520 are described below.

a. Guaranty Association Membership:

- HMOs are added to the definition of "member insurer" in Section 5M, and the exclusion of HMOs from the Act is removed. A reference to HMO business is added to Section 6A, Creation of the Association.
- A new definition for "health benefit plan" is added to Section 5J, which includes HMO subscriber contracts. This definition is consistent with other similar NAIC model definitions.
- Board membership is increased in Section 7A to account for HMO members. The drafting note gives states flexibility to address fair representation of membership on the board.

b. Assessments

- In the current Model, only the health account is assessed for LTC insurance insolvencies. In the revised Section 9C(2), Class B assessments for LTC insurance insolvencies are shared with the life account. The assessment methodology results in a 50% / 50% split between insurers of the life/annuity and health accounts. This formula factors in the assessments of life and annuity member insurers from the health account, and the assessments of health and HMO member insurers from the life account.
- The assessment methodology is to be included in the Plan of Operation, which is approved by the commissioner under the existing approval process of the state.
- The $300 limitation on Class A assessments in Section 9C(1) is eliminated, to give boards flexibility to address Class A assessments as appropriate in each state. It was noted that some states have deleted this limitation.
- A pre-funding concept for health benefit plans is mentioned in the drafting note to Section 9. A provision based on this concept was not included in Model #520, however, as there was no consensus for pre-funding, and it may be appropriate only in certain states.
- There is an optional provision for the recoupment of assessments in Section 13B. Surcharges may be considered where a member insurer is exempt from tax liability, and unable to take a tax offset. The drafting note addresses considerations for tax-exempt member insurers, such as some HMOs.

c. Coverage and Limitations

- Section 3A(1) specifies that coverage under the Act applies to health care providers rendering services covered by a health insurance policy or certificate to which the Act applies (which includes HMO certificates). Section 3A(2) extends coverage to HMO enrollees.
- Section 3B(2)(m) excludes Medicaid from guaranty association coverage, similar to the current exclusion of Medicare.

- Section 3B(3) and the Drafting Note clarify that the "Moody's Limitation" in Section 3B(2)(c) is not intended to apply to any portion of a policy or contract (including a rider) that provides LTC insurance or any other health insurance benefits.
- Section 3C(2)(a)(ii) and 3C(2)(d) clarify that "disability insurance" is intended to mean disability income insurance, which is consistent with the historical interpretation. The term "basic hospital, medical and surgical insurance or major medical insurance" is replaced with new definition of "health benefit plan" to encompass benefits provided by HMOs.
- Section 3C(2)(g) clarifies that LTC insurance riders to life and annuity contracts are considered the same as the base policy or contract.

d. Rates

- Section 8L(9)(c) clarifies that guaranty associations have the authority to file for rate or premium increases.
- Section 8B(2)(d) and (f) require that rates for substitute or reissued coverage must be "actuarially justified".
- A requirement for approval of rates by the receivership court in Section 8B(2)(e) is deleted.

e. General Changes

- The Drafting Note in Section 2 is clarified to state that the purposes of the act include: (1) having sufficient assessment capacity for all insolvencies, and (2) assessing insurers in a fair and reasonable manner.
- Throughout Model #520, amendments were made to insert terminology for "contract," "enrollee," "certificate," "health maintenance organization", "health benefit plan", "reissue", "health care providers", etc., as applicable to address the addition of HMOs as member insurers.
- Outdated language with regard to "identical …premium" is removed from Section 8B(2)(a).

PROJECT HISTORY – 2016

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT (#520)

1. Description of the Project, Issues Addressed, etc.

At the 2013 Summer National Meeting, the Rhode Island Insurance Division requested that the Receivership and Insolvency (E) Task Force study the topic of guaranty fund coverage of life settlements and factored structured settlements.

At the 2013 Fall National Meeting, the Task Force heard presentations about life settlements and factored structured settlements from industry trade groups, including the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), the National Structured Settlements Trade Association (NSSTA), the Life Insurance Settlement Association (LISA) and the American Council of Life Insurers (ACLI). Life settlements and factored structured settlements were identified as being different types of products. The Task Force limited its focus to factored structured settlements.

The Task Force postponed further discussion on the topic until 2015, when the ACLI had completed its own policy discussion. The ACLI presented clarifications for Model #520 to the Task Force at the 2015 Spring National Meeting for discussion purposes. The Task Force requested comments on the topic and received no objection to proceeding with revisions to Model #520. The Task Force submitted a Request for Model Law Development, which was adopted by the Executive (EX) Committee on Nov. 20, 2015.

The Task Force proposed to amend applicable sections of Model #520, including Section 3(A)5 and Section 3(B)2, as well as any other sections deemed relevant to this topic, to provide clarity with regard to the inapplicability of guaranty association coverage to factored structured settlement annuity benefits, which are structured settlement annuity benefits that have been sold to a third-party by the original annuitant.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force is responsible for Model #520. The 2016 members of the Task Force include: California, Chair; Texas, Vice Chair; Alaska; Arkansas; Connecticut; Delaware; District of Columbia; Florida; Hawaii; Illinois; Indiana; Iowa; Kansas; Louisiana; Massachusetts; Michigan; Missouri; Nebraska; Nevada; New Jersey; North Carolina; Oklahoma; Pennsylvania; Puerto Rico; Utah; Washington; and Wyoming.

3. Project Authorized by What Charge and Date First Given to the Group

The Receivership and Insolvency (E) Task Force is charged with addressing any issues that affect receivership law. The issue was first identified by the Rhode Island Insurance Division on Aug. 25, 2013.

4. A General Description of the Drafting Process and Due Process

The ACLI and the NSSTA submitted potential clarifications and proposed revisions relating to the applicable sections of Model #520. The Task Force exposed the concept at the 2015 Spring National Meeting for a 60-day public comment period ending May 29, 2015. The Task Force did not receive any comments in opposition.

The revisions to Model #520 were drafted and exposed April 5, 2016, for a 60-day public comment period ending June 3, 2016. The draft revisions reflected the recommendations submitted by the ACLI and the NSSTA. Comment letters were received from the ACLI and the International Association of Insurance Receivers (IAIR). Both comment letters were in support of the revisions.

The Receivership and Insolvency (E) Task Force adopted the revisions to Model #520 on Aug. 27, 2016.

The Financial Condition (E) Committee adopted the revisions to Model #520 on Aug. 28, 2016.

5. A Discussion of the Significant Issues

None.

6. Any Other Important Information

None.

PROJECT HISTORY - 2009

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT (#520)

1. Description of the Project, Issues Addressed, etc.

Following the adoption of the revised Insurer Receivership Model Act in 2005, the Receivership and Insolvency Task Force realized revisions were necessary to update the guaranty association model acts for changes in the industry since 1996. The purpose of the Model is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment, and to the extent provided in the Model, minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force was charged with updating the Life and Health Insurance Guaranty Association Model Act during 1996. The 2008 members of the Task Force that adopted the revisions to the Model on November 4, 2008, were: Iowa (Chair at the time of adoption), Texas (Vice-Chair), Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Missouri, Nevada, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, Tennessee, Utah, and Washington.

The Task Force delegated the charge to its Receivership Model Act Revision (E) Working Group. The 2008 members of the Working Group that adopted the proposed revisions to the Model during a October 21, 2008 conference call were: Pennsylvania (Chair), Arkansas, Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Massachusetts, Missouri, Nebraska, New York, Ohio, Oklahoma, Tennessee, Texas, and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

Following the adoption of the revised Insurer Receivership Model Act in 2005, the Receivership and Insolvency Task Force drafted a charge to develop revisions to the NAIC's two guaranty association model acts, which was approved by the Financial Condition (E) Committee. The Task Force then delegated the charge to its Receivership Model Act Revision (E) Working Group, who first took up the Life and Health Insurance Guaranty Association Model Act during 2006.

During 2007, the NAIC created a new framework for considering and approving model law developments. The two factors necessary to receive authorization to continue drafting were: (1) whether the issue that is the subject of the model law necessitates a national standard and requires uniformity amongst all states; and (2) where NAIC members are committed to devoting significant regulator and association resources to educate, communicate and support a model that has been adopted by the membership. Further drafting was suspended until the complete review and approval process was completed at the Task Force and parent committee levels.

On September 30, 2007, it was determined by the Executive (EX) Committee that the Life and Health Insurance Guaranty Association Model Act met the criteria for development as a Model Act by NAIC.

4. A General Description of the Drafting Process and Due Process

The Receivership Model Act Revision Working Group began working on the Life and Health Insurance Guaranty Association Model Act during 2006 and continued reviewing it through 2007, with the active participation of interested parties, including guaranty funds, their associations, insurers, other industry groups and a number of experienced receivership contractors. The draft Model had also been widely distributed via e-mail to various interested parties for an opportunity to submit written comments throughout 2006, early 2007 as well as posted for comment on the NAIC's Working Group Web page. However, during a May 30, 2007 conference call of the Task Force, the Chair advised the Working Group that it would not be able to work on the proposed revisions to the Model until the NAIC adopted a new model law process. The Task Force completed the appropriate review and paperwork according to the new process, which was subsequently exposed and adopted by E Committee. On September 30, 2007, the Executive (EX) Committee determined that the Model met the criteria for development as a Model Act and the Working Group continued discussions. Again, the Model was widely distributed via e-mail to various interested parties for comments throughout late 2007 and during 2008. Interested parties that provided written comment included: ACLI, AHIP, Arizona Life & Disability Insurance Guaranty Fund, Cantilo & Bennett LLP, Hogan & Hartson, Iowa Life & Health Insurance Guaranty Association, and NOLHGA. During an October 21, 2008, call, the Working Group adopted the proposed revisions to go before the Task Force.

During 2008, the Task Force had already provided the Working Group revisions to two sensitive and controversial topics before receiving the Working Group's adopted revisions. Interested parties that provided written comments included: ACLI, AHIP, Hogan & Hartson, and NOLHGA.

During a November 4, 2008, conference call, the Task Force exposed the revised Model for comment to interested parties and regulators and three comment letters were received. Interested parties that provided written comments were ACLI, Cantilo & Bennett LLP, and NOLHGA. The Task Force made no amendments and adopted the revised Model to be submitted to the Financial Condition (E) Committee.

On December 8, 2008, the Financial Condition (E) Committee adopted the Task Force's revised Model.

5. A Discussion of the Significant Issues

The following significant issues were discussed by the Receivership Model Act Revision Working Group and Receivership and Insolvency Task Force:

Coverage limits
Health insurance benefits-long-term care insurance coverage limits was increased from $100,000 to $300,000. Annuity benefits, Government Retirement Benefit Plan, Structured Settlement were all increased from $100,000 to $250,000. A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C and Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (Commonly known as Medicare Part C and D) was specifically excluded from coverage.

6. Any Other Important Information

As the Part A. Laws and Regulations of the NAIC Financial Regulation Standards and Accreditation Program only requires a regulatory framework such as contained in the NAIC's model acts on guaranty funds, the newly revised Life and Health Insurance Guaranty Association Model Act should not require a request to the Financial Regulation Standards and Accreditation (F) Committee to amend an accreditation standard.

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

This Act shall be known as the [State] Property and Casualty Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

A. Life, annuity, health or disability insurance;

B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

C. Fidelity or surety bonds, or any other bonding obligations;

D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

F. Title insurance;

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, "Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;

4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, "credit insurance" means insurance on accounts receivable.

The terms "disability insurance" and "accident and health insurance," and "health insurance" are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: "Ocean marine insurance" means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

A. "Account" means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.

B. "Association" means the [State] Insurance Guaranty Association created under Section 6.

C. "Association similar to the association" means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

D. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

E. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term "commissioner" appears.

F. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

G. "Covered claim" means the following:

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and:

(a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or

(b) The claim is a first party claim for damage to property with a permanent location in this State.

(2) Covered claim includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:

(a) The original member insurer has no remaining obligations on the policy after the transfer;

(b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member's coverage obligations by a court of competent jurisdiction in the insurer's State of domicile;

(c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and

(d) In cases where the member's coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

[Optional:

(3) Covered claim includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:

(a) A merger in which the surviving company was a member insurer immediately after the merger;

(b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or

(c) A transaction entered into pursuant to a plan approved by the member insurer's omiciliary regulator.]

Drafting Note: Optional Section 5G(3) provides coverage for certain claims that are not within the scope of Sections 5G(1) or (2) because the original coverage was not provided by a member insurer. Sections 5G(3)(a) and (3)(b) are based on Alternative 1 of the former definition of "assumed claims transaction" (below), and Section 5G(3)(c) is based on the additional scenario included in Alternative 2 of the former definition of assumed claims transaction (below). The reference to "assumption consideration" in that clause of the former definition is now addressed by Optional Section 8A(4).

[Assumed Claims Transaction Definition Alternative 1] "Assumed claims transaction" means the following:

(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or

(2) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies: and

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Assumed Claims Transaction Definition Alternative 2] "Assumed claims transaction" means the following:

(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or

(2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:

(a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and

(b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.

(c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or

(3) An assumption reinsurance transaction in which all of the following has occurred:

(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;

(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

(3) Except as provided elsewhere in this section, "covered claim" shall not include:

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

(i) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses.

Drafting Note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that "policyholder protection" proofs of claim, while valid to preserve rights against the estate of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

[Optional:

H. "Cybersecurity insurance", for purposes of this Act, includes first and third-party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.]

H. "Insolvent insurer" means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile.

Drafting Note: "Final order" as used in this section means an order which has not been stayed. States in which the "final order" language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

I. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

J. (1) "Member insurer" means any person who:

(a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and

(b) Is licensed to transact insurance in this State (except at the option of the State).

(2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.

K. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

[Optional:

K. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees and including all premiums and other compensation collected by a member insurer for obligations assumed under a transaction described inSection 5G(3), less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers, other than compensation received for entering into a transaction described in Section 5G(3).]

Drafting Note: Optional Section 5K is for states that have adopted Optional Section 5G(3).

L. "Person" means any individual, aggregation of individuals, corporation, partnership or other entity.

M. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of "receiver" to the definition used in the State's insurer receivership act.

N. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5J shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5J shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

A. The workers' compensation insurance account;
B. The automobile insurance account; and

C. The account for all other insurance to which this Act applies.]

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term "director" shall mean an individual serving on behalf of

an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of "the business of insurance" similar to that found in the NAIC Insurer Receivership Model Act.

B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.

D. Any board member who is an insurer in receivership shall be terminated as a boar*d member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.

E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

A. The association shall:

(1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

(iii) An amount not exceeding $500,000 per claimant for all other covered claims.

(iv) In no event shall the Association be obligated to pay an amount in excess of $500,000 for all first and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims

against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

(c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to $10,000, against the association. The maximums ($10,000 for the return of unearned premium; $500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

(3) **[Alternative 1]** Assess insurers amounts necessary to pay the obligations of the association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

(3) **[Alternative 2**] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in

the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

[Optional:

(4) Assess member insurers that have entered into transactions described in Section 5G(3), in addition to the assessment levied under Section 8A(3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this Section 8A(4) is not subject to the annual percentage limitation under Section 8A(3) and shall be the amount that would have been paid by the assuming insurer under Section 8A(3) during the three calendar years preceding the effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]

Drafting Note: Optional Section 8A(4) is for states that have adopted Optional Section 5G(3) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.

(4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims and to appoint and direct other service providers for covered services.

(5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

(6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the

settlement, release, compromise, waiver or judgment was:

(I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or

(II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

(iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

(b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

(7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

(8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.

(9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

(1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;

(5) Perform other acts necessary or proper to effectuate the purpose of this Act;

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

(6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

(1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.

(2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional:

D. (1) The legislature finds:

(a) The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;

(b) The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;

(c) The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;

(d) The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and

(e) In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.

(2) In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers

for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

(3) In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

(4) Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.

(5) In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

Drafting Note: This provision should only be considered by those States that haveserious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;

(4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(6) Establish regular places and times for meetings of the board of directors;

(7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;

(9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;

(2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

(1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan

of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than $100 per month;

(2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.

B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.

C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].

D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines "high net worth insured," has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States' net worth restrictions pursuant to those States' guaranty

association laws.

A. For purposes of this section "high net worth insured" shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

A. (1) For the purposes of Subsection B(1), "high net worth insured" shall mean any insured whose net worth exceeds $25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]

(2) For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] "high net worth insured" shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of "covered claim." The Michigan Supreme Court, in interpreting a "net worth" provision in the Michigan guaranty association statute, held that governmental entities possess a "net worth" for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.

(3) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this section.]

Drafting Note: Alternative 1 for Section 13B(3), would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:

(a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;

(b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or

(c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.

(4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.

(5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this section.]

Drafting Note: Alternative 2 to Section 13B(5) would only be a consideration in states with a net worth exclusion.

[Alternative 3 for Section 13B

B. The association shall not be obligated to pay any first party claims by a high net worth insured.*]*

C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.

E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.

(2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits

applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)

(a) The credit shall be deducted from the lesser of:

(i) The association's covered claim limit;

(ii) The amount of the judgment or settlement of the claim; or

(iii) The policy limits of the policy of the insolvent insurer.*]*

[Alternative 2 for Section 14A(2)(a)

The credit shall be deducted from the lesser of:

(i) The amount of the judgment or settlement of the claim; or

(ii) The policy limits of the policy of the insolvent insurer.*]*

(b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

(3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

(4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and

(b) Any amount payable by or on behalf of a self-insurer.

(6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[*Alternative 1 for Section 17*

A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.

B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.

D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:

(1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and

(2) The last sentence in Subsection C above shall not apply.

E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.*]*

[*Alternative 2 for Section 17*

A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years]

successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.

D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.*]*

[*Alternative 3 for Section 17*

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.*]*

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).
2023 Fall National Meeting (amended).

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-42-1 to 27-42-20 (1981/2009) (separate account option).	
Alaska		ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/2004) (separate account option).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/2014).	
Arkansas			ARK. CODE ANN. §§ 23-90-101 to 23-90-123 (1977/1999).
California			CAL. INS. CODE §§ 1063 to 1063.15 (1969/2013).
Colorado		COLO. REV. STAT. §§ 10-4-501 to 10-4-520 (1963/2002) (separate account option).	
Connecticut		CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/2011) (separate account option).	
Delaware		DEL. CODE ANN. tit.18, §§ 4201 to 4223 (1982/1991).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia		D. C. CODE §§ 31-5501 to 31-5515 (1993).	
Florida		FLA. STAT. §§ 631.50 to 631.70 (1982/2010).	
Georgia			GA. CODE ANN. §§ 33-36-1 to 33-36-20 (1970/2005).
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:16-101 to 431:16-117 (1988/2003).	
Idaho		IDAHO CODE ANN. §§ 41-3601 to 41-3621 (1970/2014).	
Illinois		215 ILL. COMP. STAT. 5/532 to 5/553 (1977/2013) (separate account option).	
Indiana		IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/2013) (separate account option).	
Iowa		I OWA CODE §§ 515B.1 to 515B.26 (1970/2010).	IOWA CODE §§ 518C.1 to 518C.19 (2000) (separate fund for state and county mutuals).
Kansas		KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/2005).	
Kentucky		KY. REV. STAT. ANN. §§ 304.36-010 to 304.36-170 (1972/1990).	
Louisiana		LA. REV. STAT. ANN. §§ 22:2051 to 22:2070 (1970/2010).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4431 to 4452 (1969/2009) (separate account option).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland		MD. CODE ANN., INS. §§ 9-301 to 9-316 (1971/1997).	
Massachusetts		MASS. GEN. LAWS ch. 175D, §§ 1 to 17 (1970/2004).	
Michigan			MICH. COMP. LAWS §§ 500.7901 to 500.7949 (1969/1982); BULLETIN 2021-20-INS (2021).
Minnesota		MINN. STAT. §§ 60C.01 to 60C.22 (1971/2003) (separate account option).	
Mississippi		MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992).	
Missouri		MO. REV. STAT. §§ 375.771 to 375.780 (1971/2013) (separate account option).	
Montana		MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971/2013).	
Nebraska		NEB. REV. STAT. §§ 44-2401 to 44-2419 (1971/1990) (separate account option).	
Nevada		NEV. REV. STAT. §§ 687A.010 to 687A.140 (1971/2005).	
New Hampshire		N.H. REV. STAT. ANN. §§ 404-H:1 to 404-H:20 (2004).	N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970/2004) (separate account option).
New Jersey		N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974/2003).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico		N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989) (separate account option).	N.M. STAT. ANN. §§ 59A-30A-1 to 59A-30A-18 (1999) (title insurance fund).
New York			N.Y. INS. LAW §§ 7601 to 7614 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/2009) (separate account option).	
North Dakota		N.D. CENT. CODE §§ 26.1-42.1-01 to 26.1-42.1-15 (1999).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. §§ 3955.01 to 3955.19 (1970/2005) (separate account option).	
Oklahoma		OKLA. STAT. tit. 36, §§ 2001 to 2020.2 (1980/2014) (separate account option).	
Oregon		OR. REV. STAT. §§ 734.510 to 734.710 (1971/2003).	
Pennsylvania		40 PA. STAT. ANN. §§ 991.1801 to 991.1820 (1994).	
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3801 to 3819 (1974/1980).	
Rhode Island		R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/2010) (separate account option).	
South Carolina		S. C. CODE ANN. §§ 38-31-10 to 38-31-170 (1988/2001) (separate account option).	
South Dakota		S.D. CODIFIED LAWS §§ 58-29A-54 to 58-29A-109 (2001/2013) (separate account option).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee		TENN. CODE ANN. §§ 56-12-101 to 56-12-121 (1971/1999).	
Texas		TEX. INS. CODE ANN. §§ 462.001 to 462.351 (2007).	
Utah		UTAH CODE ANN. §§ 31A-28-202 to 31A-28-222 (1986/2002) (separate account option).	
Vermont		VT. STAT. ANN. tit. 8, §§ 3611 to 3626 (1969/1979) (separate account option).	
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 231 to 248 (1984/1986).	
Virginia		VA. CODE ANN. §§ 38.2-1600 to 38.2-1623 (1986/2014).	
Washington		WASH. REV. CODE §§ 48.32.010 to 48.32.920 (1971/2005) (separate account option).	
West Virginia		W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (separate account option).	
Wisconsin			WIS. STAT. §§ 646.01 to 646.61 (1979/2013) (Insurance Security Fund).
Wyoming		WYO. STAT. ANN. §§ 26-31-101 to 26-31-117 (1971/2013).	

PROJECT HISTORY-2023

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT (#540)

1. Description of the Project, Issues Addressed, etc.

Restructuring

In 2019, the Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group, which was charged with documenting the various issues related to insurance business transfers (IBT) and corporate division (CD) transactions in the form of a white paper. Included in the charge was to "[consider] the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring."

The proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) were precipitated by discussions within the Restructuring Mechanisms (E) Working Group's charge. The number of states adopting laws that permit either of these transactions is still relatively low. However, one of the most significant issues that had been discussed during the Working Group's meetings was the need for policyholders subject to such transactions to retain guaranty fund coverage. The National Conference of Insurance Guaranty Funds (NCIGF) representatives suggested that an amendment to a state's guaranty fund act, or other related law, is necessary to address this issue. They specifically suggested that the NAIC update Model #540, and they developed specific language to address this issue. An amendment to Model #540 will better enable states that have incorporated Model #540 into their laws to update their laws for this important issue, ensuring policyholders in all states retain their coverage. Because guaranty association coverage follows the state of licensure rather than the state of domicile, adequately addressing these concerns is necessary regardless of the type of transfer and how few states adopt changes to their laws to allow IBT and CD transactions.

It should be noted that with respect to guaranty fund coverage for life and health insurance, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) is suggesting a different approach to address the same issue in the life and health context. NOLHGA's proposal centers around the need for such transactions to require the assuming or resulting insurer to be licensed in all states where the issuing insurer was licensed or ever was licensed to retain the needed coverage for policyholders.

On March 28, 2022, the Restructuring Mechanisms (E) Working Group sent a referral to the Receivership and Insolvency (E) Task Force to request amendments to Model #540.

The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #540 during the 2022 Summer National Meeting. The amendments are intended to preserve guaranty fund coverage for policyholders subject to insurance business transfers (IBT) and corporate divisions (CD) where the policyholder had guaranty fund coverage before the transaction.

Cybersecurity Insurance

In December 2022, NCIGF requested the Task Force amend Model #540 to ensure cybersecurity insurance policyholders in all states are provided with guaranty fund coverage for this trending line of business. According to NCIGF, cybersecurity insurance coverage is trending into the admitted market. Consequently, NCIGF anticipates the insurance insolvency resolution system will be presented with claims and other issues related to this coverage. These policy obligations may flow both from standalone cyber policies, endorsements, or from coverages that may be found to exist in commercial general liability and other lines of business typically written for business entities. For this reason, policymakers need to determine how such coverages will be handled should an insurer writing this business become insolvent.

The Executive (EX) Committee approved a separate Request for NAIC Model Law Development for additional amendments to Model #540 during the 2023 Spring National Meeting. The amendments will address clarifying guaranty association coverage of cybersecurity insurance.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force was given the task of drafting the initial revisions to Model #540. The 2022 and 2023 members of the Working Group were Illinois (Co-Chair), Pennsylvania

(Co-Chair), Arkansas, California, Colorado, Connecticut, Florida, Iowa, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Puerto Rico, Texas, and Washington.

A drafting group was formed in November 2022 to review comments received on the first exposure draft of the restructuring amendments and to draft additional revisions. Members included Illinois, Maine, Pennsylvania, Oregon, Barbara F. Cox (Barbara F. Cox LLC), Roger Schmelzer (NCIGF), Rowe Snider (Locke Lord LLP), Stephen W. Schwab (DLA Piper LLP), and Patrick H. Cantilo (Cantilo and Bennett LLP).

3. Project Authorized by What Charge and Date First Given to the Group

As described, the initial charge prompting a review of Model #540 was given to the Receivership Law (E) Working Group at the 2022 Summer National Meeting. The two separate Requests for NAIC Model Law Development to open Model #540 for revision were adopted by the Executive (EX) Committee at the 2022 Summer National Meeting (restructuring) and the 2023 Summer National Meeting (cybersecurity insurance).

4. A General Description of the Drafting Process (e.g., Drafted by a Subgroup, Interested Parties, the Full Group, etc.)—Include Any Parties Outside the Members That Participated

For both the restructuring and the cybersecurity insurance amendments, NCIGF proposed an initial draft of amendments to Model #540. As noted above, a drafting group was formed in November 2022 to review comments received on the first exposure draft of restructuring amendments and consider further edits to Model #540. Upon completion of the drafting group's efforts, the Receivership Law (E) Working Group exposed and addressed comments on both sets of amendments—restructuring and cybersecurity insurance.

After the adoption of the amendments by the Receivership Law (E) Working Group on July 24, 2023, on Aug. 14, 2023, the Receivership and Insolvency (E) Task Force exposed and considered subsequent edits to the amendments before adopting the amendments on Oct. 2, 2023.

5. A General Description of the Due Process (e.g., Exposure Periods, Public Hearings, or Any Other Means by Which Widespread Input From Industry, Consumers and Legislators Was Solicited)

On Sept. 14, 2022, the Receivership Law (E) Working Group met in open session to expose proposed amendments to the definition of covered claims in Section 5 of Model #540 a 30-day public comment period ending Oct. 14, 2022. The initial draft of amendments was proposed by NCIGF. Comments were received from Robert Wake (ME).

On Nov. 7, 2022, the Receivership Law (E) Working Group met in open session to discuss comments received. A drafting group was formed to review the comments on the restructuring amendments and to consider further edits to the Model #540 amendments.

Between January and May 2023, the drafting group met four times and had many email exchanges as they worked through different drafts. The drafting group determined it had reached a point where they needed the broader Receivership Law (E) Working Group's input before moving forward with a single version of the amendments. The drafting group delivered two versions of the amendments for restructuring, albeit each with multiple alternatives, as proposed by different members of the drafting group, to the Receivership Law (E) Working Group for consideration.

On May 23, 2023, the Receivership Law (E) Working Group met in open session to consider the two versions of the amendments. After hearing presentations from the drafting group members and receiving summary explanations of each version, the Working group agreed to move forward with one version of the amendments. The amendments to Model #540 for restructuring were exposed for a 30-day comment period that ended June 23, 2023.

On May 23, 2023, the Receivership Law (E) Working Group exposed the draft amendments regarding guaranty fund coverage of cybersecurity insurance for a 30-day comment period that ended June 23, 2023.

Three comment letters were received on the exposure of restructuring amendments from Barbara F. Cox (Barbara F. Cox LLC) representing NCIGF, Patrick H. Cantilo (Cantilo and Bennett LLP), and Joseph Torti (Fairfax (US) Inc.). No comments were received on the cybersecurity insurance amendments.

On July 24, 2023, the Receivership Law (E) Working Group met in open session to consider comments received on the restructuring amendments. NAIC staff proposed non-substantive grammatical and formatting edits. The amendments were adopted by the Receivership Law (E) Working Group on July 24, 2023, by unanimous vote.

On Aug. 14, 2023, the Receivership and Insolvency (E) Task force met in option session at the Summer National Meeting. The Task Force heard comments from Barbara F. Cox (Barbara F. Cox LLC) representing NCIGF, Patrick H. Cantilo (Cantilo and Bennett LLP), and Joseph Torti (Fairfax (US) Inc.). The Task Force exposed the Model #540 amendments, including certain subsequent editorial clean-up revisions, for a 30-day public comment period ending Sept. 14.

On Oct. 2, 2023, the Receivership and Insolvency (E) Task force met in option session on a virtual meeting to discuss comments on the exposure that were received from Dan Bumpus (VA), Robert Wake (ME), Roger Schmelzer (NCIGF), and Patrick H. Cantilo (Cantilo and Bennett LLP). No further changes were made. The amendments were adopted by the Receivership and Insolvency (E) Task Force on Oct. 2, 2023, by unanimous vote.

All exposures were distributed by email to members, interested state insurance regulators, and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and were posted to the NAIC website.

All issues raised by members, interested state insurance regulators, and interested parties were discussed, explained, or addressed through revisions to the original proposed amendments.

The amendments were adopted by the Financial Condition (E) Committee on Oct. 25, 2023.

6. A Discussion of the Significant Issues (Items of Some Controversy Raised During the Due Process and the Group's Response)

Amendments to the Assumed Claims Transaction Provisions in Model #540:

The Restructuring Mechanisms (E) Working Group referral on IBT and CD transactions that kicked off this project included initial draft language suggested by NCIGF specific to the definition of covered claims. During the initial exposure of that draft definition, concerns were raised that the proposed definition for expanding the definition of guaranty association covered claims did not fully address the issue of continuing coverage when a policy is transferred by assumption, rather IBT or CD; and that any amendments to preserve guaranty fund coverage for policyholders subject to IBT and CDs, should not be at the exclusion of preserving coverage for policyholders subject to other transfers, such as assumption transactions where business is transferred by non-guaranty association members, like a reciprocal, fraternal or trust, to GA member insurers. The amendment adopted by the Working Group and the Task Force is intended to preserve both through the new Section 5G(2) and the new optional Section 5G(3). Therefore, the Working Group and the Task Force believe it met the charge.

Two commenters disagreed with amending the provisions in Model #540 related to deleting the 2009 assumed claims transactions provision and one interested party proposed alternative language. Specifically, provisions in Section 5D, Section 5Q, and the alternatives in Section 8A(3) related to assumed claims transactions were deleted. A new Section 5G(2) was added to ensure that coverage is preserved if coverage existed before an IBT or CD transaction. Because this amendment is broad, it automatically includes common law novation and assumption reinsurance without stating those specifically. In drafting the new Sections 5G(2) and 5G(3), the Working Group understood that there may be some states that feel there is a need for coverage in certain situations where a non-member transfers claims to a member insurer when it is not clear whether the member insurer issued a replacement policy. A new Section 5G(3) was added as optional for those states that want to include assumed claims transaction language.

With regard to the optional Section 5G(3), while the 2009 amendments were proposed to be deleted, the optional language was added, in essence, to preserve the assumed claims transaction language for those states that still may want to consider proposing that coverage to their legislatures. It was noted that only three states have adopted the 2009 assumed claims transaction language. It was the belief of members of the Working Group that the new language in Section 5G(2) and the optional language in Sections 5G(3), 5K and 8A4 are more streamlined and consequently result in greater clarity between the two options, rather than simply adding 5G(2) while retaining the former definition of assumed claim transaction. They also felt that the new proposed language would fit better into the existing statutes of the 47 states that have not adopted the 2009 assumed claims transaction language. By making the replacement language in Section 5G(3) optional, it gives states two avenues to pursue. States can try to pass both Sections 5G(2) and 5G(3) through their legislatures or if they have significant legislative objection to 5G(3), they can propose 5G(2) to address specifically the IBT and CD coverage issue. Members did not agree that the interested party's proposal would sufficiently address the transfer of policyholders being discussed.

The issue was discussed by the drafting group, the Receivership Law (E) Working Group, and the Receivership and Insolvency (E) Task Force.

7. Any Other Important Information (e.g., Amending an Accreditation Standard).

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Guaranty Association accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revision to Model #540. However, it should be noted that the accreditation standard for Model #540 is not a substantially similar standard. The Task Force will consider this and make appropriate referrals prior to the 2024 Spring National Meeting.

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PROJECT HISTORY - 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT (#540)

1. Description of the Project, Issues Addressed, etc.

Following the adoption of the revised Insurer Receivership Model Act in 2005, the Receivership and Insolvency Task Force realized revisions were necessary to update the guaranty association model acts for changes in the industry since 1996. The purpose of the Model is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment, and to the extent provided in the Model, minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force was charged with updating the Post-Assessment Property and Liability Insurance Guaranty Association Model Act. The 2008 members of the Task Force that adopted the revisions to the Model in March 2008 were: Delaware (Chair at the time of adoption), Texas (Vice-Chair), Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Missouri, Nevada, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, Tennessee, Utah, and Washington.

The Task Force delegated the charge to its Receivership Model Act Revision (E) Working Group. The 2006 members of the Working Group that adopted the proposed revisions to the Model during a October 27, 2006 conference call were: Pennsylvania (Chair), Arkansas, Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Kentucky, Massachusetts, Missouri, Nebraska, New York, Ohio, Oklahoma, Tennessee, Texas, and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

Following the adoption of the revised Insurer Receivership Model Act in 2005, the Receivership and Insolvency Task Force drafted a charge to develop revisions to the NAIC's two guaranty association model acts, which was approved by the Financial Condition (E) Committee. The Task Force then delegated the charge to its Receivership Model Act Revision (E) Working Group, who first took up the Post Assessment Property and Liability Insurance Guaranty Association Model Act in late 2005.

During 2007, the NAIC created a new framework for considering and approving model law developments. The two factors necessary to receive authorization to continue drafting are: (1) whether the issue that is the subject of the model law necessitates a national standard and requires uniformity amongst all states; and (2) whether NAIC members are committed to devoting significant regulator and association resources to educate, communicate and support a model that has been adopted by the membership. Further drafting was suspended until the complete review and approval process was completed at the Task Force and parent committee levels.

On September 30, 2007, it was determined by the Executive (EX) Committee that the Property and Casualty Insurance Guaranty Association Model Act met the criteria for development as a Model Act by NAIC.

4. A General Description of the Drafting Process and Due Process

The Receivership Model Act Revision Working Group began working on the Post Assessment Property and Liability Insurance Guaranty Association Model Act in late 2005 and continued reviewing it through October 2006, with the active participation of interested parties, including guaranty funds, their associations, insurers, other industry groups and a number of experienced receivership contractors. The draft Model had also been widely distributed via e-mail to various interested parties for an opportunity to submit written comments in late 2005 and throughout 2006, as well as posted for comment on the NAIC's Working Group Web page. Interested parties that provided written comment include: Allstate, Cantilo & Bennett LLP, Frost Brown Todd LLC, NCIGF, NOLHGA, Puerto Rico Property and Casualty Insurance Guaranty Association. Before the Working Group forwarded the proposed revisions to the Task Force, the Working Group decided during a September 11, 2006, meeting to provide additional guidance to the Task Force in the form of the Highlighted Issues memorandum. The memo was developed to make all participants aware of the Working Group's actions on the more controversial issues contained in the Model. During an October 27, 2006, call, the Working Group adopted the proposed revisions to go before the Task Force.

The Task Force provided an additional opportunity to address the issues in the Highlighted Issues memorandum, as well as other issues not discussed in the memo at the March 12, 2007, meeting. Interested parties that provided written comments include: AIA, Cantilo & Bennett LLP, Frost Brown Todd LLC, NCIGF, NOLHGA, and PCI. However, during a May 30, 2007, conference call, the Chair advised the Task Force that it would not be able to take a vote on the proposed revisions to the Model as in the interim the NAIC adopted a new model law process. The Task Force completed the appropriate review and paperwork according to the new process, which was subsequently exposed and adopted by E Committee. On September 30, 2007, the Executive (EX) Committee determined that the Model met the criteria for development as a Model Act.

During a November 28, 2007, conference call, the Task Force re-exposed the revised Model for comment to interested parties and regulators on issues that had not been previously submitted to the Task Force or Working Group. However, no new comments were received. During a March 30, 2008, meeting, the Task Force made amendments to some revisions initially proposed by the Working Group and then adopted a newly revised Model to be submitted to the Financial Condition (E) Committee.

On March 31, 2008, the Financial Condition (E) Committee received the Task Force's report and adopted a motion to expose the Model for comment. On May 23, 2008, an interim conference call took place to discuss interested party and regulator comments. A few proposed amendments to the proposed model regulation were submitted by regulators and adopted by the Financial Condition (E) Committee. In addition, the newly revised Model was adopted by the Committee.

5. A Discussion of the Significant Issues

The following significant issues were discussed by the Receivership Model Act Revision Working Group and Receivership and Insolvency Task Force:

Purpose and Construction
Section 2 and 4 of the current model was deleted from the proposed model by the Working Group based on concerns that the clauses have, in some cases, expanded the coverages provided by the guaranty associations. Two roll call votes were taken on this section by the Working Group. On December 3, 2005, the vote was 5-7 in favor of retaining the section. On May 25, 2006, the vote was 6-4 in favor of deleting it. On March 30, 2008, the Task Force voted 13-7 in favor of retaining Section 2 and 4 with comments from regulators suggesting that the aforementioned problems arose from specific issues with judges.

Assumption of business from unlicensed carriers
Under the current model, policies assumed from an unlicensed carrier are not included within the definition of covered claims for the guaranty association. On May 9, 2006, by a vote of 7-4, these policies were included as covered claims by the Working Group. On March 30, 2008, the Task Force voted 11-9 in favor of excluding assumption of business from unlicensed carriers from the definition of covered claims.

Policy protection claims by insureds
On August 31, 2006, a motion to remove the exclusion of claims based on IBNR from the definition of "Covered Claims" (§ 3H(2)(j)), was defeated by a vote of 8-6. Due to lack of a motion, the Task Force did not consider this issue.

Coverage limits
On January 17, 2006, a straw vote was taken to determine if there was a consensus on changing the process for determining the coverage limit. Three members favored a fixed $500,000 cap, three favored an adjustable cap starting at $500,000, two favored an adjustable cap, and other members were opposed to any change. Because there was no consensus for a change, a fixed cap of $500,000 was presented and adopted by voice vote in § 6A(1)(a)(iii). Due to lack of a motion, the Task Force did not consider this issue.

Claims bar date
On February 7, 2006, a 25-month claims bar date was established in § 6A(1)(b) by a vote of 7-2 with one abstention by the Working Group. On August 31, 2006, the issue was reconsidered, and the 25-month bar date was deleted by a vote of 8-5 with one abstention by the Working Group. The language in the proposed Model requires the guaranty fund bar date to be the same as the estate bar date. The Working Group reached this conclusion in order to avoid confusion. Due to lack of a motion, the Task Force did not consider this issue.

Receiver bound by GA claims determination.
On March 4, 2006, a motion to delete § 10C entirely was defeated 9-7 by the Working Group. A subsequent motion to delete only the last sentence of the subsection passed by a vote of 10-5 by the Working Group, so the Act is silent with regard to

whether the receiver would be bound by the guaranty association claim determination. On March 30, 2008, a motion to restore the language failed with a Task Force vote of 8 to 12.

Net worth exclusion.
During several meetings in June 2006, the Working Group discussed and approved each subsection of § 11. On July 11, 2006, this section was accepted by the Working Group as an optional section by a vote of 5-4 with one abstention. On July 18, 2006, a motion to reconsider the earlier vote was defeated by a vote of 8-4 by the Working Group; therefore, this section as drafted is included as optional. Though already enacted in some form in 35 states according to NCIGF, the existence and operation of the high net worth exclusion is still highly controversial. Due to lack of a motion, the Task Force did not consider this issue.

Immunity
On May 25, 2006, by a vote of 6-4, the Working Group adopted a revised version of § 16 on immunity of the guaranty association, its staff, members, directors, and the receiver and its staff. The immunity section in the prior model was substantially unlimited other than as it was interpreted by the courts. The new version of the provision removes immunity for the association for tort claims and for contract claims arising out of its statutory obligations. On March 30, 2008, the Task Force voted in favor of deleting the Working Group's revision given representations from NCIGF that the language is not necessary given the long-standing case law and adding the language could create some ambiguity and litigation.

6. Any Other Important Information

As the Part A. Laws and Regulations of the NAIC Financial Regulation Standards and Accreditation Program only requires a regulatory framework such as contained in the NAIC's model acts on guaranty funds, the newly revised Property and Casualty Insurance Guaranty Association Model Act should not require a request to the Financial Regulation Standards and Accreditation (F) Committee to amend an accreditation standard.

INSURER RECEIVERSHIP MODEL ACT

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ARTICLE I. GENERAL PROVISIONS

Section 101. Construction and Purpose

A. This Act shall be cited as the Insurer Receivership Act.

B. This Act shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.

C. This Act shall be liberally construed to support the purposes stated in Subsection E.

D. All powers and authority of a receiver under this Act are cumulative and are in addition to all powers and authority that are available to a receiver under law other than this Act.

E. The purpose of this Act is the protection of the interests of insureds, claimants, creditors and the public generally through:

(1) Early detection of any potentially hazardous condition in an insurer and prompt application of appropriate corrective measures;

(2) Improved methods for conserving and rehabilitating insurers;

(3) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) Apportionment of any unavoidable loss in accordance with the statutory priorities set out in this Act;

(5) Lessening the problems of interstate receivership by facilitating cooperation among states in delinquency proceedings, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(6) Regulation of the business of insurance by the impact of the law relating to delinquency procedures and related substantive rules; and

(7) Providing for a comprehensive scheme for the receivership of insurance companies and those subject to this Act as part of the regulation of the business of insurance in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

Section 102. Conflicts of Law

This Act, Title [XXX], and the state insurance guaranty association acts constitute this state's insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail.

Section 103. Persons Covered

The provisions of this Act shall be applied to:

A. All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future, and to all persons subject to examination by the commissioner;

B. All insurers who purport to do an insurance business in this state;

C. All insurers who have insureds resident in this state;

D. All other persons organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state;

E. All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to [insert statute identification if desired];

F. All title insurance companies subject to [insert statute identification if desired];

G. All prepaid health care delivery plans [insert statute identification if desired]; and

H. [Any other specialty type insurer not covered by the general law that should be subject to this Act].

Drafting Note: In considering other specialty type insurers, special attention should be given to surety companies. They are intended to be included under this Act; but, because of the enacting state's law, may not be included in the general provisions related to the business of insurance.

Section 104. Definitions

For the purposes of this Act:

A The terms "affiliate" of, or person "affiliated" with, a specific person, "control" and "subsidiary" shall have the meanings ascribed to them in [insert citation equivalent to Section 1 of the NAIC Model Insurance Holding Company System Regulatory Act].

B. "Alien insurer" means an insurer incorporated or organized under the laws of a jurisdiction that is not a state.

C. "Commissioner" means the insurance commissioner [or the equivalent title, such as director or superintendent, utilized by the enacting state] of this state, or his or her designee, unless the context requires otherwise.

D. "Creditor" or "claimant" is a person having any claim against an insurer, whether the claim is matured or not, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

E. "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating or conserving the insurer, and any summary proceeding under Section 201.

F. "Department" means the Insurance Department of this state unless the context requires otherwise.

G. "Doing business" (including "doing insurance business" and the "business of insurance") includes, but is not limited to, any of the following acts, whether effected by mail, electronic means, or otherwise:

(1) The issuance or delivery of contracts, certificates or binders of insurance, either to persons resident in or covering a risk located in this state;

(2) The solicitation of applications for the contracts, or other negotiations preliminary to the execution of the contracts;

(3) The collection of premiums, membership fees, assessments or other consideration for the contracts;

(4) The transaction of matters subsequent to execution of the contracts and arising out of them;

(5) Operating as an insurer under a license or certificate of authority issued by the Insurance Department; or

(6) The acts identified in [cite to state unauthorized insurance act].

H. "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry. In the case of a risk retention group, the domiciliary state shall be the state in which the risk retention group is chartered as contemplated in the Liability Risk Retention Act (15 U.S.C. § 3901, *et seq*).

I. "Foreign insurer" means any insurer domiciled in another state.

J. "Formal delinquency proceeding" means any conservation, rehabilitation or liquidation proceeding.

K. (1) "General assets" includes all property of the estate that is not:

(a) Subject to a properly perfected secured claim;

(b) Subject to a valid and existing express trust for the security or benefit of specified persons or classes of persons; or

(c) Required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons.

(2) "General assets" includes all property of the estate or its proceeds in excess of the amount necessary to discharge claims described in Paragraph (1) of this subsection.

L. "Good faith" means honesty in fact and intention, and in regard to the provisions of Article VI of this Act also requires the absence of information that would lead a reasonable person in the same position to know that the insurer is financially impaired or insolvent, together with the absence of knowledge regarding the imminence or pendency of any delinquency proceeding against the insurer.

M. "Guaranty association" means any mechanism mandated by [insert citation to guaranty association enabling acts] or a similar mechanism in another state, which is created for the payment of claims or continuation of policy obligations of financially impaired or insolvent insurers.

N. "Impaired" means that the insurer does not have admitted assets at least equal to all its liabilities together with the minimum surplus required to be maintained by [cite states insurance statutes and regulations regarding minimum capital and surplus requirements] or has a total adjusted capital that is less than its Authorized Control Level Risk Based Capital (RBC) as defined in [cite to states enactments related to the RBC Model Act, Risk RBC For Health Organizations Model Act and any related regulations].

O. "Insolvency" or "insolvent" means the insurer is unable to pay its obligations when they are due or does not have admitted assets at least equal to all its liabilities or has a total adjusted capital that is less than its Mandatory Control Level RBC as defined in [cite to state's enactments related to the RBC Model Act, RBC For Health Organizations Model Act and any related regulations]. For purposes of this Act "admitted assets" and "liabilities" will have the meanings ascribed to them and be measured in accordance with the NAIC Statements of Statutory Accounting Principles as incorporated in this state by [cite state's insurance statute incorporating the NAIC Statements of Statutory Accounting Principles].

P. "Insurer" means any person who has done, purports to do, is doing or is licensed to do the business of insurance, or is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision or conservation by, any insurance commissioner. For purposes of this Act, any other persons included under Section 103 shall be deemed to be insurers.

Q. "Netting agreement" means (1) a contract or agreement (including terms and conditions incorporated by reference therein), including a master agreement (which master agreement, together with all schedules, confirmations, definitions and addenda thereto and transactions under any thereof, shall be treated as one netting agreement), that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration or close out under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements thereunder (including liquidation or close-out values relating to such obligations or entitlements) among the parties to the netting agreement; (2) any master agreement or bridge agreement for one or more master agreements

described in Paragraph (1) of this subsection; or (3) any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in Paragraph (1) or (2) of this subsection; provided that any contract or agreement described in Paragraph (1) or (2) of this subsection relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

R. "New value" means money or money's worth in goods, services or new credit, or release by a transferee of property previously transferred to the transferee in a transaction that is neither void nor voidable by the insurer or the receiver under any applicable law, including proceeds of the property, but does not include an obligation substituted for an existing obligation.

S. "Party in interest" means the commissioner, any non-domiciliary commissioner in whose state the insurer has outstanding claims liabilities, and any of the following parties that have filed a request with the receivership court for inclusion as a party in interest and to be on the service list: an insurer that ceded to or assumed business from the insurer, a policyholder, a third party claimant, a creditor, a ten percent (10%) or greater equity security holder in the insolvent insurer, any affected guaranty association and any person, including any indenture trustee, with a financial or regulatory interest in the delinquency proceeding.

T. "Person" means individual, aggregation of individuals, partnership, corporation or other entity.

U. "Policy" means a written contract of insurance or written agreement for or effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers that are a part of the policy. For purposes of this Act, the term "policy" shall not include a contract of reinsurance.

V. "Property of the insurer" or "property of the estate" includes:

(1) All right, title and interest of the insurer in property, whether legal or equitable, tangible or intangible, choate or inchoate, and includes choses in action, contract rights, and any other interest recognized under the laws of this state;

(2) Entitlements that existed prior to the entry of an order of conservation, rehabilitation or liquidation, and entitlements that may arise by operation of the provisions of this part or other provisions of law allowing the receiver to avoid prior transfers or assert other rights; and

(3) All records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of a managing general agent, third-party administrator, management company, data processing company, accountant, attorney, affiliate or other person.

W. "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the commissioner determines by regulation, resolution or order to be a qualified financial contract for the purposes of this Act.

(1) "Commodity contract" means:

(a) A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the Commodity Exchange Act (7 U.S.C. § 1, *et seq.*) or a board of trade outside the United States;

(b) An agreement that is subject to regulation under Section 19 of the Commodity Exchange Act (7 U.S.C. § 1, *et seq.*) and that is commonly known to the commodities trade as a margin account, margin contract, leverage account or leverage contract;

(c) An agreement or transaction that is subject to regulation under Section 4c(b) of the Commodity Exchange Act (7 U.S.C. § 1, *et seq.*) and that is commonly known to the commodities trade as a commodity option;

(d) Any combination of the agreements or transactions referred to in this paragraph; or

(e) Any option to enter into an agreement or transaction referred to in this paragraph.

(2) "Forward contract," "repurchase agreement," "securities contract" and "swap agreement" shall have the meanings set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time.

Drafting Note: This definition of "qualified financial contract" is intended to be consistent with definitions applicable under federal law in instances of insolvency of other types of financial institutions. It is not the intention of this provision, or of Section 711, to affect the scope of permissible investments of insurers or the valuation thereof, or to modify any other regulatory framework applicable to investments or investment practices of insurers.

X. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Y. "Receivership" means any liquidation, rehabilitation, conservation or ancillary receivership, as the context requires.

Z. "Receivership court" refers to the court [may insert specific court] in which a delinquency proceeding is pending, unless the context requires otherwise.

AA. "Reinsurance" means transactions or contracts whereby an assuming insurer agrees to indemnify a ceding insurer against all, or a part, of any loss that the ceding insurer may sustain under the policy or policies that it has issued or will issue.

BB. "Secured claim" means a claim secured by an asset that is not a general asset, but not including special deposit claims or a claim based on mere possession. The right to set off as provided in Section 609 shall be a secured claim. A secured claim shall not include any claim arising from a constructive or resulting trust.

CC. "Special deposit" means a deposit established pursuant to statute for the security or benefit of a limited class or classes of persons.

DD. "Special deposit claim" means any claim secured by a special deposit, but does not include any claim secured by the general assets of the insurer.

EE. "State" means any state, district or territory of the United States.

FF. "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, including a setoff, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily or involuntarily, by or without judicial proceedings. The retention of a security title in property delivered to an insurer and foreclosure of the insurer's equity of redemption shall be deemed a transfer suffered by the insurer.

GG. "Unauthorized insurer" means an insurer transacting the business of insurance in this state that has not received a Certificate of Authority from this state, or some other type of authority that allows for the transaction of the business of insurance in this state.

Section 105. Jurisdiction and Venue

A. No delinquency proceeding under this Act shall be commenced by a person other than the commissioner of this state and no court shall have jurisdiction to entertain, hear or determine any delinquency proceeding commenced by any other person.

B. No court of this state shall have jurisdiction to entertain, hear or determine any complaint praying for the liquidation, rehabilitation, seizure, sequestration, conservation or receivership of any insurer, or praying for a stay or injunction or restraining order or other relief preliminary to, incidental to or relating to the proceedings other than in accordance with this Act.

C. The receivership court shall, as of the commencement of a delinquency proceeding under this Act, have exclusive jurisdiction of all property of the insurer, wherever located, including property located outside the territorial limits of the state. The receivership court shall have original but not exclusive jurisdiction of all civil proceedings arising under this Act or arising in or related to delinquency proceedings under this Act.

D. In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the [insert citation to state rules of civil procedure] or other applicable provisions of law in an action brought by the receiver:

(1) If the person served is or has been an agent, broker or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(2) If the person served is or has been an insurer or reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an intermediary, agent or broker of or for the reinsurer, or with respect to the contract, in any action on or incident to the reinsurance contract;

(3) If the person served is or has been an officer, director, manager, trustee, organizer, promoter or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(4) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

E. If the receivership court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the receivership court may enter an appropriate order to stay further proceedings on the action in this state. Except as to claims against the estate and in regard to any contracts rejected by the receiver under Section 114, nothing in this Act shall deprive a reinsurer of any contractual right to pursue arbitration. A party in arbitration may bring a claim or counterclaim against the estate, but the claim or counterclaim shall be subject to this Act.

F. Service shall be made upon the person named in the petition in accordance with the [insert state] Rules of Civil Procedure. In lieu of such service, upon application to the receivership court, service may be made in such a manner as the receivership court directs whenever it is satisfactorily shown by affidavit:

(1) In the case of a corporation, that the officers of the corporation cannot be served because they have departed from the state or have otherwise concealed themselves with intent to avoid service;

(2) In the case of an insurer whose business is conducted, at least in part, by an attorney in fact, managing general agent, or other such entity (including but not limited to, a reciprocal, Lloyd's association or inter-insurance exchange), that the individual attorney-in-fact, managing general agent, or other such entity, or its officers of the corporate attorney-in-fact cannot be served because of their departure or concealment; or

(3) In the case of a natural person, that the person cannot be served because of the person's departure or concealment.

G. All actions herein authorized shall be brought in the [identify proper court].

Drafting Note: Each state will need to consider the appropriate court and county for delinquency proceedings under this Act. In general, the venue is more appropriate if it is in the county where the office of the insurance commissioner is located. This assures expeditious and expert handling by concentrating these cases in the court with the most experience with regulatory affairs of all kinds, including insurance. An option could also be provided in the county where the principal office of the insurer is located.

H. At any time after an order is entered pursuant to Section 201, 301, 401 or 501, the commissioner or receiver may transfer the case to the county of the principal office of the person proceeded against. In the event of transfer, the court in which the proceeding was commenced shall, upon application of the commissioner or receiver, direct its clerk to transmit the court's file to the clerk of the court to which the case is to be transferred. The proceeding shall thereafter be conducted in the same manner as if it had been commenced in the court to which the matter is transferred.

I. **[Alternative 1]** No person shall be allowed to intervene in any liquidation proceeding in this state for the purpose of seeking or obtaining payment of any judgment, lien or other claim of any kind. The claims procedure set forth in this Act constitutes the exclusive means for obtaining payment of claims from the liquidation estate. Upon application to and approval by the receivership court, any guaranty association or its designated representative may intervene as a party and appear and participate in any court proceeding concerning a liquidation proceeding against an insurer if the association is or may become liable to act as a result of the liquidation proceeding. Intervention by any guaranty association or its designated representative conferred under this subsection shall not constitute grounds to establish general personal jurisdiction by the courts of this state. The intervening guaranty association or its designated representative shall be subject to the receivership court's jurisdiction for the limited purpose for which it intervenes.

[Alternative 2] No person shall be allowed to intervene in any liquidation proceeding in this state for the purpose of seeking or obtaining payment of any judgment, lien or other claim of any kind. The claims procedure set forth in this Act constitutes the exclusive means for obtaining payment of claims from the liquidation estate. Any guaranty association or its designated representative may intervene as a party as a matter of right and otherwise appear and participate in any court proceeding concerning a liquidation proceeding against an insurer if the association is or may become liable to act as a result of the liquidation proceeding. Intervention by any guaranty association or its designated representative conferred under this subsection shall not constitute grounds to establish general personal jurisdiction by the courts of this state. The intervening guaranty association or its designated representative shall be subject to the receivership court's jurisdiction for the limited purpose for which it intervenes.

[Alternative 3] No person shall be allowed to intervene in any liquidation proceeding in this state for the purpose of seeking or obtaining payment of any judgment, lien or other claim of any kind. The claims procedure set forth in this Act constitutes the exclusive means for obtaining payment of claims from the liquidation estate.

Drafting Note: States may choose Alternative 1, 2 or 3 for Subsection I depending on the ability of guaranty associations to intervene in liquidation proceedings. Alternative 1 permits guaranty associations to intervene for a limited purpose upon application to and approval by the receivership court. Alternative 2 permits intervention by guaranty associations as a matter of right, upon application to and approval by the receivership court. Alternative 3 is silent as to guaranty associations and contains the same general prohibition on intervention in liquidation proceedings as Alternatives 1 and 2.

J. The foregoing provisions of this section notwithstanding, the provisions of this Act do not confer jurisdiction on the receivership court to resolve coverage disputes between guaranty associations and those asserting claims against them resulting from the initiation of a receivership proceeding under this Act except to the extent that the guaranty association has otherwise expressly consented to the jurisdiction of the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its obligations to covered policyholders. The determination of any dispute with respect to the statutory coverage obligations of any guaranty association by a court or administrative agency or body with jurisdiction in the guaranty association's state of domicile shall be binding and conclusive as to the guaranty association's claim in the liquidation proceeding.

K. Upon the request of the receiver the receivership court [or a chief administrative judge] may order that one judge hear all cases and controversies arising out of or related to the delinquency proceeding.

L. Delinquency proceedings shall be exempt from any dormancy or similar program maintained for the early closure of civil actions.

Section 106. Exemption from Fees

The receiver shall not be required to pay any filing, recording, transcript or authentication fee to any public officer in this state.

Section 107. Notice and Hearing on Matters Submitted by the Receiver for Receivership Court Approval

A. Upon written request to the receiver, a person shall be placed on the service list to receive notice of matters filed by the receiver. It shall be the responsibility of the person requesting notice to inform the receiver in writing of any changes in his or her address, or to request that his or her name be deleted from the service list. The receiver may require that the persons on the service list provide confirmation that they wish to remain on the service list. Any person who fails to confirm his or her intent to remain on the service list may be purged from the service list. Inclusion on the service list does not confer standing in the delinquency proceeding to raise, appear or be heard on any issue.

B. Except as otherwise provided by this Act, notice and hearing of any matter submitted by the receiver to the receivership court for approval under this Act shall be conducted as follows:

(1) The receiver shall file an application explaining the proposed action, and the basis therefore. The receiver may include any evidence in support of the application. If the receiver determines that any documents supporting the application are confidential, the receiver may submit them to the receivership court under seal for *in camera* inspection.

(2) The receiver shall provide notice of the application to all persons on the service list and any other parties as determined by the receiver. Notice may be provided by first class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion. For purposes of this section, notice is deemed to be given on the date that it is deposited with the U.S. Postmaster or transmitted, as applicable, to the last known address as shown on the service list.

(3) Any party in interest objecting to the application shall file an objection specifying the grounds therefore within [insert number] days or such longer time as the court may specify of the notice of the filing of the application or such other time as the receivership court may set and shall serve copies on the receiver and any other persons served with the application within the same time period. An objecting party shall have the burden of showing why the receivership court should not authorize the proposed action.

Drafting Note: Number of days for filing objections should be consistent with the state civil procedure or receivership practice.

(4) If no objection to the application is timely filed, the receivership court may enter an order approving the application without a hearing, or hold a hearing to determine if the receiver's application should be approved. The receiver may request that the receivership court enter an order or hold a hearing on an expedited basis.

(5) If an objection is timely filed, the receivership court may hold a hearing. If the receivership court approves the application and, upon a motion by the receiver, determines that the objection was frivolous or filed merely for delay or for other improper purpose, the receivership court shall order the objecting party to pay the receiver's reasonable costs and fees of defending the action.

Drafting Note: States may utilize the term application, petition, motion or such other term that is considered appropriate in their state. The state may also incorporate its procedures under its civil rules for the briefing and hearing of applications. "Petition" should be reserved for the initiation of delinquency proceedings.

Section 108. Injunctions and Orders

A. The receivership court may issue any order, process or judgment, including stays or injunctions or other orders necessary or appropriate to carry out the provisions of this Act or an approved rehabilitation plan.

B. No provision of this Act shall be construed to limit the ability of the receiver to apply to a court other than the receivership court in any jurisdiction to carry out any provision of this Act or for the purpose of pursuing claims against any person.

C. Except as provided in Subsections E and F or as otherwise provided in this Act the commencement of a delinquency proceeding under this Act operates as a stay, applicable to all persons, of:

(1) The commencement or continuation, including the issuance or employment of process, of a judicial, administrative or other action or proceeding against the insurer, including an arbitration proceeding, that was or could have been commenced before the commencement of the delinquency proceeding under this Act, or to recover a claim against the insurer that arose before the commencement of the delinquency proceeding under this Act;

(2) The enforcement against the insurer or against property of the insurer of a judgment obtained before the commencement of the delinquency proceeding under this Act;

(3) Any act to obtain or retain possession of property of the insurer or of property from the insurer or to exercise control over property or records of the insurer;

(4) Any act to create, perfect or enforce any lien against property of the insurer;

(5) Any act to collect, assess or recover a claim against the insurer that arose before the commencement of a delinquency proceeding under this Act;

(6) The commencement or continuation of an action or proceeding against a reinsurer of the insurer, by the holder of a claim against the insurer, seeking reinsurance recoveries that are contractually due to the insurer;

(7) The commencement or continuation of an action or proceeding by a governmental unit to terminate or revoke an insurance license; and

(8) Termination, failure to renew, suspension of performance, declaration of default, demand for additional, substitute, or replacement security or performance, or other adverse action, with respect to any contract, agreement, or lease (including but not limited to policies, insurance and reinsurance contracts, surety bonds, or surety undertakings), whether or not the insurer is a party to the contract, agreement, lease, policy, bond, or undertaking, if the sole basis for the termination, failure to renew, suspension of performance, declaration of default, demand for additional, substitute, or replacement security or performance, or other adverse action is (i) the fact that the insurer is the subject of delinquency proceedings, and/or (ii) the fact that one or more of the insurer's licenses have been suspended or revoked because the insurer is the subject of delinquency proceedings.

D. Except as provided in Subsections E and F or as otherwise provided in this Act, the commencement of a delinquency proceeding under this Act operates as a stay, applicable to all persons, of the commencement or continuation, including the issuance or employment of process, of a judicial, administrative or other action or proceeding, including without limitation the enforcement of any judgment, against any insured that was or could have been commenced before the commencement of the delinquency proceeding under this Act, or to recover a claim against the insured that arose before or after the commencement of the delinquency proceeding under this Act and for which the insurer is or may be liable under a policy of insurance or is obligated to defend a party. The stay provided by this subsection shall terminate ninety (90) days after appointment of the receiver unless extended by order of the receivership court, for good cause shown, after notice to any affected parties and such hearing as the receivership court determines is appropriate; provided, however, that any applicable statute of limitation with respect to any claim against an insured shall be tolled during the period of the stay provided by this subsection and any extensions.

E. Notwithstanding Subsection C, the commencement of a delinquency proceeding under this Act does not operate as a stay or prohibition of:

(1) Except as provided in Subsection C(7), regulatory actions by the commissioners of non-domiciliary states, including, but not limited to the suspension of licenses;

(2) Criminal actions;

(3) Any act to perfect, or to maintain or continue the perfection of, an interest in property to the extent the act is accomplished within any relation back period under applicable law;

(4) Setoff as permitted by Section 609;

(5) Pursuit and enforcement of non-monetary governmental claims, judgments and proceedings;

(6) Presentment of a negotiable instrument and the giving of notice of and protesting dishonor of the instrument;

(7) Enforcement of rights against single beneficiary trusts established pursuant to and in compliance with [cite to the credit for reinsurance law];

(8) Any right to cause the netting, liquidation, setoff, termination, acceleration or close out of obligations, or enforcement of any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation, under or in connection with any netting agreement or qualified financial contract as provided for in Section 711;

(9) Discharge by the guaranty association of statutory responsibilities under any applicable guaranty association act; or

(10) Any of the following actions:

(a) An audit by a governmental unit to determine tax liability;

(b) The issuance to the insurer by a governmental unit of a notice of tax deficiency;

(c) A demand for tax returns; or

(d) The making of an assessment for any tax and issuance of a notice and demand for payment of the assessment.

F. Except as provided in Subsection H:

(1) The stay of an act against property of the insurer under Subsection C continues until the property is no longer property of the receivership estate;

(2) The stay of any other act under Subsection C continues until the earlier of:

(a) The time the delinquency proceeding is closed; or

(b) The time the delinquency proceeding is dismissed.

G. Notwithstanding the provision of Subsection C, but only to the extent not inconsistent with Section 609, claims against the insurer that arose before the commencement of the delinquency proceeding under this Act may be asserted as a counterclaim in any judicial, administrative or other action or proceeding initiated by or on behalf of the receiver against the holder of the claims.

H. On request of a party in interest and after notice and such hearing as the receivership court determines appropriate, the receivership court may grant relief from the stay of Subsections C or D, such as by terminating, annulling, modifying or conditioning the stay:

(1) For cause; or

(2) With respect to a stay of an act against property under Subsection C if:

(a) The insurer does not have any equity in the property; and

(b) The property is not necessary to an effective plan.

(3) For the purposes of this section, "cause" includes, but is not limited to, if (a) the receiver cancels a policy, a surety bond, or a surety undertaking, and (b) the creditor is entitled, by contract or law, to require the insured or the principal to have a policy, a surety bond, or a surety undertaking, and (c) the insured or the principal fails to obtain a replacement policy, surety bond, or surety undertaking within the later of thirty (30) days from the date of cancellation or the time permitted by contract or law.

I. In any hearing under Subsection H, the party seeking relief from the stay shall have the burden of proof on each issue, which shall be established by clear and convincing evidence.

J. The estate of an insurer that is injured by any willful violation of a stay provided by this section shall be entitled to actual damages, including costs and attorneys' fees, and, in appropriate circumstances, the receivership court may impose additional sanctions.

K. Notwithstanding any other provision of law, no bond shall be required of the commissioner or receiver in relation to any stay or injunction under this section.

Section 109. Statutes of Limitation

A. If applicable law, an order, or an agreement fixes a period within which the insurer may commence an action, and this period has not expired before the date of the filing of the initial petition in a delinquency proceeding, the receiver shall not by reason thereof be barred from commencing such an action if the receiver does so on or before the later of:

(1) The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

(2) Four (4) years after the entry of the most recent receivership order.

B. Except as provided in Subsection A, if applicable law, an order or an agreement fixes a period within which the insurer may file any pleading, demand, notice, or proof of claim or loss, or cure a default in a case or proceeding, or perform any other similar act, and the period has not expired before the date of the filing of the petition initiating formal delinquency proceedings, the receiver shall not by reason thereof be barred from filing, curing or performing, as the case may be, if the receiver does so on or before the later of:

(1) The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

(2) Sixty (60) days after the entry of the most recent receivership order.

C. If applicable law, an order or an agreement fixes a period for commencing or continuing a civil action in a court other than the receivership court on a claim against the insurer, and the period has not expired before the date of the filing of the initial petition in a delinquency proceeding, then the period does not expire until the later of:

(1) The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

(2) Thirty (30) days after termination or expiration of the stay pursuant to this section with respect to the claim.

Section 110. Cooperation of Officers, Owners and Employees

A. Any present or former officer, manager, director, trustee, owner, employee or agent of an insurer, or any other person with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner or receiver in any proceeding under this Act or any investigation preliminary to the proceeding. The term "person" as used in this section, shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(1) To reply promptly in writing to any inquiry from the commissioner or receiver requesting a reply; and

(2) To promptly make available to the commissioner or receiver any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his or her possession, custody or control.

B. No person shall obstruct or interfere with the commissioner or receiver in the conduct of any delinquency proceeding or any preliminary or incidental investigation.

C. This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

D. Any person included within Subsection A who fails to cooperate with the commissioner or receiver, or any person who obstructs or interferes with the commissioner or receiver in the conduct of any delinquency proceeding or any preliminary or incidental investigation, or who violates any order validly issued under this Act, may:

(1) Be sentenced to pay a fine not exceeding $10,000 or to undergo imprisonment for a term of not more than one year, or both; or

(2) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed $10,000 and shall be subject further to the revocation or suspension of any insurance licenses issued by the commissioner.

Section 111. Delinquency Proceedings Commenced Prior to Enactment

Drafting Note: States may draft any provision with regard to application as to existing estates as long as this Act is applicable in its entirety to new delinquency proceedings. States may provide that this Act will apply to pending delinquency proceedings retrospectively with regard to procedural matters and prospectively with regard to the substantive rights of persons.

[Alternative 1] The provisions of this Act shall be applicable to proceedings instituted prior to the effective date of this Act. The provisions of this section shall not affect any final judgment or order entered by a court of competent jurisdiction prior to the effective date of this Act.

[Alternative 2] The provisions of this Act shall be applicable to proceedings instituted prior to the effective date of this Act. The provisions of this section shall not affect any final judgment or order entered by a court of competent jurisdiction prior to the effective date of this Act. Provided that claims against insurers under formal delinquency proceedings prior to the effective date of this Act shall be adjudicated under the law in effect prior to the effective date of this Act.

[Alternative 3] The provisions of this Act shall not apply to proceedings initiated prior to its effective date, unless the court, on motion of the commissioner, and after notice and hearing and for good cause shown, directs that all or any part of this Act shall be applicable to such proceedings.

Drafting Note: States that do not have *Fabe* cure legislation (proposed as a result of *United States Dept. of Treasury v. Fabe*, 608 U.S. 491 (1993)) enacted prior to the proposed effective date of this Act should adopt the *Fabe* cure legislation prior to the proposed effective date of this Act or should otherwise take steps to ensure that the *Fabe* cure is applied in open estates.

[Provision that may be added to Alternative 1, 2 or 3] Litigation filed in any court of competent jurisdiction under [cite to sections of prior law applicable to asset recovery in formal delinquency proceedings] shall be concluded as though [cite to sections of prior law applicable to asset recovery in formal delinquency proceedings] had not been repealed. Prior sections regarding insurer receiverships will sunset and be fully repealed after all asset recovery actions under proceedings filed in any court of competent jurisdiction prior to the effective date of this Act have been concluded.

Section 112. Actions By and Against the Receiver

A. An allegation by the receiver of improper or fraudulent conduct against any person shall not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party, but the third party is not barred by this section from seeking to establish independently as a defense that the conduct was materially and substantially related to the contractual obligation for which enforcement is sought.

B. No prior wrongful or negligent actions of any present or former officer, manager, director, trustee, owner, employee or agent of the insurer may be asserted as a defense to a claim by the receiver under a theory of estoppel, comparative fault, intervening cause, proximate cause, reliance, mitigation of damages or otherwise; except that the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract and a principal under a surety bond or a surety undertaking shall be entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that the receiver has possession or control of the property or the insurer or its agents misappropriated (including, but not limited to, commingling) such property. Evidence of fraud in the inducement will be admissible only if it is contained in the records of the insurer.

C. No action or inaction by the insurance regulatory authorities may be asserted as a defense to a claim by the receiver.

D. A judgment or order entered against an insured or the insurer in contravention of any stay or injunction under this Act, or at any time by default or collusion, shall not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

E. The provisions of Subsection D do not apply to guaranty associations' claims for amounts paid on settlements and judgments in pursuit of their statutory obligations.

F. The receiver shall not be deemed a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Section 113. Unrecorded Obligations and Defenses Of Affiliates

A. In any proceeding or claim by the receiver, no affiliate, controlled or controlling person, or present or former officer, manager, director, trustee or shareholder of the insurer may assert any defense, unless evidence of the defense was recorded in the books and records of the insurer at or about the time the events giving rise to the defense occurred and, if required by statutory accounting practices and procedures, was timely reported on the insurer's official financial statements filed with the [insert state regulatory official].

B. No affiliate, controlled or controlling person, or present or former officer, manager, director, trustee or shareholder of the insurer may assert any claim**,** unless the obligations were recorded in the books and records of the insurer at or about the time the obligations were incurred and, if required by statutory accounting practices and procedures, were timely reported on the insurer's official financial statements filed with the [insert state regulatory official].

C. Claims by the receiver against any affiliate, controlled or controlling person, or present or former officer, manager, director, trustee or shareholder of the insurer based on unrecorded or unreported transactions shall not be barred by this section.

Section 114. Executory Contracts

A. The receiver may assume or reject any executory contract or unexpired lease of the insurer.

B. If there has been a default in an executory contract or unexpired lease of the insurer, the receiver may not assume the contract or lease unless, at the time of the assumption of the contract or lease, the receiver:

(1) Cures or provides adequate assurance that the receiver will promptly cure the default; and

(2) Provides adequate assurance of future performance under the contract or lease.

C. Subsection B does not apply to a default that is a breach of a provision relating to:

(1) The insolvency or financial condition of the insurer at any time before the closing of the delinquency proceeding;

(2) The appointment of or taking possession by a receiver in a case under this Act or a custodian before the commencement of the delinquency proceeding; or

(3) The satisfaction of any penalty rate or provision relating to a default arising from any failure of the insurer to perform non-monetary obligations under the executory contract or unexpired lease.

D. A claim arising from the rejection, under this section or under a plan of rehabilitation or liquidation, of an executory contract or unexpired lease of the insurer that has not been assumed shall be determined, and shall be treated and classified as though the claim had arisen before the date of the filing of a successful petition commencing the delinquency proceeding.

Section 115. Immunity and Indemnification of the Receiver and Assistants

[Alternative 1]

A. For the purposes of this section, the persons entitled to immunity and indemnification, and those entitled to only immunity, as applicable, are:

(1) All present and former receivers responsible for the conduct of a delinquency proceeding under this Act;

(2) All of the receiver's present and former assistants. For purposes of this section, "receiver's assistants" shall be defined to include the following:

(a) All present and former special deputies and assistant special deputies engaged by contract or otherwise;

(b) All persons whom the receiver, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this Act; and

(c) Any state employees acting with respect to a delinquency proceeding under this Act; and

(3) All of the receiver's present and former contractors. For purposes of this section, "receiver's contractors" shall be defined to include all persons with whom the receiver, special deputies or assistant special deputies have contracted to assist in a delinquency proceeding under this Act, e.g. attorneys, accountants, auditors, actuaries, investment bankers, financial advisors, and any other professionals or firms who are retained or contracted with by the receiver as independent contractors and all employees of the contractors.

B. The receiver, the receiver's assistants, and the receiver's contractors shall have immunity under this Act, as follows:

(1) The receiver, the receiver's assistants, and the receiver's contractors shall have official immunity and shall be immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error or omission of the receiver or any assistant or contractor arising out of or by reason of their duties or employment.

(2) In addition, the receiver, the receiver's assistants, and the receiver's contractors shall have absolute judicial immunity and shall be immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error or omission of the receiver, assistant or contractor arising out of or by reason of any matters that have been subject to review by the receivership court after notice and opportunity to be heard, provided that the alleged act, error or omission was not disapproved or disallowed by the receivership court.

(3) Nothing in this Act shall be construed to provide official immunity or judicial immunity or to otherwise hold the receiver or any assistant or contractor immune from suit and liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of the receiver, any assistant or contractor.

C. The receiver and the receiver's assistants shall be entitled to indemnification under this Act, as follows:

(1) If any legal action is commenced against the receiver or any assistant, whether against the receiver or assistant personally or in their official capacity, alleging property damage, property loss, personal injury or other civil liability caused by or resulting from any alleged act, error or omission of the receiver or any assistant arising out of or by reason of their duties or employment, the receiver and any assistant shall be indemnified from the assets of the insurer for all expenses, attorneys' fees, judgments, settlements, decrees or amounts due and owing or paid in satisfaction of or incurred in the defense of the legal action unless it is determined upon a final adjudication on the merits that the alleged act, error or omission of the receiver or assistant giving rise to the claim did not arise out of or by reason of their duties or employment, or was caused by intentional or willful and wanton misconduct.

(2) Attorneys' fees and any and all related expenses incurred in defending a legal action for which immunity or indemnity is available under this section shall be paid from the assets of the insurer, as they are incurred, in advance of the final disposition of the action upon receipt of an agreement by or on behalf of the receiver or assistant to repay the attorneys' fees and expenses if it shall ultimately be determined upon a final adjudication on the merits that the receiver or assistant is not entitled to immunity or indemnity under this section.

(3) Any indemnification for expense payments, judgments, settlements, decrees, attorneys' fees, surety bond premiums or other amounts paid or to be paid from the insurer's assets pursuant to this section shall be an administrative expense of the insurer.

(4) In the event of any actual or threatened litigation against a receiver or any assistant for which immunity or indemnity may be available under this section, a reasonable amount of funds which in the judgment of the receiver may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer as security for the payment of indemnity until all applicable statutes of limitation shall have run and all actual or threatened actions against the receiver or any assistant have been completely and finally resolved, and all obligations under this section shall have been satisfied.

(5) In lieu of segregation and reserving of funds, the receiver may, in the receiver's discretion, obtain a surety bond or make other arrangements that will enable the receiver to fully secure the payment of all obligations under this section.

(6) If any legal action against an assistant for which indemnity may be available under this section is settled prior to final adjudication on the merits, the receiver shall pay the settlement amount on behalf of the assistant, or indemnify the assistant for the settlement amount, unless the receiver determines:

(a) That the claim did not arise out of or by reason of the assistant's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the assistant.

(7) In any legal action in which a claim is asserted against the receiver, that portion of any settlement relating to the alleged act, error or omission of the receiver shall be subject to the approval of the receivership court. The receivership court shall not approve that portion of the settlement if it determines:

(a) That the claim did not arise out of or by reason of the receiver's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the receiver.

D. Nothing contained or implied in this section shall operate, or be construed or applied to deprive the receiver, the receiver's assistants or receiver's contractors of any immunity, indemnity, benefits of law, rights or any defense otherwise available.

E. The immunity and indemnification provided to the receiver's assistants and the immunity provided to the receiver's contractors under this section shall not apply to any action by the receiver against such person.

F. Subsection B shall apply to any suit based in whole or in part on any alleged act, error or omission that takes place on or after the effective date of this Act.

G. No legal action shall lie against the receiver or any assistant based in whole or in part on any alleged act, error or omission that took place prior to the effective date of this Act, unless suit is filed and valid service of process is obtained within twelve (12) months after the effective date of this Act.

H. Subsection C shall apply to any suit that is pending on or filed after the effective date of this Act without regard to when the alleged act, error or omission took place.

Drafting Note: If state law provides for a self-insurance program that affords protection that is substantially similar to the provisions of Section 115, the state may utilize the program for indemnification purposes and corresponding immunity provisions in lieu of Section 115.

[Alternative 2] There shall be no liability on the part of, and no cause of action of any nature shall arise against, the department or its employees, the commissioner, in his or her capacity as receiver or otherwise, a special deputy, the receiver's assistants or the receiver's contractors for any action taken by them in performance of their powers and duties under this Act.

Section 116. Approval and Payment of Expenses

A. The receiver may pay any expenses under contracts, leases, employment agreements or other arrangements entered into by the insurer prior to receivership, as he or she deems necessary for the purposes of this Act. The receiver is not required to pay any such expenses that he or she determines are not necessary and may reject any contract pursuant to Section 114.

B. Receivership expenses other than those described in Subsection A shall be paid as follows:

(1) The receiver shall submit an application pursuant to Section 107 to the receivership court to approve:

(a) The terms of compensation of each special deputy or contractor where the total amount of the compensation is reasonably expected by the receiver for the duration of the delinquency proceeding to exceed an amount established by the receivership court; and

(b) Any other anticipated expense in excess of an amount established by the receivership court.

(2) The receiver may, as the receiver deems appropriate, submit an application to approve any compensation, anticipated expenses or incurred expenses not described in Paragraph (1).

(3) The receiver may pay as incurred any expenses not requiring receivership court approval and any expenses approved in the rehabilitation or liquidation order.

(4) The approval of expenses by the receivership court shall not prejudice the right of the receiver to seek any recovery, recoupment, disgorgement or reimbursement of fees based on contract or causes of action recognized in law or in equity.

C. On an annual or more frequent basis, the receiver shall submit to the receivership court a report summarizing the expenses incurred in the prior period.

D. Receivership court approval shall not be required to pay expenses incurred by the receiver in connection with the appeal of an order of the receivership court.

E. **[Alternative 1]** All expenses of receivership shall be paid from the assets of the insurer, except as provided in this subsection. In the event that the insurer does not have sufficient cash or liquid assets to defray the expenses incurred, the commissioner may advance funds out of any appropriation for the maintenance of the insurance department. Any amounts advanced shall be repaid to the commissioner out of the first available moneys of the insurer.

[Alternative 2] All expenses of receivership shall be paid from the assets of the insurer, except as provided in this subsection. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the expenses incurred, the commissioner may advance funds from the account established under Subsection 804C. Any amounts advanced shall be repaid to the account out of the first available moneys of the insurer.

Drafting Note: States may utilize the term "application", "motion" or such other term that is considered appropriate in their state.

Drafting Note: Alternative 2 is only appropriate if Alternative 1 to Section 804 is enacted.

Section 117. Financial Reporting

A. Within 180 days after the entry of an order of receivership by the receivership court, and at least quarterly thereafter, the receiver shall comply with all requirements for receivership financial reporting as specified by the National Association of Insurance Commissioners. The financial reports shall include, at a minimum, a statement of the assets and liabilities of the insurer, the changes in those assets and liabilities and all funds received or disbursed by the receiver during that reporting period. These reports will also be filed with the receivership court. The receiver may qualify any financial report or provide notes to the financial statement for further explanation. The receivership court may order the receiver to provide such additional information as it deems appropriate.

B. Within 180 days after the entry of an order of liquidation by the receivership court, and at least quarterly thereafter, or at such other intervals as may be agreed to between the liquidator and the guaranty associations, but in no event less than annually, each affected guaranty association shall file reports with the liquidator. The reports shall be in a format compatible to that specified by the National Association of Insurance Commissioners. These reports also shall be filed with the receivership court.

C. For good cause shown, the receivership court may grant relief for an extension or modification of time to comply with Subsection A or B above or such other relief as may be appropriate.

Section 118. Records

A. Upon entry of an order of conservation, rehabilitation or liquidation, the receiver shall be vested with title to all of the books, documents, papers, policy information, claim files and all other records of the insurer of whatever nature, in whatever medium and wherever located, regardless of whether the records are in the custody and control of third-party administrators, managing general agents, attorneys or other representatives of the insurer. The receiver may immediately take possession and control of all of the records of the insurer, and of the premises where the records are located. Third-party administrators, managing general agents, attorneys and other representatives of the insurer shall release all such records to the receiver, or to the receiver's designee, at the request of the receiver. The guaranty associations that have or may have obligations under policies issued by the insurer have the right, with the receiver's approval, to take necessary actions to obtain directly from any third-party administrator, managing general agent, attorney or other representative of the insurer all records pertaining to the insurer's business that are appropriate or necessary for the guaranty associations to fulfill their statutory obligations.

B. The receiver shall have the authority to certify the records of a delinquent insurer described in Subsection A and the records of the receiver's office created and maintained in connection with a delinquent insurer, as follows:

(1) Records of a delinquent insurer may be certified by the receiver in an affidavit stating that the records are true and correct copies of records of the insurer that were received from the custody of the insurer, or found among its effects.

(2) Records created by or filed with the receiver's office in connection with a delinquent insurer may be certified by the receiver's affidavit stating that the records are true and correct copies of records maintained by the receiver's office.

C. Original books, documents, papers, and other records, or copies thereof certified under Subsection B, when admitted in evidence shall be *prima facie* evidence of the facts disclosed and shall be admissible in evidence in the same manner as documents certified pursuant to [insert citation to state equivalent of F.R.E. 902(1)]. Certification of records by the receiver pursuant to this section shall be deemed to satisfy the requirements of [insert citation to state equivalent of F.R.E. 803(6)] and such records shall not be subject to objection under the hearsay rule.

D. The records of a delinquent insurer held by the receiver shall not be considered as records of the Department of Insurance for any purposes, and the [insert citation to public records act] shall not apply to these records.

ARTICLE II. PROCEEDINGS

Section 201. Receivership Court's Seizure Order

A. The commissioner may file in the [insert proper court] court of this state a petition with respect to an insurer domiciled in this state, an unauthorized insurer or, pursuant to Section 1001, a foreign insurer:

(1) Alleging that there exist grounds that would justify a court order for a formal delinquency proceeding against the insurer under this Act;

(2) Alleging that the interests of policyholders, creditors or the public will be endangered by delay; and

(3) Setting forth the contents of a seizure order deemed necessary by the commissioner.

B. Upon a filing under Subsection A, the receivership court may issue forthwith, *ex parte* and without notice or hearing, the requested seizure order, which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents and other records of an insurer, and of the premises occupied by it for transaction of its business, and until further order of the receivership court enjoin the insurer and its officers, managers, agents and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner. Any person having possession or control of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued shall be guilty of a misdemeanor and punishable by a fine not exceeding $1,000 or imprisonment not exceeding one year, or both fine and imprisonment.

C. Any petition that prays for injunctive relief shall be verified by the commissioner or the commissioner's designee, but need not plead or prove irreparable harm or inadequate remedy at law. The commissioner shall provide only such notice as the receivership court may require.

D. The receivership court shall specify in the seizure order what its duration shall be, which shall be the time the receivership court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of the commissioner or the insurer or on its own motion, the receivership court may from time to time hold such hearings as it deems desirable after the notice as it deems appropriate, and may extend, shorten or modify the terms of the seizure order. The receivership court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this Act after having had a reasonable opportunity to do so. An order of the receivership court pursuant to a formal proceeding under this Act shall vacate the seizure order.

E. Entry of a seizure order under this section shall not constitute a breach or an anticipatory breach of any contract of the insurer.

F. An insurer subject to an *ex parte* seizure order under this section may petition the receivership court at any time after the issuance of a seizure order for a hearing and review of the seizure order. The receivership court shall hold the hearing and review not more than fifteen (15) days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

G. If, at any time after the issuance of a seizure order, it appears to the receivership court that any person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person. An order that notice be given shall not stay the effect of any seizure order previously issued by the receivership court.

H. Whenever the commissioner makes any seizure as provided in Subsection B, on the demand of the commissioner, it shall be the duty of the sheriff of any county of this state, and of the police department of any municipal corporation therein to furnish the commissioner with necessary deputies, patrolmen or officers to assist the commissioner in making and enforcing the seizure order.

Section 202. Commencement of Formal Delinquency Proceeding

A. Any formal delinquency proceeding against a person shall be commenced by filing a petition in the name of the commissioner or department.

B. The petition shall state the grounds upon which the proceeding is based and the relief requested, and may include a prayer for restraining orders and injunctive relief as described in Section 108. Upon the filing of the petition, a notice thereof shall be forwarded by first class mail or electronic communication as permitted by the receivership court to the commissioners and guaranty associations in states in which the insurer did business.

C. Any petition that prays for injunctive relief shall be verified by the commissioner or the commissioner's designee, but need not plead or prove irreparable harm or inadequate remedy at law. The commissioner shall provide only such notice as the receivership court may require.

D. If any temporary restraining order is prayed for:

(1) The receivership court may issue an initial order containing the relief requested;

(2) The order shall state the time and date of its issuance;

(3) The receivership court shall set a time and date for the return of summons, not more than ten (10) days from the time and date of the issuance of the initial order, at which time the person proceeded against may appear before the receivership court for a summary hearing; and

(4) The order shall not continue in effect beyond the time and date set for the return of summons, unless the receivership court shall expressly enter one or more orders extending the restraining order.

E. If no temporary restraining order is requested, the receivership court shall cause summons to be issued. The summons shall specify a return date not more than thirty (30) days after issuance and that an answer must be filed at or before the return date.

Section 203. Return of Summons and Summary Hearing

A. The receivership court shall hold a summary hearing at the time and date for the return of summons on a petition to commence a formal delinquency proceeding.

B. If a person is not served with summons on a petition to commence a formal delinquency proceeding and fails to appear for the summary hearing, the receivership court shall:

(1) Continue the summary hearing not more than ten (10) days;

(2) Provide for alternative service of summons upon the person; and

(3) Extend any restraining order.

C. Upon a showing of good faith efforts to effect personal service upon a person who has failed to appear for a continued summary hearing, the receivership court shall order notice of the petition to commence a formal delinquency proceeding to be published. The order and notice shall specify a return date not less than ten (10) nor more than twenty (20) days after the publication and that the restraining order has been extended to the continued hearing date.

D. If a person fails to appear for a summary hearing on a petition to commence a formal delinquency proceeding after service of summons, the receivership court shall enter judgment in favor of the commissioner against that person.

E. (1) A person who appears for the summary hearing on a petition to commence a formal delinquency proceeding shall file its answer at the hearing and the receivership court shall:

(a) Determine whether to extend any temporary restraining orders pending final judgment; and

(b) Set the case for trial on a date not more than ten (10) days from the summary hearing.

(2) The receivership court shall grant no continuance for filing an answer.

Section 204. Proceedings for Expedited Trial: Continuances, Discovery, Evidence

A. The receivership court shall proceed to hear the case on the petition to commence a formal delinquency proceeding at the time and date set forth for trial without a jury and without unnecessary delays. To the extent practicable, the receivership court shall give precedence to the matter over all other matters. To the extent authorized by law, the receivership court may assign the matter to other judges if necessary to comply with the need for expedited proceedings under this Act.

B. Continuances for trial shall be granted only in extreme circumstances.

C. The receivership court shall admit as self-authenticated any of the following when offered by the commissioner:

(1) Certified copies of the financial statements made by the insurer or an affiliate;

(2) Certified copies of examination reports of the insurer or an affiliate made by or on behalf of the commissioner;

(3) Certified copies of any other document filed with any insurance department by the insurer or an affiliate.

D. The facts contained in any examination report of the insurer or an affiliate made by or on behalf of the commissioner shall be presumed to be true as of the date of the hearing if the examination was made as of a date not more than 270 days before the petition was filed. The presumption shall be rebuttable and shall shift the burden of production and persuasion to the insurer.

E. Discovery shall be limited to grounds alleged in the petition, and shall be concluded on an expedited basis.

Section 205. Decision and Appeals

A. The receivership court shall enter judgment on the petition to commence formal delinquency proceeding within fifteen (15) days after the conclusion of the evidence.

B. Any order entered pursuant to Subsection A shall be final when entered. Any appeal shall be handled on an expedited basis and shall be taken within five (5) days of entry of the judgment.

C. Absent entry of an order staying the order pursuant to Subsection D, the order shall be of full force and effect and the receiver shall carry out its terms and the provisions of this Act. No request for reconsideration, review or appeal, and no posting of a bond, shall dissolve or stay the judgment.

D. A motion for a stay of the judgment, for approval of a supersede as bond or for other relief pending appeal must be presented to the receivership court in the first instance. Subject to the power of the appropriate appellate courts, the receivership court may suspend or otherwise modify an order entered under Subsection A or make any other appropriate order governing the enforceability of such order during the pendency of an appeal on such terms as will protect the rights of all parties in interest.

E. The receivership court or any appellate court to which the matter is presented may condition any relief it grants under Subsection D on the filing of a bond or other appropriate security with the receivership court.

F. The provisions of Section 115 shall apply to all acts taken during the pendency of an appeal regardless of its ultimate disposition.

G. The reversal or modification on appeal of an order of conservation, rehabilitation or liquidation does not affect the validity of the acts of the receiver pursuant to the order unless the order is stayed pending appeal.

Section 206. Confidentiality

A. In all proceedings and judicial reviews under Section 201, all records of the insurer, department files, court records and papers, and other documents, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential, and all papers filed with the clerk of the [insert proper court] court shall be held by the clerk in a confidential file as permitted by law, except to the extent necessary to obtain compliance with any order entered in connection with the proceedings, unless and until:

(1) The [insert proper court] court, after hearing argument in chambers, shall order otherwise;

(2) The insurer requests that the matter be made public; or

(3) The commissioner applies for an order under Section 207.

B. The commissioner, conservator or rehabilitator may share documents, materials or other information in the possession, custody or control of the department, pertaining to an insurer that is the subject of a delinquency proceeding under this Act, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, with an auditor appointed by the receivership court in accordance with Section 905, with representatives of guaranty associations that may have statutory obligations as a result of the insolvency of the insurer provided that the recipient agrees to maintain the confidentiality of the documents, material or other information. In the event that the domiciliary receiver believes that certain information is sensitive, the receiver may share that information subject to a continuation of the confidentiality obligations beyond the period allowed in Subsection D. Nothing in this section shall limit the power of the commissioner to disclose information under other applicable law.

C. A domiciliary receiver shall permit a commissioner of another state or a guaranty association to obtain a listing of policyholders and certificate holders residing in the requestor's state, including current addresses and summary policy information, provided that the commissioner of another state or the guaranty association agrees to maintain the confidentiality of the records, and agrees that the records will be used only for regulatory or guaranty association purposes. Access to records may be limited to normal business hours. In the event that the domiciliary receiver believes that certain information is sensitive and disclosure might cause a diminution in recovery, the receiver may apply for a protective order imposing additional restrictions on access.

D. The confidentiality obligations imposed by this section shall end upon the entry of an order of liquidation against the insurer, unless otherwise agreed to by the parties or pursuant to an order of the receivership court. Any continuation of confidentiality as provided in Subsection B shall not apply to any insurer records necessary for the guaranty associations to discharge their statutory responsibilities.

E. No waiver of any applicable privilege or claim of confidentiality shall occur as a result of any disclosure, or any sharing of documents, materials or other information, made pursuant to this section.

Section 207. Grounds for Conservation, Rehabilitation or Liquidation

The commissioner may file in the [insert proper court] court of this state a petition with respect to an insurer domiciled in this state or an unauthorized insurer for an order of conservation, rehabilitation or liquidation on any one or more of the following grounds:

A. The insurer is impaired;

B. The insurer is insolvent;

C. The insurer is about to become insolvent. An insurer is about to become insolvent for purposes of this section if it is reasonably anticipated that the insurer will not have liquid assets to meet its next ninety (90) days' current obligations;

D. The insurer has neglected or refused to comply with an order of the commissioner to make good within the time prescribed by law any deficiency, whenever its capital and minimum required surplus, if a stock company, or its surplus, if a company other than stock, has become impaired;

E. The insurer, its parent company, its subsidiaries or its affiliates have converted, wasted or concealed property of the insurer, or otherwise improperly disposed of, dissipated, used, released, transferred, sold, assigned, hypothecated or removed the property of the insurer;

F. The insurer is in such condition that it could not meet the requirements for organization and authorization as required by law, except as to the amount of the original surplus required of a stock company under Section [insert proper section], and except as to the amount of the surplus required of a company other than a stock company in excess of the minimum surplus required to be maintained;

G. The insurer, its parent company, its subsidiaries or its affiliates have concealed, removed, altered, destroyed or failed to establish and maintain books, records, documents, accounts, vouchers and other pertinent material adequate for the determination of the financial condition of the insurer by examination under Section [insert citation to examination authority statute in state's general insurance laws], or has failed to properly administer claims or maintain claims records that are adequate for the determination of its outstanding claims liability;

H. At any time after the issuance of an order under Section [insert citation to corrective orders statute in state's general insurance laws], or at the time of instituting any proceeding under this Act, it appears to the commissioner that upon good cause shown, it would not be in the best interest of the policyholders, creditors or the public to proceed with the conduct of the business of the insurer;

I. The insurer is in such condition that the further transaction of business would be hazardous financially, according to [insert citation to state's enactment of the NAIC Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition] or otherwise, to its policyholders, creditors or the public;

J. There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's property, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer;

K. Control of the insurer is in a person who is dishonest, untrustworthy or so lacking in insurance company managerial experience or capability as to be hazardous to policyholders, creditors or the public;

L. Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, shareholder, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere; or if examined under oath refuses to divulge pertinent information reasonably known to the person; and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his or her influence on management;

M. After demand by the commissioner under Section [cite examination law] or under this Act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer;

N. Without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to Sections [cite holding company law] or [cite bulk reinsurance law], substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person;

O. The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state;

P. Within the previous five (5) years the insurer has willfully and continuously violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner;

Q. The insurer has failed to pay within sixty (60) days after the due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter except that nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts;

R. The insurer has systematically engaged in the practice of reaching settlements with and obtaining releases from claimants, and then unreasonably delaying payment, or failing to pay the agreed-upon settlements, or systematically attempted to compromise with claimants or other creditors on the ground that it is financially unable to pay its claims or obligations in full;

S. The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law;

T. The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in Section 103, request or consent to conservation, rehabilitation or liquidation under this Act;

U. The insurer does not comply with its domiciliary state's requirements for issuance to it of a certificate of authority, or its certificate of authority has been revoked by its state of domicile; or

V. When authorized by [cite risk-based capital law].

Section 208. Entry of Order

If the commissioner establishes any of the grounds provided in Section 207, then the receivership court shall grant the petition and issue the order of conservation, rehabilitation or liquidation requested in the petition. Upon the issuance of the order, a copy shall be forwarded by first class mail or electronic communication as permitted by the receivership court to the commissioners and guaranty associations in states in which the insurer did business.

Section 209. Effect of Order of Conservation, Rehabilitation or Liquidation

A. The filing or recording of an order of receivership with the clerk of the [insert proper court] court or recorder of deeds of the county in which the principal business of the company is conducted, or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

Drafting Note: Filing requirements should conform to existing state law.

B. Neither the filing of a petition commencing delinquency proceedings under this Act nor the entry of any order of seizure, conservation, rehabilitation or liquidation shall constitute a breach or an anticipatory breach of any contract or lease of the insurer.

C. The receiver may appoint one or more special deputies. A special deputy shall have all the powers and responsibilities of the receiver granted under this section, unless specifically limited by the receiver and shall serve at the pleasure of the receiver. The receiver may employ or contract with legal counsel, actuaries, accountants, appraisers, consultants, clerks, assistants and such other personnel as may be deemed necessary. Any special deputy or other person with whom the receiver contracts under this subsection shall be considered to be an agent of the commissioner only in the commissioner's capacity as receiver, and shall not be considered an agent of the state. The provisions of any law governing the procurement of goods and services by the state shall not apply to any contract entered into by the commissioner as receiver. The compensation of any special deputies, employees and contractors and all expenses of taking possession of the insurer and of conducting the receivership shall be determined by the receiver, with the approval of the receivership court in accordance with Section 116, and shall be paid out of the property of the insurer. If the receiver, in his or her sole discretion, deems it necessary to the proper performance of the receiver's duties under this Act, the receiver may appoint an advisory committee of policyholders, claimants or other creditors including guaranty associations. The committee shall serve at the pleasure of the receiver and shall serve without compensation and without reimbursement for expenses. The receiver or the receivership court in proceedings conducted under this Act may not appoint any other committee of any nature.

ARTICLE III. CONSERVATION

Section 301. Conservation Orders

A. An order to conserve the business of an insurer shall appoint the commissioner and his or her successors in office as the conservator and shall direct the conservator to take possession [and title] of the assets of the insurer, and to administer them under the general supervision of the court.

Drafting Note: Adding "and title" is optional.

B. Any order issued under this section shall require accountings to the receivership court by the conservator. Accountings shall be at such intervals as the receivership court specifies in its order, but no less frequently than semi-annually.

C. Unless otherwise directed by the receivership court, the conservator shall, within five (5) days of entry of an order of conservation, give or cause to be given notice of the order of conservation by first class mail or electronic communication to the guaranty associations of this state and any other guaranty association that has or may have obligations as a result of the delinquency proceeding.

Section 302. Powers and Duties of the Conservator

A. The conservator shall conduct an analysis of the business and financial condition of the insurer to determine if, in the best judgment of the conservator, it will be possible to correct the problems that led to the order of conservation and restore the insurer to private management and normal operations. Within 180 days of an order of conservation, the conservator shall file a [motion or application] in the receivership court asking that:

(1) The insurer be released from conservation, subject to Section 901;

(2) The insurer be placed into rehabilitation; or

(3) The insurer be placed into liquidation.

B. The period for filing the [motion or application] may be extended by the receivership court upon the motion of the conservator for one additional period of 180 days.

C. With receivership court approval pursuant to Section 107, the conservator may take such action as the conservator deems necessary or appropriate to reform and revitalize the insurer, including but not limited to, canceling policies, insurance and reinsurance contracts (other than life or health insurance or annuities), surety bonds or surety undertakings, or transferring policies, insurance and reinsurance contracts, surety bonds or surety undertakings to a solvent assuming insurer. The conservator shall have all the powers of the directors, officers and managers of the insurer, whose authority shall be suspended, except as redelegated by the conservator. The conservator shall have full power to direct and manage, to hire and discharge employees, and to deal with the property and business of the insurer. The conservator shall not be liable under [cite to state version of statute imposing liability for issuing policies while insolvent] as the result of good faith issuance or renewal of policies while in conservation.

D. If it appears to the conservator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, affiliate or other person, the conservator may pursue all appropriate legal remedies on behalf of the insurer.

E. The conservator may assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition pursuant to Sections 201 or 207 has been filed shall not bind the conservator.

F. The enumeration, in this section, of the powers and authority of the conservator shall not be construed as a limitation upon the conservator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of conservation.

Section 303. Coordination With Guaranty Associations and Orderly Transition to Rehabilitation or Liquidation

A. Upon the entry of an order of conservation or as soon thereafter as is practical, the conservator or his or her designated representative shall consult with the potentially obligated guaranty associations or their designated representatives to determine the extent to which the guaranty associations will be impacted by or may assist in the efforts to conserve the insurer, and shall also provide appropriate information to the guaranty associations to allow them to evaluate and discharge their statutory responsibilities. The conservator shall begin appropriate contingency planning and organizing so that an orderly transition to liquidation occurs, if liquidation is necessary. An orderly transition to liquidation requires, among other things, that: (i) the conservator to the fullest extent possible reserve sufficient assets to continue to meet obligations under insurance policies of the insolvent insurer until the guaranty associations are triggered, and (ii) the conservator shall conduct affairs in such a way and cooperate as necessary with the guaranty associations that may become liable as a result of the insolvency of the insurer to ensure that the guaranty associations are provided with appropriate information, along with necessary updates at reasonable intervals, and a reasonable period of time to plan and organize so that the guaranty associations are able to properly discharge statutory responsibilities upon being triggered.

B. Upon a determination by the commissioner or conservator that the insurer should be rehabilitated, the commissioner or conservator or his or her designated representative shall consult with the potentially obligated guaranty associations to advise them of the decision to seek an order of rehabilitation.

C. Upon a determination by the commissioner or a receiver that the insurer should be liquidated, the commissioner or receiver or his or her designated representative shall participate in cooperative efforts with the potentially obligated guaranty associations to ensure that an orderly transition to liquidation occurs. The conservator shall make available to the guaranty associations the information necessary to discharge their responsibilities upon becoming statutorily obligated. To the extent that information is available, or as it becomes available, the conservator shall provide appropriate information to guaranty associations in the states where the insurer transacted business.

D. Appropriate information as referred to in this section at a minimum includes the following for lines of business written by the insurer (whether covered or not covered by guaranty associations): a general description of the different types of business written or assumed by the insurer; claim counts and policy counts by state and by line of business; claim and policy reserves; account values; cash surrender values; policy loans; interest crediting history; premiums and mode of payment; unpaid claims and amounts; sample policies and endorsements; listing of different locations of claim files; if third party administrators were used, copies of executed contracts and a description of the contractual arrangements; and information concerning claims in litigation or dispute, including a listing of claims with assigned defense counsel for those claims going to trial in the near future after a possible liquidation date. Appropriate information also includes information concerning states in which the insurer is or was licensed and time periods for which the insurer is or was licensed; and other information reasonably requested by a guaranty association necessary for it to fulfill its statutory duties. In the case of a property and casualty insurer, the conservator, in cooperation with the guaranty associations, shall make all reasonable efforts to prepare the insurer's electronic policy and claims data so that, upon the entry of an order of liquidation the data will be ready for transmission using the Uniform Data Standards as promulgated by the National Association of Insurance Commissioners.

E. The listing of information in Subsection D is not necessarily an exclusive list and other information in order to ensure that an orderly transition to liquidation occurs may be needed and may be appropriately provided by the receiver.

ARTICLE IV. REHABILITATION

Section 401. Rehabilitation Orders

A. An order to rehabilitate the business of an insurer shall appoint the commissioner and his or her successors in office as the rehabilitator and shall direct the rehabilitator to take possession [and title] of the assets of the insurer, and to administer them under the general supervision of the court.

Drafting Note: Adding "and title" is optional.

B. Any order issued under this section shall require accountings to the receivership court by the rehabilitator. Accountings shall be at such intervals as the receivership court specifies in its order, but no less frequently than semi-annually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under Section 403 will be prepared by the rehabilitator and the timetable for doing so.

C. In recognition of the need for a prompt and final resolution for all persons affected by a plan of rehabilitation, any appeal from an order of rehabilitation or an order approving a plan of rehabilitation shall be heard on an expedited basis. A stay of an order of rehabilitation or an order approving a plan of rehabilitation shall not be granted unless the appellant demonstrates that extraordinary circumstances warrant delaying the recovery under the plan of rehabilitation of all other persons, including policyholders. If the plan provides an appropriate mechanism for adjustment in the event of any adverse ruling from an appeal, no stay shall be granted.

Section 402. Powers and Duties of the Rehabilitator

A. The rehabilitator may take such action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer, including but not limited to, canceling policies, insurance and reinsurance contracts (other than life or health insurance or annuities), surety bonds or surety undertakings, or transferring policies, insurance and reinsurance contracts, surety bonds or surety undertakings to a solvent assuming insurer, with court approval. The rehabilitator shall have all the powers of the directors, officers and managers of the insurer, whose authority shall be suspended, except as redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees, and to deal with the property and business of the insurer. The rehabilitator shall not be liable under [insert citation to state version of statute imposing liability for issuing policies while insolvent] as the result of good faith issuance or renewal of policies while in rehabilitation.

B. If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, affiliate, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

C. The rehabilitator may assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition pursuant to Sections 201 or 207 has been filed shall not bind the rehabilitator.

D. The enumeration, in this section, of the powers and authority of the rehabilitator shall not be construed as a limitation upon the rehabilitator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of rehabilitation.

Section 403. Filing of Rehabilitation Plans

A. The rehabilitator shall prepare and file a plan to effect rehabilitation with the receivership court within one year after the entry of the rehabilitation order or such further time as the receivership court may allow. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the receivership court may prescribe, the receivership court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be in compliance with applicable law and fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for a period not to exceed one year from the entry of the order approving the rehabilitation plan, unless the receivership court, for good cause shown, shall extend the moratorium.

B. Once a plan has been filed, any party in interest may object to the plan.

C. A plan shall:

(1) Except as provided at Subsection E, provide no less favorable treatment of a claim or class of claims than would occur in liquidation, unless the holder of a particular claim or interest agrees to a less favorable treatment of that particular claim or interest;

(2) Provide adequate means for the plan's implementation;

(3) Contain information concerning the financial condition of the insurer and the operation and effect of the plan, as far as is reasonably practicable in light of the nature and history of the insurer, the condition of the insurer's books and records and the nature of the plan; and

(4) Provide for the disposition of the books, records, documents and other information relevant to the duties and obligations covered by the plan.

D. A plan may include any other provisions not inconsistent with the provisions of this Act, including, but not limited to:

(1) Payment of distributions;

(2) Assumption or reinsurance of all or a portion of the insurer's remaining liabilities by, and transfer of assets and related books and records to, a licensed insurer or other entity;

(3) To the extent appropriate, application of insurance company regulatory market conduct standards to any entity administering claims on behalf of the receiver or assuming direct liabilities of the insurer;

(4) Contracting with a state guaranty association or any other qualified entity to perform the administration of claims;

(5) Annual independent financial and performance audits of any entity administering claims on behalf of the receiver that is not otherwise subject to examination pursuant to state insurance law; and

(6) Termination of the insurer's liabilities other than those under policies of insurance as of a date certain.

E. A plan may designate and separately treat one or more separate sub-classes consisting only of those claims within these classes that are for or reduced to *de minimis* amounts. A *de minimis* amount shall be any amount equal to or less than a maximum *de minimis* amount approved by the receivership court as being reasonable and necessary for administrative convenience.

Section 404. Termination of Rehabilitation

A. Whenever the rehabilitator believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the rehabilitator may move for an order of liquidation. In accordance with Section 405, the rehabilitator or the rehabilitator's designated representative shall coordinate with the guaranty associations that may become liable as a result of the liquidation and any national association of guaranty associations to plan for transition to liquidation.

B. The protection of the interests of insureds, claimants and the public requires the timely performance of all insurance policy obligations; therefore, if the payment of policy obligations is suspended in substantial part for a period of six (6) months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under Section 403, the rehabilitator shall petition the receivership court for an order of liquidation or seek an order, on good cause shown, for a longer suspension period.

C. The rehabilitator or the directors of the insurer may at any time petition the receivership court for, or the receivership court on its own motion may enter, an order terminating rehabilitation of an insurer. Subject to the provisions of Section 901, if the receivership court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Section 207 no longer exist, it shall order that the insurer be restored to title and possession of its property and the control of the business.

Section 405. Coordination with Guaranty Associations and Orderly Transition to Liquidation

A. Upon the entry of an order of rehabilitation or as soon thereafter as is practical, the rehabilitator or his or her designated representative shall consult with the potentially obligated guaranty associations or their designated representatives to determine the extent to which the guaranty associations will be impacted by or may assist in the efforts to rehabilitate the insurer, and shall also provide appropriate information to the guaranty associations to allow them to evaluate and discharge their statutory responsibilities. The rehabilitator shall begin appropriate contingency planning and organizing so that an orderly transition to liquidation occurs, if liquidation is necessary. An orderly transition to liquidation requires, among other things, that: (i) the rehabilitator to the fullest extent possible reserve sufficient assets to continue to meet obligations under insurance policies of the insolvent insurer until the guaranty associations are triggered, and (ii) the rehabilitator shall conduct affairs in such a way and cooperate as necessary with the guaranty associations that may become liable as a result of the insolvency of the insurer to ensure that the guaranty associations are provided with appropriate information, along with necessary updates at reasonable intervals, and a reasonable period of time to plan and organize so that the guaranty associations are able to properly discharge statutory responsibilities upon being triggered.

B. Appropriate information as referred to in this section at a minimum includes the following for lines of business written by the insurer (whether covered or not covered by guaranty associations): a general description of the different types of business written or assumed by the insurer; claim counts and policy counts by state and by line of business; claim and policy reserves; account values; cash surrender values; policy loans; interest crediting history; premiums and mode of payment; unpaid claims and amounts; sample policies and endorsements; listing of different locations of claim files; if third party administrators were used, copies of executed contracts and a description of the contractual arrangements; and information concerning claims in litigation or dispute, including a listing of claims with assigned defense counsel for those claims going to trial in the near future after a possible liquidation date. Appropriate information also includes information concerning states in which the insurer is or was licensed and time periods for which the insurer is or was licensed; and other information reasonably requested by a guaranty association necessary for it to fulfill its statutory duties. In the case of a property and casualty insurer, the conservator or rehabilitator, in cooperation with the guaranty associations, shall make all reasonable efforts to prepare the insurer's electronic policy and claims data so that, upon the entry of an order of liquidation the data will be ready for transmission using the Uniform Data Standards as promulgated by the National Association of Insurance Commissioners.

C. The listing of information in Subsection B is not necessarily an exclusive list and other information in order to ensure that an orderly transition to liquidation occurs may be needed and may be appropriately provided by the receiver.

ARTICLE V. LIQUIDATION

Section 501. Liquidation Orders

A. An order to liquidate the business of an insurer shall appoint the commissioner and any successor in office as the liquidator and shall direct the liquidator to take possession of the property of the insurer and to administer it subject to this Act. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation.

B. Upon issuance of the order of liquidation, the rights and liabilities of the insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in Sections 502 and 705, unless otherwise fixed by the [insert applicable court] court.

C. An order to liquidate the business of an alien insurer in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer.

D. Whenever applicable, a petition for liquidation should include a request for a judicial declaration [or finding] of insolvency. After providing proper notice and hearing, the receivership court may at any time make the declaration of insolvency.

E. In the event an order of liquidation is set aside upon appeal, the company shall not be released from delinquency proceedings except in accordance with Section 901.

Section 502. Continuance of Coverage

A. Notwithstanding any policy or contract language or any other statute, and unless ordered otherwise by the receivership court upon application by the receiver, all reinsurance contracts by which the insurer has assumed the insurance obligations of another insurer are cancelled upon entry of an order of liquidation.

B. Notwithstanding any policy or contract language or any other statute, all policies, insurance contracts (other than reinsurance by which the insurer has ceded insurance obligations to another person), surety bonds or surety undertakings, other than life, disability income, long term care or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force as provided in this section, unless further extended by the receiver with the approval of the receivership court, until the earlier of:

(1) Thirty (30) days from the date of entry of the liquidation order;

(2) The date of expiration of the policy coverage;

(3) The date the insured has replaced the insurance coverage with equivalent insurance with another insurer or otherwise terminated the policy;

(4) The date the liquidator has effected a transfer of the policy obligation pursuant to Section 504A(5); or

(5) The date proposed by the liquidator and approved by the receivership court to cancel coverage.

Drafting Note: The provision in Paragraph (5) is designed to allow for possible immediate cancellation of policies in the event there is no guaranty fund coverage.

C. An order of liquidation under Section 501 shall terminate coverages at the time specified in Subsections A and B for purposes of any other statute.

D. Policies of life, disability income, long term care or health insurance or annuities covered by a guaranty association or portions of such policies covered by one or more guaranty associations, under applicable law, shall continue in force, subject to the terms of the policy (including any terms restructured pursuant to a court-approved rehabilitation plan) to the extent necessary to permit the guaranty associations to discharge their statutory obligations. Policies of life, disability income, long term care or health insurance or annuities, or portions of such policies, not covered by one or more guaranty associations shall terminate as provided under Subsection B, except to the extent the liquidator proposes and the receivership court approves the use of property of the estate, consistent with Section 801, for the purpose of continuing the contracts or coverage by transferring them to an assuming reinsurer.

E. The cancellation of any bond or surety undertaking shall not release any co-surety or guarantor.

F. Except as otherwise provided in this Act, the obligations of the insolvent insurer's reinsurers shall not be released or discharged by a termination under this section of the policies ceded to reinsurers.

G. Contracts by which the insurer has reinsured obligations arising under policies of life, disability income, long-term care insurance or annuities shall continue or terminate as provided in Section 612 of this Act.

Section 503. Sale or Dissolution of the Insurer's Corporate Entity

A. Notwithstanding the entry of a liquidation order, the liquidator may apply for an order to sell or dissolve the corporate entity or charter of a domestic insurer or the United States branch of an alien insurer domiciled in this state, at any time after an order of liquidation of the insurer has been granted, consistent with the provisions of this section.

B. Upon an application to sell the corporate entity or charter, with notice as prescribed in this Act, the receivership court may enter an order;

(1) Separating the corporate entity or charter, together with any of its licenses to do business and such assets as the liquidator deems appropriate to the transaction, from the remaining estate in liquidation and all of its assets and the claims or interests of all claimants, creditors, policyholders and stockholders;

(2) Canceling all outstanding stock and other securities of, and other equity interests in, the corporate entity or charter, provided that the cancellation shall not affect any claim against the estate by holders of the equity interests;

(3) Authorizing the issuance and sale of new stock or other securities for the purpose of transferring to one or more buyers control and ownership of the corporate entity or charter; and

(4) Authorizing the sale of the corporate entity or charter, together with any of its licenses to do business and such general assets as the liquidator deems appropriate to the transaction, free and clear from the claims or interest of all claimants, creditors, policyholders and stockholders.

C. The sale of the corporate entity or charter may be made in the manner and on the terms and conditions applied for by the liquidator and ordered by the receivership court. Any sale shall be subject to the domiciliary state's laws regarding acquisition of an insurer [refer to state's Insurance Holding Company law or other law regarding the transfer of control of insurers]. The proceeds from the sale of the corporate entity or charter shall become a part of the property of the estate in liquidation, and the then separate corporate entity or charter, together with any of its licenses to do business and such assets as the liquidator deems appropriate to the transaction, shall thereafter be free and clear from the claims or interest of all claimants, creditors, policyholders and stockholders of the insurer in liquidation. The court shall be deemed to have broad powers to effect the disposition of corporate entities and their charters including, without limiting the foregoing, reorganizations and conversions thereof.

D. This section shall be liberally construed to accomplish its purposes to provide an expeditious and effective procedure to realize the maximum proceeds possible from the sale of a corporate entity or charter separated from an estate in liquidation and to ensure that the purchasers receive clear and marketable titles.

E. If permission to sell the corporate entity or charter is not granted prior to discharge of the liquidator, in accordance with this section or otherwise with receivership court approval, the receivership court may order dissolution of the corporate entity or charter, or dissolution shall be deemed complete by operation of law upon the discharge of the liquidator if the insurer is insolvent, or dissolution may be ordered by the receivership court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

Section 504. Powers of the Liquidator

A. The liquidator shall have the power:

(1) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any persons to subscribe to their testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records or other documents that the liquidator deems relevant to the inquiry;

(2) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(3) To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(a) To institute action in other jurisdictions, in order to forestall garnishment and attachment proceedings against those debts;

(b) To pay Class 1 administrative costs of the estate, at the liquidator's sole discretion and upon approval of the receivership court, where the payments assist or result in the collection or recovery of property of the insurer that provides a net benefit to creditors of the estate;

(c) To do such other acts as are necessary or expedient to collect, conserve or protect its property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as the liquidator deems consistent with this Act; and

(d) To pursue any creditor's remedies available to enforce the insurer's claims;

(4) To conduct public and private sales of the property of the insurer;

(5) (a) To use property of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 801;

(b) To use property of the estate of an insurer under a liquidation order to transfer the insurer's obligations under surety bonds and surety undertakings, and collateral held by the insurer with respect to the reimbursement obligations of the principals under those surety bonds and surety undertakings, to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 801; and if all insureds, principals, third party claimants, and obliges under the policies, surety bonds, and surety undertakings consent, or if the receivership court so orders, the estate shall have no further liability under the transferred policies, surety bonds, or surety undertakings after the transfer is made;

(6) Subject to Subsection D, to acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the estate at its market value or upon such terms and conditions as are fair and reasonable. The liquidator shall also have the power to execute, acknowledge and deliver any deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(7) To borrow money on the security of the property of the estate or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution;

(8) To enter into such contracts as are necessary to carry out the order to liquidate, and, subject to the provisions of Section 114, to assume or reject any executory contract or unexpired lease to which the insurer is a party;

(9) To continue to prosecute and to institute in the name of the insurer or in the liquidator's own name suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims the liquidator deems unprofitable to pursue further. If the insurer is dissolved under Section 503, the liquidator shall have the power to apply to any court in this state or elsewhere for leave to substitute the liquidator for the insurer as a party;

(10) To prosecute or assert with exclusive standing any action that may exist on behalf of the creditors, members, policyholders or shareholders of the insurer or the public against any person, except to the extent that a claim is personal to a specific creditor, member, policyholder or shareholder and recovery on the claim would not inure to the benefit of the estate. This subsection does not infringe or impair any of the rights provided to a guaranty association pursuant to its enabling statute or otherwise;

(11) To take possession of such records and property of the insurer as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations shall have reasonable access to the records of the insurer necessary for them to carry out their statutory obligations;

(12) To deposit in one or more banks in this state sums required for meeting current administration expenses and dividend distributions;

(13) To invest all sums not currently needed, unless the receivership court orders otherwise;

(14) To file any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located;

(15) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds and the defense of usury. A waiver of any defense by the insurer after a petition pursuant to Sections 201 or 207 has been filed shall not bind the liquidator. Whenever a guaranty association has an obligation to defend any suit, the liquidator shall defer to that obligation and may defend only in cooperation with the guaranty association or in the absence of the guaranty association's defense;

(16) To exercise and enforce all the rights, remedies and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer or lien that may be voidable under this Act or otherwise;

(17) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee for the insurer or any of its property, and to act as the receiver or trustee whenever the appointment is offered;

(18) To enter into agreements with any receivers or commissioners of any other states; and

(19) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this Act.

B. The liquidator is vested with all the rights of the entity or entities in receivership.

C. The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon the liquidator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, to the extent necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

D. The liquidator may hypothecate, encumber, lease, sell, transfer, abandon or otherwise dispose of or deal with any property of the insurer, or settle or resolve any claim brought by the liquidator on behalf of the insurer, or commute or settle any claim of reinsurance under any contract of reinsurance, as follows:

(1) If the property or claim has a market or settlement value that does not exceed the lesser of $1,000,000 or ten percent (10%) of the general assets of the estate, as shown on the receivership's financial statements, the liquidator may take the action at his or her discretion. The receivership court may, upon petition of the liquidator, increase the threshold upon a showing that compliance with this requirement is burdensome to the liquidator in administering the estate and is unnecessary to protect the material interests of creditors.

(2) In all instances other than those described in Paragraph (1), the liquidator may take the action only after obtaining approval of the receivership court as provided in Section 107.

(3) The liquidator may, at the liquidator's discretion, request the receivership court to approve a proposed action as provided in Section 107 if the value of the property or claim appears to be less than the threshold provided in Paragraph (1) but cannot be ascertained with certainty, or for any other reason as determined by the liquidator.

(4) After obtaining approval of the receivership court as provided in Section 107 of this Act, the liquidator may transfer rights to payment under ceding reinsurance agreements covering policies to a third party transferee. The transferee shall have the rights to collect and enforce collection of the reinsurance for the amount payable to the ceding insurer or to its receiver, without diminution because of the insolvency or because the receiver has failed to pay all or a portion of the claim, based on the amounts paid or allowed pursuant to Subsection 611. The transfer of these rights shall not give rise to any defense regarding the reinsurer's obligations under the reinsurance agreement regardless of whether the agreement or other applicable law prohibits the transfer of rights under the reinsurance agreement. Except as provided in this subsection, any transfer of rights pursuant to this provision shall not impair any rights or defenses of the reinsurer that existed prior to the transfer or would have existed in the absence of the transfer. Except as otherwise provided in this subsection, any transfer of rights pursuant to this provision shall not relieve the transferee or the liquidator from obligations owed to the reinsurer pursuant to the reinsurance or other agreement.

E. The liquidator shall not be obligated to defend any action against the insurer or insured. Any insureds not defended by a guaranty association may provide their own defense, and include the cost of the defense as part of their claims, if the defense was an obligation of the insurer. The right of the liquidator to contest coverage on a particular claim shall be deemed preserved without the necessity for an express reservation of rights.

Section 505. Notice to Creditors and Others

A. Unless the receivership court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) By first class mail or electronic communication as permitted by the receivership court to all the insurer's agents, brokers, or producers of record, with current appointments or current licenses to represent the insurer, and to all other agents, brokers or producers as the liquidator deems appropriate at their last known address;

(2) By first class mail or electronic communication as permitted by the receivership court to all current policyholders, pending claimants and, as determined by the receivership court, former policyholders and other creditors; and

Drafting Note: Notice under this paragraph should include notices to various state and federal agencies with an interest in the delinquency proceeding, *e.g.* Interstate Commerce Commission and state public utility commissions.

(3) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in other locations that the liquidator deems appropriate.

B. The notice of the entry of an order of liquidation shall contain or provide directions for obtaining the following information:

(1) A statement that the insurer has been placed in liquidation;

(2) A statement that states that certain acts are stayed under Section 108 and describes any additional injunctive relief ordered by the receivership court;

(3) A statement whether, and to what extent, the insurer's policies continue in effect;

(4) To the extent applicable, a statement that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws;

(5) A statement of the deadline for filing claims, if established, and the requirements for filing a proof of claim pursuant to Section 701 on or before that date;

(6) A statement of the date, time and location of any initial status hearing scheduled at the time the notice is sent;

(7) A description of the process for obtaining notice of matters before the receivership court; and

(8) Such other information as the liquidator or the receivership court deems appropriate.

C. If notice is given in accordance with this section, the distribution of property of the insurer under this Act shall be conclusive with respect to all claimants, whether or not they received notice.

D. Notwithstanding the foregoing, the liquidator shall have no duty to locate any persons or entities if no address is found in the records of the insurer, or if mailings are returned to the liquidator because of inability to deliver at the address shown in the company's books and records. In these circumstances the notice by publication as required by this Act or actual notice received is sufficient notice. Written certification by the liquidator or other knowledgeable person acting for the liquidator, that the notices were deposited in the United States mail, postage prepaid, or that the notices have been electronically transmitted shall be *prima facie* evidence of mailing and receipt. All claimants shall have a duty to keep the liquidator informed of any changes of address.

E. Notwithstanding Subsection A, upon application of the liquidator the receivership court may find that notice by publication as required in this section is sufficient notice to those persons holding an occurrence policy that expired more than four (4) years prior to the entry of the order of liquidation, and under which there are no pending claims; or the receivership court may order other notice to those persons that it deems appropriate.

Section 506. Duties of Agents

A. At the request of the liquidator, an agent receiving notice of the entry of the liquidation order shall, within fifteen (15) days of receipt, or such longer time as the liquidator may require, provide notice of that order on a form prescribed by the liquidator to each policyholder and other person named in any policy issued through the agent. Within thirty (30) days of the mailing, the agent shall provide a certification of mailing and list of insureds noticed as prescribed by the liquidator.

B. Every person who represented the insurer as an agent and receives notice in the form prescribed in Section 505, shall within thirty (30) days of the notice provide to the liquidator (in addition to the information the agent may be required to provide pursuant to Section 110) the information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to the general agent, including the name and address of the sub-agent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his or her possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

C. Any agent failing to provide information to the liquidator as required in Subsection B may be subject to payment of a penalty of not more than $1,000, in addition, the agent's license may be suspended after a hearing held by the commissioner.

D. Notwithstanding an agent's property interest, if any, in the expiration of the policy, the liquidator shall have the exclusive power to determine whether, and under what terms, to cancel or transfer the policy.

ARTICLE VI. ASSET RECOVERY

Section 601. Turnover of Assets

A. If the receiver determines that funds or property in the possession of another person are rightfully the property of the estate, the receiver shall deliver to the person a written demand for immediate delivery of the funds or property, referencing this section by number, referencing the court and docket number of the receivership action, and notifying the person that any claim of right to the funds or property by the person shall be presented to the receivership court within twenty (20) days after the date of the written demand. Any person who holds funds or other property belonging to an entity subject to an order of receivership under this Act shall deliver the funds or other property to the receiver on demand. Should the person allege any right to retain the funds or other property, the person shall file a pleading with the receivership court setting out that right within twenty (20) days of the receipt of the demand that the funds or property be delivered to the receiver. The person shall serve a copy of the pleading on the receiver. The pleading shall inform the receivership court as to the nature of the claim to the property, the alleged value of the property or amount of funds held, and what action has been taken by the person to preserve and protect the property or to preserve any funds pending determination of the dispute. The relinquishment of possession of funds or property by any person who has received a demand pursuant to this section does not constitute a waiver of a right to make a claim in the receivership.

B. If requested by the receiver, the receivership court shall hold a hearing to determine where and under what conditions the property or funds shall be held by the person pending determination of the dispute. The receivership court may impose such conditions as it may deem necessary or appropriate for the preservation of the property until the receivership court can determine the validity of the person's claim to the property or funds. If any property or funds are allowed to remain in the possession of the person after demand made by the receiver, that person shall be strictly liable to the estate for any waste, loss or damage to or diminution of value of the property or funds retained.

C. If a person has filed a pleading alleging any right to retain funds or property as provided in Subsection A, the receivership court shall hold a subsequent hearing to determine the entitlement of the person to the funds or property claimed by the receiver.

D. If a person fails to deliver the property or to file the pleading described by Subsection A within the twenty-day period, the receivership court may, upon petition of the receiver and upon a copy of the petition being served by the petitioner to that person, issue its summary order directing the immediate delivery of the funds or property to the receiver and finding that the person has waived all claims of right to the funds or property.

Section 602. Recovery from Affiliates

The receiver shall have a right to recover from any affiliate of the insurer any property of the insurer transferred to or for the benefit of the affiliate, or its value, subject to the following limitations:

A. The transfer was made within the five (5) years preceding the initial petition for receivership,

B. No transfer is recoverable under this section if the affiliate shows that, when the transfer was made:

(1) The insurer was solvent,

(2) The transfer was lawful, and

(3) Neither the insurer nor the affiliate knew or reasonably should have known that the transfer, under then-applicable statutory accounting standards, would:

(a) Place the insurer in violation of applicable capital or surplus requirements;

(b) Place the insurer below the risk-based capital level as defined by Section [insert citation to applicable risk-based capital statute];

(c) Place the insurer in violation of statutory writing ratios [reference to state statutes defining, if applicable, or eliminate this provision];

(d) Cause the insurer's filed financial statements not to present fairly the capital and surplus of the insurer; or

(e) Otherwise cause the insurer to be in a hazardous financial condition.

Section 603. Unauthorized Post-Petition Transfers

A. Except as otherwise provided in this section, the receiver may avoid any transfer of an interest of the insurer in property, or any obligation incurred by the insurer, that was made or incurred after the petition for receivership was filed, and that is not authorized by the receiver and approved by the receivership court.

B. Except to the extent that a transfer or obligation voidable under this section is otherwise voidable under this Act, a transferee or obligee of such a transfer or obligation that takes for value and in good faith has a lien on or may retain, at the option of the receivership court, any interest transferred or may enforce any obligation incurred, as the case may be, to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation.

Section 604. Voidable Preferences and Liens

A. A preference is a transfer of any interest in property of an insurer:

(1) To or for the benefit of a creditor;

(2) For or on account of an antecedent debt;

(3) Made or suffered by the insurer within two (2) years preceding the filing of a successful petition commencing delinquency proceedings; and

(4) That enables the creditor to receive more than the creditor would receive if:

(a) The insurer was liquidated under this Act;

(b) The transfer had not been made; and

(c) The creditor was entitled to receive payment of the debt to the extent provided by this Act.

Drafting Note: Paragraph (4) substitutes a review of the benefit to the creditor rather than the effect on "this debt" as provided in the prior model act provisions. The objective is to eliminate the ambiguity in situations where a creditor may hold multiple "debts."

B. Any preference may be avoided by the receiver if:

(1) The insurer was insolvent at the time of the transfer;

(2) The transfer was made within 120 days before the filing of the petition commencing delinquency proceedings;

(3) The creditor receiving it or being benefited thereby or its agent in reference to the transfer had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(4) The creditor receiving it was:

(a) An officer or director of the insurer;

(b) An employee, attorney or other person who was in fact in a position to effect a level of control or influence over the actions of the insurer comparable to that of an officer or director, whether or not the person held that position; or

(c) An affiliate.

C. The receiver may not avoid a transfer under this section:

(1) To the extent that the transfer was:

(a) Intended by the insurer and the creditor to or for whose benefit the transfer was made to be a contemporaneous exchange for new value given to the insurer; and

(b) In fact a substantially contemporaneous exchange;

(2) To the extent that the transfer was in payment of a debt incurred by the insurer in the ordinary course of business or financial affairs between the insurer and the transferee and the transfer was:

(a) Made in the ordinary course of business or financial affairs between the insurer and the transferee; or

(b) Made according to ordinary business terms;

(3) To or for the benefit of a creditor, to the extent that, after the transfer, the creditor gave new value to or for the benefit of the insurer:

(a) Not secured by an otherwise unavoidable security interest; and

(b) On account of which new value the insurer did not make an otherwise unavoidable transfer to or for the benefit of the creditor; or

(4) To the extent the transfer was made in respect of a bond posted in connection with an administrative or judicial proceeding in order to appeal, set aside, or stay execution of a judgment.

D. For purposes of this section:

(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer that creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filing of a petition for receivership shall be deemed to be made immediately before the filing commencing delinquency proceedings.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

E. A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens that under applicable law are given a special priority over other liens that are prior in time.

F. A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of Subsection D, if these consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of Subsection D through any acts subsequent to the obtaining of the lien or subsequent to such a purchase that requires the agreement or concurrence of any third party or that require any further judicial action or ruling.

G. A transfer of property for or on account of a new and contemporaneous consideration that is deemed under Subsection D to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer that becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

H. (1) If any lien deemed voidable under Subsection B has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition commencing delinquency proceedings, the indemnifying transfer or lien shall also be deemed voidable.

(2) The property affected by any lien deemed voidable under Subsections B and H(1) shall be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the receiver, except that the receivership court may upon due notice order the lien to be preserved for the benefit of the estate and the receivership court may direct that the conveyance be executed as may be proper or adequate to evidence the title of the receiver.

(3) Reasonable notice of any hearing in the proceeding shall be given to all parties as required by law including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the receivership court may in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the receivership court, to the receiver, within such reasonable times as the receivership court shall fix.

(4) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the receiver, or where the property is retained under Subsection H(3), to the extent of the amount paid to the receiver.

I. Nothing in this section shall prejudice any other claim by the receiver against any person.

Section 605. Fraudulent Transfers and Obligations

A. The receiver may avoid any transfer of an interest of the insurer in property, any reinsurance transaction or any obligation incurred by an insurer that was made or incurred on or within two (2) years before the date of the initial filing of a petition commencing delinquency proceedings under this Act, if the insurer voluntarily or involuntarily:

(1) Made the transfer or incurred the obligation with actual intent to hinder, delay or defraud any person to which it was or became indebted on or after the date that the transfer was made or the obligation was incurred; or

(2) Received less than a reasonably equivalent value in exchange for the transfer or obligation.

B. Except to the extent that a transfer or obligation voidable under this section is voidable under other provisions of this Act, a transferee or obligee of such a transfer or obligation that takes for value and in good faith has a lien on or may retain any interest transferred or may enforce any obligation incurred, as the case may be, to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation. For purposes of this section, a transfer is made when the transfer is so perfected that a bona fide purchaser from the insurer against whom applicable law permits the transfer to be perfected cannot acquire an interest in the property transferred that is superior to the interest in the property of the transferee, but if the transfer is not so perfected before the commencement of the delinquency proceeding, the transfer is deemed to have been made immediately before the date of the initial filing of the petition commencing delinquency proceedings.

C. For purposes of this section, "value" means property or satisfaction or securing of a present or antecedent debt of the insurer.

D. In the event a reinsurance transaction is avoided under this section:

(1) The receiver shall tender to the reinsurer the value of any consideration transferred to the insurer in connection with the transaction less the amount of matured and liquidated liabilities owing by the reinsurer to the estate; and

(2) The parties shall be returned to their relative positions prior to the implementation of the transaction avoided.

Section 606. Receiver As Lien Creditor

A. The receiver may avoid any transfer of or lien upon the property of, or obligation incurred by, an insurer that the insurer or a policyholder, creditor, member or stockholder of the insurer may have avoided without regard to any knowledge of the receiver, the commissioner, the insurer or any policyholder, creditor, member or stockholder of the insurer and whether or not such a policyholder, creditor, member or stockholder exists.

B. The receiver shall be deemed a creditor without knowledge for purposes of pursuing claims under the Uniform Fraudulent Transfer Act, the Uniform Fraudulent Conveyance Act or similar provisions of state or federal law.

Section 607. Liability of Transferee

A. Except as otherwise provided in this section, to the extent that the receiver obtains an order pursuant to Section 601, or avoids a transfer under Sections 602, 603, 604, 605 or 606, the receiver may recover the property transferred, or the value of the property, from:

(1) The initial transferee of the transfer or the entity for whose benefit the transfer was made; or

(2) Any immediate or mediate transferee of the initial transferee.

B. The receiver may not recover under Subsection A(2) of this section from:

(1) A transferee that takes for value, including satisfaction or securing of a present or antecedent debt, in good faith, and without knowledge of the voidability of the transfer avoided; or

(2) Any immediate or mediate good faith transferee of the transferee.

C. Any transfer avoided in accordance with this Act is preserved for the benefit of the receivership estate, but only with respect to property of the insurer.

D. In addition to the remedies specifically provided in Sections 601, 602, 603, 604, 605 and 606 and Subsection A, should the receiver be successful in establishing a claim to the property or any part thereof, the receiver shall be entitled to recover judgment for the following:

(1) Rental for the use of tangible property from the later of the entry of the receivership order or the date of the transfer;

(2) In the case of funds or intangible property, the greater of (a) the actual interest or (b) income earned by the property or (c) interest at the statutory rate for judgments, from the later of the entry of the receivership order or the date of the transfer; and

(3) Except as to recoveries from guaranty associations, all costs and investigative and other expenses necessary to the recovery of the property or funds, and reasonable attorney fees.

E. In any action pursuant to this section, the receivership court may allow the receiver to seek recovery of the property involved or its value.

F. In any action pursuant to Sections 601, 602, 603, 604, 605, 606 and 609, the receiver has the burden of proving the avoidability of a transfer, and the person against whom recovery or avoidance is sought has the burden of proving the nature and extent of any affirmative defense.

Section 608. Claims of Holders of Void or Voidable Rights

A. The receiver may disallow all claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this Act, unless the creditor surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the receiver within thirty (30) days from the date of the entering of the final judgment, except that the receivership court may allow further time if there is an appeal or other continuation of the proceeding.

B. A claim allowable under Subsection A by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance, may be filed as an excused late filing under Subsection 701B if filed within thirty (30) days from the date of the avoidance, or within the further time allowed by the receivership court under Subsection A.

Section 609. Setoffs

A. Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this Act, shall be set off and the balance only shall be allowed or paid, except as provided in Subsection B, Section 612 and Section 613. Obligations arising out of the termination of life, disability income or long term care reinsurance contracts pursuant to Section 612 may be set off against other debts and credits arising out of contracts between the insurer and the reinsurer.

B. No setoff shall be allowed after the commencement of a delinquency proceeding under this Act in favor of any person if:

(1) The claim against the insurer is disallowed;

(2) The claim against the insurer was purchased by or transferred to the person on or after the filing of the receivership petition or within 120 days preceding the filing of the receivership petition;

(3) The obligation of the insurer is owed to an affiliate or entity other than the person, absent written assignment of the obligation made more than 120 days before the filing of the petition for receivership;

(4) The obligation of the person is owed to an affiliate or entity other than the insurer, absent written assignment of the obligation made more than 120 days before the filing of the petition for receivership;

(5) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution;

(6) The obligations between the person and the insurer arise out of transactions by which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations. Notwithstanding the provisions of this subsection, the receiver may permit setoffs if in his or her discretion a setoff is appropriate because of specific circumstances relating to a transaction;

(7) The obligation of the person arises out of any avoidance action taken by the receiver; or

(8) The obligation of the insured is for the payment of earned premiums or retrospectively rated earned premiums in accordance with Section 613.

C. The receiver may avoid pursuant to Sections 604, 605 and 606, and subject to defenses under those sections any setoff that occurred prior to the commencement of the delinquency proceeding under this Act when the setoff would otherwise be disallowed pursuant to subsection B of this section.

Drafting Note: It is the intent of the drafters, with respect to Subsections B(3) and B(4), to deny setoffs between companies who are affiliated so as to not allow one company to use setoffs of another affiliate. Contractual provisions contrary to this intent would not be effective.

Section 610. Assessments

A. As soon as practicable but not more than four (4) years from the date of an order of receivership of an insurer issuing assessable policies, the receiver shall make a report to the receivership court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable total liabilities;

(3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) A recommendation as to whether or not an assessment should be made and in what amount.

B. Upon the basis of the report provided in Subsection A, including any supplements and amendments thereto, the receivership court may approve, solely on application by the receiver, one or more assessments against all members of the insurer who are subject to assessment. The order approving the assessment shall provide instructions regarding notice of the assessment, deadlines for payment and other instructions to the receiver regarding collection of the assessment.

C. Subject to any applicable legal limits on ability to assess, the aggregate assessment shall be for the amount by which the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

D. After levy of assessment under Subsection B, the receiver shall petition the receivership court for an order directing each member who has not paid the assessment pursuant to the levy to show cause why a judgment therefore should not be entered.

E. At least twenty (20) days before the return day of the order, the receiver shall give notice of the order to show cause by publication or by first class mail to each member liable on the assessment mailed to the member's last known address as it appears on the insurer's records or such other method of notification as the receivership court may direct. Failure of the member or subscriber to receive the notice of the assessment or of the order, within the time specified therein or at all, shall be no defense in any proceeding to collect the assessment.

F. If a member does not appear and serve duly verified objections upon the receiver on or before the return day of the order to show cause under Subsection D, the receivership court shall make an order adjudging the member liable for the amount of the assessment against the member pursuant to Subsection D together with costs, and the receiver shall have a judgment against the member therefore.

G. If on or before the return day, the member appears and serves duly verified objections upon the receiver, the receivership court may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant.

H. The receiver may enforce any order or collect any judgment under Subsection F by any lawful means.

I. Any assessment of a subscriber or member of an insurer made by the receiver pursuant to the order of receivership court fixing the aggregate amount of the assessment against all members or subscribers and approving the classification and formula made by the receiver under this section shall be *prima facie* correct.

J. Any claim filed by an assessee who fails to pay an assessment, after the conclusion of any legal action by the assessee objecting to the assessment, shall be deemed a late filed claim under Section 801.

Drafting Note: This section may be eliminated if the state has no insurers issuing assessable policies.

Section 611. Reinsurer's Liability

A. Except as otherwise provided in this Act, the amount recoverable by the receiver from reinsurers shall not be reduced as a result of a delinquency proceeding with a finding of insolvency, regardless of any provision in the reinsurance contract or other agreement. No agreement, written, oral or otherwise shall be enforceable to the extent it is in conflict, or not in strict compliance, with this section. Except as expressly provided herein, no other person whether as a creditor, third party beneficiary or otherwise shall have a direct right to reinsurance proceeds from any reinsurer of the insolvent insurer on the basis of any written or oral agreement, or pursuant to any action or cause of action seeking any equitable or legal remedy. This section shall apply to all the insurer's reinsurance contracts including but not limited to treaty reinsurance, quota share reinsurance, facultative reinsurance, or fronting or captive reinsurance arrangements.

B. Except as otherwise provided in Subsection I of this section, the amount recoverable by the liquidator from reinsurers shall be payable under a contract or contracts reinsured by the reinsurer on the basis of:

(1) Proof of payment of the insured claim by a guaranty association, the insurer or the receiver to the extent of the payment; or

(2) The allowance of the claim pursuant to Section 708, an order of the receivership court or a plan of rehabilitation.

C. If an insurer takes credit for a reinsurance contract in any filing or submission made to the commissioner, and the reinsurance contract does not contain the provisions required with respect to the obligations of reinsurers in the event of insolvency of the reinsured, that reinsurance contract shall be deemed to contain the provisions required with respect to the obligations of reinsurers in the event of insolvency of the reinsured in order to obtain credit for reinsurance or other applicable statutes.

D. All reinsurance contracts that are presumed or construed to contain provisions pursuant to Subsection C, shall be deemed to contain the following provision:

> In the event of insolvency and the appointment of a receiver, the reinsurance obligation shall be payable to the ceding insurer or to its receiver without diminution because of the insolvency or because the receiver has failed to pay all or a portion of the claim. Payment shall be made upon either:
>
> (1) Proof of payment of the insured claim by a guaranty association, the insurer or the receiver to the extent of the payment; or

(2) The allowance of the claim pursuant to Section 708 of the Insurer Receivership Act, or the allowance of claims pursuant to an order of the receivership court or plan of rehabilitation.

E. The receiver shall give written notice, in accordance with the terms of the contract, to each reinsurer obligated in relation to the claim of the pendency of a claim against the reinsured company. Failure of the receiver to give notice of a pending claim pursuant to a provision in the reinsurance contract shall not excuse the obligation of the reinsurer unless it is prejudiced thereby, and if it is prejudiced, its obligations shall be reduced only to the extent of the prejudice. The reinsurer may interpose, at its own expense, in the proceeding in which the claim is to be adjudicated, any defense or defenses that it may deem available to the reinsured company or its receiver.

F. The entry of an order of conservation, rehabilitation or liquidation shall not be deemed a breach or an anticipatory breach of any reinsurance contract, nor shall it be grounds for retroactive revocation or retroactive cancellation of any reinsurance contracts by the reinsurer.

G. In the event that reinsurance payments to a receiver of a ceding insurer are later determined to be payments in excess of the amounts actually due to the receiver, the excess shall be credited against future payments due to the receiver or shall be repaid to the reinsurer as an administrative expense of the estate pursuant to Section 801A. Any repayment may be limited based on the property remaining in the estate.

H. (1) Subject to Subsection A, payments made by the reinsurer directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate and payments made by the reinsurer shall be made directly to the ceding insurer or its receiver, except when:

(a) The reinsurance contract, or other written agreement to which the insured, ceding insurer and reinsurer are all parties specifically provides another payee, other than an affiliate of the ceding insurer or reinsurer, of the reinsurance in the event of the insolvency or receivership of the ceding insurer; provided that the provision is contained in the reinsurance contract as it was written on the date of its initial execution; or the provision is contained in the other written agreement as it was written on the date of the initial policy issuance;

(b) The reinsurance contract, as it was written on the date of its initial execution contains a provision where the assuming insurer with the consent of the direct insured and the ceding insurer has assumed all policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the entire obligations of the ceding insurer to the payees; or

(c) A life and health insurance guaranty association has made the election to succeed to the rights and obligations of the insolvent insurer under a contract of reinsurance in accordance with Section 612, the life and health guaranty association laws of its domiciliary state, or pursuant to other applicable law, rule, order or assignment contract, in which case payments shall be made directly to or at the direction of the guaranty association.

(2) Both the receiver and the reinsurer shall be entitled to recover from any person (other than the receiver or a guaranty association), who unsuccessfully makes a claim directly against the reinsurer, their attorneys' fees and expenses incurred in preventing any collection by that person.

I. Nothing in this Act shall be construed to authorize the liquidator or any other entity to compel payment from a non-life reinsurer on the basis of estimated incurred but not reported losses or loss expenses or case reserves for unpaid losses and loss expenses, except under Sections 614 and 615 and with respect to claims allowed in accordance with Section 705.

Section 612. Life and Health Reinsurance

A. Contracts reinsuring life, disability income or long term care insurance policies or annuities issued by a ceding insurer that has been placed in conservation or rehabilitation proceedings pursuant to this Act shall be continued or terminated pursuant to the terms or conditions of each contract and the provisions of this section.

B. Contracts reinsuring life, disability income or long term care insurance policies or annuities issued by a ceding insurer that has been placed into liquidation pursuant to this Act shall be continued, subject to the provisions of this section, unless either (i) the contracts were terminated pursuant to their terms prior to the date of the order of liquidation (the "coverage date"); or (ii) the contracts were terminated pursuant to the order of liquidation, in which case the provisions of Subsection I shall apply.

C. (1) At any time within 180 days of the coverage date, a guaranty association covering life, disability income or long term care insurance policies or annuities, in whole or in part, may elect to assume the rights and obligations of the ceding insurer that relate to the policies or annuities covered, in whole or in part, by the guaranty association, in each case under any one or more reinsurance contracts between the insolvent insurer and its reinsurers selected by the guaranty association. Any such assumption shall be effective as of the coverage date. The election shall be effected by the guaranty association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(2) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding insurer shall make available upon request to affected guaranty associations or to NOLHGA on their behalf as soon as possible after commencement of formal delinquency proceedings (i) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and (ii) notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(3) The following Subparagraphs (a) through (d) shall apply to reinsurance contracts so assumed by a guaranty association:

(a) The guaranty association shall be responsible for all unpaid premiums due under the reinsurance contracts, for periods both before and after the coverage date, and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case that relates to policies of life, disability income or long term care insurance or annuities covered, in whole or in part, by the guaranty associations. The guaranty association may charge policies of insurance or annuities covered in part by the guaranty association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the guaranty association and shall provide notice and an accounting of these charges to the liquidator.

(b) The guaranty association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods on or after the coverage date and that relate to policies of life, disability income or long term care insurance or annuities covered, in whole or in part, by the association, provided that, upon receipt of the amounts, the guaranty association shall be obliged to pay to the beneficiary under the insurance policy or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(i) The amount received by the guaranty association; and

(ii) The excess of the amount received by the guaranty association over the amount equal to the benefits paid by the guaranty association on account of the policy or annuity less the retention of the insurer applicable to the loss or event.

(c) Within thirty (30) days following the guaranty association's election (the "election date"), the guaranty association and each reinsurer under contracts assumed by the guaranty association shall calculate the net balance due to or from the guaranty association under each reinsurance contract as of the election date with respect to policies or annuities covered, in whole or in part, by the guaranty association, which calculation shall give full credit to all items paid by either the insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the coverage date, subject to any set-off for premiums unpaid for periods prior to the date, and the guaranty association or reinsurer shall pay any remaining balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the guaranty association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, pursuant to the provisions of Subsection I(4). If the receiver has received any amounts due the guaranty association pursuant to Subparagraph (b) of this paragraph, the receiver shall remit the same to the guaranty association as promptly as practicable.

(d) If the guaranty association or receiver, on the guaranty association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies of life, disability income or long term care insurance or annuities covered, in whole or in part, by the guaranty association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premiums, insofar as the reinsurance contracts relate to policies of life, disability income or long term care insurance or annuities covered, in whole or in part, by the guaranty association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the guaranty association, against amounts due the guaranty association.

D. When, pursuant to court approval under Section 502 of this Act, a receiver continues policies of life, disability income or long term care insurance or annuities in force following an order of liquidation, and the policies of insurance are not covered in whole or in part by one or more guaranty associations, the receiver may, within 180 days of the coverage date, elect to assume the rights and obligations of the ceding insurer under any one or more of the reinsurance contracts that relate to the policies or annuities, provided the contracts have not been terminated as set forth in Subsection B. The election shall be effected by sending written notice, return receipt requested, to the affected reinsurers. In that event, payment of premiums on the reinsurance contracts for the policies and annuities, for periods both before and after the coverage date, shall be chargeable against the estate as a Class 1 administrative expense. Amounts paid by the reinsurer on account of losses on the policies and annuities shall be to the estate of the insolvent insurer.

E. During the period from the coverage date until the election date,

(1) (a) Neither the guaranty association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the guaranty association has the right to assume under Subsection C, whether for periods prior to or after the coverage date;

(b) Neither the receiver nor the reinsurer shall have any rights or obligations under reinsurance contracts that the receiver has the right to assume under Subsection D with respect to the period after the coverage date, but their respective rights and obligations for the period prior to the coverage date shall remain unchanged; and

(c) The reinsurer, the receiver and the guaranty associations shall, to the extent practicable, provide each other data and records reasonably requested;

(2) Provided that once the guaranty association or the receiver, as the case may be, has elected, or declined to elect, to assume a reinsurance contract, the parties' rights and obligations shall be governed by Subsection C, D or I, as applicable.

F. (1) If a guaranty association does not elect to assume a reinsurance contract by the election date pursuant to Subsection C, the guaranty association shall have no rights or obligations, in each case for periods both before and after the coverage date, with respect to the reinsurance contract.

(2) If a receiver does not elect to assume a reinsurance contract by the election date pursuant to Subsection D, the receiver and the reinsurer shall retain their respective rights and obligations with respect to the reinsurance contract for the period before the coverage date, but shall have no rights or obligations to each other for the period after the coverage date, except as provided in Subsection I.

(3) Where a guaranty association or the receiver, as the case may be, does not elect to assume a reinsurance contract by the election date, the reinsurance contract shall be terminated retroactively effective on the coverage date. Reinsurance contracts covering policies of life, disability income or long term care insurance or annuities that are terminated pursuant to Section 502 shall terminate effective on the coverage date. In either case, Subsection I shall apply.

G. When policies of life, disability income or long term care insurance or annuities, or guaranty association obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies or annuities may also be transferred by the guaranty association, in the case of contracts assumed under Subsection C, or the receiver, in the case of contracts assumed under Subsection D, as the case may be, subject to the following:

(1) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance or annuities in addition to those transferred;

(2) The obligations described in Subsections C and D of this section shall no longer apply with respect to matters arising after the effective date of the transfer; and

(3) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

H. The provisions of this section shall, to the extent provided in this Act, supersede the provisions of any law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the coverage date, subject to provisions of this Act including applicable setoff provisions.

I. When a contract reinsuring life, disability income or long term care insurance policies or annuities is terminated pursuant to this Act, the procedures set forth in this subsection shall apply.

(1) The reinsurer and the receiver shall, upon written notice to the other party to the reinsurance contract no later than thirty (30) days after the receipt by the reinsurer of notice of termination, commence a mandatory negotiation and arbitration procedure in accordance with this subsection.

(2) Each party shall appoint an actuary to determine an estimated sum due as a result of the termination of the reinsurance contract calculated in a way expected to make the parties economically indifferent as to whether the reinsurance contract continues or terminates, giving due regard to the economic effects of the insolvency. The sum shall take into account the present value of future cash flows expected under the reinsurance contract and be based on a gross premium valuation of net liability using current assumptions that reflect post-insolvency experience expectations, with no additional margins, net of any amounts payable and receivable, with a market value adjustment to reflect premature sale of assets to fund the settlement.

(3) Within ninety (90) days of the written request pursuant to Paragraph (1), each party shall provide the other party with its estimate of the sum due as a result of the termination of the reinsurance contract, together with all relevant documents and other information supporting the estimate. The parties shall make a good faith effort to reach agreement on the sum due.

(4) If the parties are unable to reach agreement within ninety (90) days following the submission of materials required in Paragraph (3), either party may initiate arbitration proceedings as provided in the reinsurance contract. In the event that the reinsurance contract does not contain an arbitration clause, either party may initiate arbitration pursuant to this paragraph by providing the other party with a written demand for arbitration. The arbitration shall be conducted pursuant to the following procedures:

(a) Venue for the arbitration shall be within the county of the court's jurisdiction or another location agreed to by the parties.

(b) Within thirty (30) days of the responding party's receipt of the arbitration demand, each party shall appoint an arbitrator who is a disinterested active or retired officer or executive of a life insurance or reinsurance company, or other professional with no less than ten (10) years' experience in or relating to the field of life insurance or life reinsurance. The two arbitrators shall appoint an independent, impartial, disinterested umpire who is an active or retired officer or executive of a life insurance or reinsurance company, or other professional with no less than ten (10) years' experience in the field of life insurance or life reinsurance. If the arbitrators are unable to agree on an umpire, each arbitrator shall provide the other with the names of three (3) qualified individuals, each arbitrator shall strike two (2) names from the other's list and the umpire shall be chosen by drawing lots from the remaining individuals.

(c) Within sixty (60) days following the appointment of the umpire, the parties shall, unless otherwise ordered by the panel, submit to the arbitration panel their estimates of the sum due as a result of the termination of the reinsurance contract, together with all relevant documents and other information supporting the estimate.

(d) The time periods set forth in these subparagraphs may be extended upon mutual agreement of the parties.

(e) The panel shall have all powers necessary to conduct the arbitration proceedings in a fair and appropriate manner, including the power to request additional information from the parties, authorize discovery, hold hearings and hear testimony. The panel also may, if it deems necessary, appoint independent actuarial experts, the expense of which shall be shared equally between the parties.

(5) An arbitration panel considering the matters set forth in this subsection shall apply the standards set forth in Subsection I(2) and shall issue a written award specifying a net settlement amount due from one party or the other as a result of the termination of the reinsurance contract. The supervising court shall confirm that award absent proof of statutory grounds for vacating or modifying arbitration awards under the Federal Arbitration Act.

(6) If the net settlement amount agreed or awarded pursuant to this subsection is payable by the reinsurer, the reinsurer shall pay the amount due to the estate subject to any applicable set-off under Section 609. If the net settlement amount agreed or awarded pursuant to this subsection is payable by the insurer, the reinsurer shall be deemed to have a timely filed claim against the estate for that amount, which claim shall be paid pursuant to the priority established in Section 801G. The guaranty associations shall not be entitled to receive the net settlement amount, except to the extent they are entitled to share in the estate assets as creditors of the estate, and shall have no responsibility for the net settlement amount.

J. Except as otherwise provided in this section, nothing in this section shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policyholder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect any guaranty association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

Drafting Note: For those states that have adopted Section 8N of the NAIC Life and Health Insurance Guaranty Association Model Act, this section should be read in conjunction with that section.

Section 613. Recovery of Premiums Owed

A. An insured shall pay, either directly to the receiver or to an agent that has paid or is obligated to pay the receiver on behalf of the insured, any unpaid earned premium or retrospectively rated premium due the insurer. Premium on surety business is deemed earned at inception if no policy term can be determined. All other premium will be deemed earned and will be prorated equally over the determined policy term, regardless of any provision in the bond, guaranty, contract or other agreement.

B. A person, other than the insured, responsible for the remittance of a premium, shall turn over to the receiver any unpaid premium due and owing as shown on the records of the insurer, including any amount representing commissions, for the full policy term due the insurer at the time of the entry of the receivership order, whether earned or unearned based on the termination of coverage under Section 502. The unpaid premium due the receiver from any person other than the insured excludes any premium not collected from the insured and not earned based on the termination of coverage under Section 502.

C. A person, other than the insured, responsible for the remittance of a premium, shall turn over to the receiver any unearned commission of that person based on the termination of coverage under Section 502. Credits or setoffs or both shall not be allowed to an agent, broker, premium finance company or any other person for any amounts advanced to the insurer by the person on behalf of, but in the absence of a payment by, the insured, or for any other amount paid by the person to any other person after the entry of the order of receivership.

D. Persons that collect premium, or finance premium under a premium finance contract, that is due the insurer in receivership are deemed to hold that premium in trust as a fiduciary for the benefit of the insurer and to have availed themselves of the laws of this state, regardless of any provision to the contrary in any agency contract or other agreement.

E. A premium finance company is obligated to pay any amounts due the insurer from premium finance contracts, whether the premium is earned or unearned. The receiver has the right to collect any unpaid financed premium directly from the premium finance company by taking an assignment of the underlying premium finance contracts, or directly from the insured that is a party to the premium finance contract.

F. Upon satisfactory evidence of a violation of this section, by a person other than an insured, the commissioner may pursue one or more of the following courses of action:

(1) Suspend or revoke or refuse to renew the licenses of the offending party or parties;

(2) Impose a penalty of not more than $1,000 for each act in violation of this section by the party or parties; and

(3) Impose any other sanction or penalty allowed for by law.

G. Before the commissioner shall take any action as set forth in Subsection F of this section, written notice shall be given to the person, company, association or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least ten (10) days thereafter, when a hearing on the matter shall be held. After a hearing, or upon failure of the accused to appear at a hearing, the commissioner, if a violation is found, shall impose the penalties under Subsection F of this section that he or she deems advisable. If the commissioner takes action under this subsection, the party aggrieved may appeal from that action as provided in Section [insert citation to state administrative procedure act].

Section 614. Commutation and Release Agreements

A. Notwithstanding Section 611, the liquidator and any reinsurer may negotiate a voluntary commutation and release of all obligations arising from reinsurance agreements in which the insurer was the ceding party. Any commutation and release agreement voluntarily entered into by the parties shall be commercially reasonable, actuarially sound, and in the best interests of the creditors of the insurer. Any agreement subject to this subsection that has a gross consideration in excess of $250,000 shall be submitted pursuant to Section 107 to the receivership court for approval. The agreement shall be approved if it meets the standards described in this subsection.

B. Without derogating from the provisions of Section 611, in the event that the liquidator is unable to negotiate a voluntary commutation with a reinsurer with respect to the reinsurance agreements between the insurer and that reinsurer, the liquidator may, in addition to any other remedy available under applicable law, apply to the receivership court, with notice to the reinsurer, for an order requiring that the parties submit commutation proposals with respect to the reinsurance agreements to a panel of three (3) arbitrators:

(1) At any time after seventy-five percent (75%) of the actuarially estimated ultimate incurred liability for all of the casualty claims against the liquidation estate, calculated as of the date of the entry of the order of liquidation by or at the instance of the liquidator, is reached by allowance of claims in the liquidation estate pursuant to Sections 703 and 705; provided that for purposes of this subsection, the calculation shall not be performed during the five-year period subsequent to the entry of the order of liquidation; or

(2) At any time in regard to a reinsurer if that reinsurer has a total adjusted capital that is less than 250 percent of its Authorized Control Level Risk Based Capital (RBC) as defined in [cite to states enactments related to the RBC Model Act and any related regulations].

C. For purposes of this section "casualty claims" means the insurer's aggregate claims arising out of insurance contracts in the following lines: farm owners multiperil, homeowners multiperil, commercial multiperil, medical malpractice, workers' compensation, other liability, products liability, auto liability, aircraft (all peril) and international (of the foregoing lines).

D. Venue for the arbitration shall be within the district of the receivership court's jurisdiction, or another location agreed to by the parties.

E. If the liquidator determines that commutation would be in the best interests of the creditors of the liquidation estate, the liquidator may petition the receivership court to order arbitration, in which case the receivership court shall require that the liquidator and the reinsurer each appoint an arbitrator within thirty (30) days after the date of entry of the order for arbitration. If either party fails to appoint an arbitrator within the thirty-day period, the other party shall be entitled to appoint both arbitrators, which appointments shall be binding on the parties. The two (2) arbitrators shall be active or retired executive officers of insurance or reinsurance companies, not under the control of or affiliated with the insurer or the reinsurer. Within thirty (30) days after appointment of the two (2) arbitrators, the two (2) arbitrators shall attempt to agree on the appointment of a third independent, impartial, disinterested arbitrator and if agreement is not reached within the thirty-day period, the third arbitrator shall be appointed by the receivership court. The disinterested arbitrator shall be or, if retired, have been, an executive officer of a U.S. domiciled insurance or reinsurance company, not under the control of or affiliated with either of the parties, who has had at least fifteen (15) years' experience in the reinsurance industry.

F. The arbitration panel may choose to retain as an expert to assist the panel in its determinations, a retired, disinterested executive officer of a U.S. domiciled insurance or reinsurance company having at least fifteen (15) years loss reserving actuarial experience. In the event that the panel is unable to unanimously agree on the identity of the expert within fourteen (14) days, the expert shall be appointed by the president of the Casualty Actuarial Society should the matter involve underlying property and casualty insurance or the president of the Society of Actuaries should the matter involve underlying life insurance. The expert shall not be entitled to vote in the proceeding, but shall issue a written report and recommendation to the panel within sixty (60) days after receipt of the commutation proposals submitted by the parties pursuant to Subsection G, which shall be included as part of the arbitration record and accompany the award issued by the panel pursuant to Subsection H. The cost of the expert should be paid equally by the parties.

G. Within ninety (90) days following the appointment of the third arbitrator under Subsection E, the parties shall submit to the arbitration panel their commutation proposals and other documents and information relevant to the determination of the parties rights and obligations under the reinsurance agreement to be commuted, including a written review of any disputed paid claim balances, any open claim files and related case reserves at net present value, and any actuarial estimates with the basis of computation of any other reserves and any incurred-but-not-reported losses at net present value.

H. Within ninety (90) days following the parties' submissions under Subsection G, the arbitration panel shall:

(1) Issue an award, determined by a majority of the panel, specifying the terms of a commercially reasonable and actuarially sound commutation agreement between the parties; or

(2) If a majority of the panel determines that it is unable to derive a commercially reasonable and actuarially sound commutation based upon the submissions of the parties and, if applicable, the report and recommendation of the expert retained in accordance with Subsection F, the panel shall be entitled to issue an award declining commutation between the parties for a period not to exceed two (2) years. Following expiration of the two-year period allowable under this paragraph, the liquidator shall be entitled to again invoke arbitration in accordance with Subsection B, in which event the provisions of Subsections B through I will be applied to the renewed proceeding, except that the panel shall be obliged to issue an award under Paragraph (1).

I. Once an award is issued, the liquidator shall promptly submit the award to the receivership court for confirmation.

J. Within thirty (30) days of confirmation of the award by the receivership court, the reinsurer shall give notice to the receiver that it:

(1) Will commute its liabilities to the insurer for the amount of the award in return for a full and complete release of all liabilities between the parties, whether past, present or future; or

(2) Will not commute its liabilities to the insurer, in which case the reinsurer shall establish and maintain in accordance with Section 615 a Reinsurance Recoverable Trust in the amount of 102 percent of the award. The reinsurer shall pay the costs and fees associated with establishing and maintaining the trust established under this subsection.

K. If the reinsurer notifies the liquidator that it will commute its liabilities pursuant to Subsection J(1), the liquidator shall have thirty (30) days to:

(1) Tender to the reinsurer a proposed commutation and release agreement providing for a full and complete release of all liabilities between the parties, whether past, present or future, which agreement shall require that the reinsurer effect payment of the commutation amount within fourteen (14) days from the date of consummation of the agreement; or

(2) Reject the commutation in writing, subject to receivership court approval, in which event the reinsurer shall be obliged to establish and maintain a Reinsurance Recoverable Trust in accordance with Section 615. The liquidator and the reinsurer shall share equally in the costs and fees associated with establishing and maintaining the trust established under this subsection.

L. Except for the period provided in Paragraph H(2), the time periods established in Subsections F, G, H, J and K may be extended upon the consent of the parties or by order of the receivership court, for good cause shown.

M. Subject to Subsection N, nothing in this section shall be construed to supersede or impair any provision in a reinsurance agreement that establishes a commercially reasonable and actuarially sound method for valuing and commuting the obligations of the parties to the reinsurance agreement by providing in the contract the specific methodology to be used for valuing and commuting the obligations between the parties.

N. A commutation provision in a reinsurance agreement is not effective if it is demonstrated to the receivership court that the provision was entered into in contemplation of the insolvency of one or more of the parties. A contractual commutation provision entered into within one year of the liquidation order of the insurer shall be rebuttably presumed to have been entered into in contemplation of insolvency.

Section 615. Reinsurance Recoverable Trust Provisions

A. As used in this section:

(1) "Beneficiary" means the domiciliary insurance commissioner, as liquidator of the insurer for whose sole benefit a Reinsurance Recoverable Trust is established.

(2) "Grantor" means the reinsurer who has established a Reinsurance Recoverable Trust for the sole benefit of the beneficiary.

(3) A "qualified U.S. financial institution" means an institution that:

(a) Is organized, or in the case of a U.S. branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(b) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(4) "Reinsurance Recoverable Trust" means a trust established pursuant to Section 614.

B. The trust agreement governing a Reinsurance Recoverable Trust shall:

(1) Be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified U.S. financial institution;

(2) Create a trust account into which assets shall be deposited in accordance with Section 614;

(3) Provide that the beneficiary shall have the right to withdraw assets from the trust only:

(a) Based on filed claims allowed pursuant to Sections 703 or 705;

(b) Where the grantor has been notified, in writing, of the allowance of the claim;

(c) To the extent that the amount to be withdrawn exceeds any setoff permitted by Section 609 due to the grantor; and

(d) Where sixty (60) days has expired during which the grantor has failed to either pay the claim or, subject to and without derogation from Section 611, the provisions of which shall at all times be and remain binding on the reinsurer, file notice of a written dispute with respect to the claim under and in terms of the reinsurance agreement; or

(e) If the beneficiary has complied with any different or other terms and conditions mutually agreed to by the beneficiary and the grantor in the trust agreement;

(4) Require the trustee to:

(a) Receive assets and hold all assets at the trustee's office in the United States in a safe place;

(b) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate the assets, without consent or signature from the grantor or any other person or entity;

(c) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter; and

(d) Notify the grantor and the beneficiary within ten (10) days of any deposits to or withdrawals from the trust account;

(5) Be made subject to and governed by the laws of this state;

(6) Prohibit the invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee;

(7) Provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith;

(8) Provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice, provided that a resignation or removal shall not be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee;

(9) Provide that the grantor shall have the full and unqualified right to vote any shares of stock in the trust account. Subject to other provisions of this section, any interest or dividends paid on shares of stock or other obligations in the trust account shall remain in the trust;

(10) Specify categories of investments reasonably acceptable to the beneficiary and authorize the trustee to invest funds and to accept substitutions, by the grantor, that the trustee determines are at least equal in market value to the assets withdrawn provided that no investment or substitution shall be made without prior approval from the beneficiary, which shall not be unreasonably or arbitrarily withheld;

(11) Provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets;

(12) Specify the types of assets that may be included in the trust account, which shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. bank and payable in U.S. dollars, and investments permitted by this state's insurance law or any combination of the above, provided investments in or issued by any entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. Assets deposited in the trust account shall be valued according to their current fair market value;

(13) Give the grantor the right to seek approval from the beneficiary, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the grantor, provided that:

(a) The grantor shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets so as to maintain at all times the deposit in the required amount; or

(b) After withdrawal and transfer, the market value of the trust account is no less than 102 percent of the award made pursuant to Section 614G (1);

(14) Provide for the return of any amount withdrawn in excess of the actual amounts required for payment of reported allowed claims under Paragraph (3) of this subsection, and for interest payments at a rate not in excess of the prime rate of interest on the excess amounts withdrawn; and

(15) Provide for termination of the Reinsurance Recoverable Trust in accordance with Subsection F.

C. Nothing in this subsection shall be construed to alter the rights or obligations of the parties pursuant to contractual and statutory provisions providing for notice and the determination of claims.

D. The grantor shall, prior to depositing assets with the trustee, execute assignments or endorsements in blank, or transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the beneficiary, or the trustee upon the direction of the beneficiary, may whenever necessary negotiate these assets without consent or signature from the grantor or any other entity.

E. Without derogating the provisions of Section 611, in the event that the Reinsurance Recoverable Trust is exhausted or is insufficient to respond to claims allowed pursuant to Sections 703 or 705, should the grantor or the beneficiary believe that the amount held in the Reinsurance Recoverable Trust is either deficient or overstated, as the case may be, the grantor or the beneficiary may, should they fail to reach agreement on the extent, if any, to which supplementation or reduction of the Reinsurance Recoverable Trust should be occasioned, request that the receivership court order review of the amount held. This review shall be conducted applying procedures and terms as the receivership court shall, in its sole discretion, direct.

F. A Reinsurance Recoverable Trust shall terminate upon the earlier of

(1) The receivership court approval of a voluntary commutation between the grantor and the beneficiary pursuant to Section 614A;

(2) The mutual agreement of the grantor and the beneficiary; or

(3) A finding by the receivership court that the grantor has discharged its liabilities to the beneficiary.

G. Upon termination of the Reinsurance Recoverable Trust, all assets not previously withdrawn by the beneficiary, pursuant to Subsection B(3) of this section, shall, with written approval of the beneficiary, be delivered to the grantor.

ARTICLE VII. CLAIMS

Section 701. Filing of Claims

A. Proof of all claims shall be filed with the liquidator in the form required by Section 702 on or before the last day for filing specified in the notice required under Section 505, which date shall not be later than eighteen (18) months after entry of the order of liquidation unless the receivership court, for good cause shown, extends the time, except that proofs of claim for cash surrender values or other investment values in life insurance and annuities and for any other policies insuring the lives of persons need not be filed unless the liquidator expressly so requires. Only upon application of the liquidator, the receivership court may allow alternative procedures and requirements for the filing of proofs of claim or for allowing or proving claims. Upon application, if the receivership court dispenses with the requirements of filing a proof of claim by a person, class or group of persons, a proof of claim for such a person, class or group shall be deemed as having been filed for all purposes, except that the receivership court's waiver of proof of claim requirements shall not impact guaranty association proof of claim filing requirements or coverage determinations to the extent that the guaranty fund statute or filing requirements are inconsistent with the receivership court's waiver of proof.

B. The liquidator shall permit a claimant that makes a late filing to share ratably in distributions, whether past or future, as if the claim were not filed late, to the extent that the payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) The eligibility to file a proof of claim was not known to the claimant, and the claimant filed a proof of claim within ninety (90) days after first learning of the eligibility;

(2) A transfer to a creditor was avoided under Sections 603, 604 or 606, or was voluntarily surrendered under Section 608, and the filing satisfies the conditions of Section 608; or

(3) The valuation of security held by a secured creditor under Section 710 shows a deficiency and the claim for the deficiency is filed within thirty (30) days after the valuation.

C. Claims filed by reinsurers whose reinsurance contracts are terminated pursuant to Section 612, which arise from the termination, shall not be deemed late if they are filed within ninety (90) days of the termination and shall receive a ratable share of distributions, whether past or future, as if the claims were not late.

D. The liquidator may petition the receivership court, subject to Section 107, to set a date certain after which no further claims may be filed, notwithstanding any other provision of this Act.

Section 702. Proof of Claim

A. Proof of claim shall consist of a statement signed by the claimant or on behalf of the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

(2) The identity and amount of the security on the claim;

(3) The payments made on the debt, if any;

(4) That the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(5) Any right of priority of payment or other specific right asserted by the claimant;

(6) The name and address of the claimant and the attorney, if any, who represents the claimant; and

(7) The claimant's social security or federal employer identification number.

B. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

C. At any time the liquidator may require the claimant to present information or evidence supplementary to that required under Subsection A and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

D. A guaranty association shall be permitted to file a single omnibus proof of claim for all claims of the association in connection with payment of claims of the insurer. The omnibus proof of claim may be periodically updated by the association without regard to the deadline specified in Section 701A, and the association may be required to submit a reasonable amount of documentation in support of the claim.

Section 703. Allowance of Claims

A. Except as provided in Subsections K and L, the liquidator shall review all claims duly filed in the liquidation proceeding and shall further investigate, as the liquidator considers necessary. Consistent with the provisions of this Act, the liquidator may allow, disallow or compromise claims that will be recommended to the receivership court unless the liquidator is required by law to accept claims as settled by a person or organization, including a guaranty association, subject to any statutory or contractual rights of the affected reinsurers to participate in the claims allowance process. Notwithstanding any other provision of this Act, no claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits or otherwise beyond or contrary to the coverage provided under the terms of the insurer's policies or contracts.

B. Pursuant to the review, the liquidator shall provide notice of the claim determination by any means authorized under Subsection 107 of this Act to the claimant or the claimant's attorney. The notice shall set forth the amount of the claim allowed by the liquidator, if any, and the priority class of the claim as established in Section 801. In regard to claims to be allowed pursuant to Section 705, preliminary notice of the amount of the claim determination shall be provided to any reinsurer that is or may be liable in respect to the claim at least forty-five (45) days before notice is provided to the claimant pursuant to this subsection. In regard to claims being allowed other than pursuant to Section 705, the same notice may be provided to any reinsurer that is or may be liable in respect of the claim. If no timely objection is submitted, the determination is binding on the reinsurer upon allowance.

C. Within forty-five (45) days after the date the notice set forth in Subsection B was mailed, the claimant noticed may submit written objections to the liquidator. Any such objections shall clearly set out all facts and the legal basis, if any, for the objections and the reasons why the claim should be allowed at a different amount or in a different priority class. If no timely objection is submitted, the determination is final. The liquidator may accelerate the allowance of claims by obtaining waivers of objections.

D. A claim that is not mature as of the coverage termination date established under Section 502 may be allowed as if it were mature, except it shall be discounted to present value. A claim is not mature if payment on the claim is not yet due.

E. A judgment or order against an insured or the insurer entered after the date of the initial filing of a successful petition for receivership, or within 120 days before the initial filing of the petition, and a judgment or order against an insured or the insurer entered at any time by default or by collusion need not be considered as evidence of liability or of the amount of damages.

F. Claims under employment contracts by directors, officers or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to any order of receivership, unless explicitly approved in writing by the commissioner prior to an order of receivership or by the conservator or rehabilitator before the entry of an order of liquidation or by the liquidator after the entry of an order of liquidation.

G. The total liability of the liquidator to all claimants arising out of the same act or policy shall be no greater than the insurer's total liability would have been were the insurer not in liquidation.

H. The liquidator shall disallow claims that are for or determined to be for *de minimis* amounts. A *de minimis* amount shall be any amount equal to or less than a maximum *de minimis* amount approved by the receivership court as being reasonable and necessary for administrative convenience.

I. Claims that do not contain all the applicable information required by Section 702, need not be further reviewed or adjudicated and may be denied or disallowed by the liquidator subject to the notice and objection procedures in this section

J. The liquidator may reconsider a claim on the basis of additional information and amend the recommendation to the receivership court. The claimant shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The receivership court may amend its allowance or disallowance as appropriate.

K. The liquidator is not required to process claims for any class until it appears reasonably likely that property will be available for a distribution to that class. If there are insufficient assets to justify processing all claims for any class listed in Section 801, the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims.

L. Any claim of a lessor for damages resulting from the termination of a lease of real property shall be disallowed to the extent the claim exceeds:

(1) The rent reserved by the lease, without acceleration, for the greater of one year, or fifteen percent (15%), not to exceed three (3) years, of the remaining term of the lease, following the earlier of:

(a) The date of the filing of the petition; and

(b) The date on which the lessor repossessed, or the lessee surrendered, the leased property; plus

(2) Any unpaid rent due under the lease, without acceleration, on the earlier of these dates.

Section 704. Claims under Occurrence Policies, Surety Bonds and Surety Undertakings

A. Subject to the provisions of Section 703, any insured shall have the right to file a claim for the protection afforded under the insured's policy, irrespective of whether a claim is then known, if the policy is an occurrence policy.

B. Subject to the provisions of Section 703, any obligee shall have the right to file a claim for the protection afforded under a surety bond or a surety undertaking issued by the insurer as to which the obligee is the beneficiary, irrespective of whether a claim is then known.

C. After a claim is filed under Subsection A or B, when a specific claim is made by or against the insured or by the obligee, the insured or the obligee shall supplement the claim, and the receiver shall treat the claim as a contingent or unliquidated claim under Section 705.

Section 705. Allowance of Contingent and Unliquidated Claims

A. A claim of an insured or third party may be allowed under Section 703, regardless of the fact that it was contingent or unliquidated if any contingency is removed in accordance with Subsection B and the value of the claim is determined in accordance with Subsection C.

(1) A claim is contingent if the accident, casualty, disaster, loss, event or occurrence insured, reinsured or bonded against occurred on or before the date fixed under Section 501, but the act or event triggering the company's obligation to pay has not occurred as of that date.

(2) A claim is unliquidated if the insurer's obligation to pay has been established, but the amount of the claim has not been determined.

B. Unless the receivership court directs otherwise, a contingent claim may be allowed if:

(1) The claimant has presented proof of the insurer's obligation to pay reasonably satisfactory to the liquidator; or

(2) The claim was based on a cause of action against an insured of the insurer; and

(a) It may be reasonably inferred from proof presented upon the claim that the claimant would be able to obtain a judgment; and

(b) The person has furnished suitable proof, unless the receivership court for good cause shown shall otherwise direct, that no further valid claims can be made against the insurer arising out of the cause of action other than those already presented.

C. (1) An unliquidated claim may be allowed if its amount has been determined.

(2) If the amount of an unliquidated claim filed pursuant to Section 701 remains undetermined, the valuation of the unliquidated claim may be made by estimate whenever the liquidator determines that either liquidation of the claim would unduly delay the administration of the liquidation proceeding or that the administrative expense of processing and adjudicating the claim or group of claims of a similar type would be unduly excessive when compared with the property that is estimated to be available for distribution with respect to the claim. Any estimate shall be based on an accepted method of valuing claims with reasonable certainty at their net present value, such as actuarial evaluation.

D. As used in this section, "claim" means a demand for payment pursuant to Section 701 under the terms and conditions of a contract issued by the insurer as a result of a known accident, casualty, disaster, loss, event or occurrence.

E. Notwithstanding the other provisions of this section, claims for the value or breach of any life, disability income, or long term care insurance policy or annuity shall not result in or serve as the basis of any liability of any reinsurer of the insurer. The reinsurers' liability to the insurer shall be determined exclusively on the basis of their contracts of reinsurance and the provisions of Section 612.

F. The liquidator may petition the receivership court to set a date certain prior to which all claims under this section shall be final. In addition to the notice requirements of Section 107, the liquidator shall give notice of the filing of the petition to all claimants with claims that remain contingent or unliquidated under this section.

Section 706. Special Provisions for Third Party Claims

A. Whenever a third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator on or before the last day for filing claims.

B. Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation.

C. The liquidator may make recommendations to the receivership court for the allowance of an insured's claim after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the receivership court, the liquidator shall withhold any distribution payable on the claim, pending the outcome of litigation and negotiation between the insured and the third party. The liquidator may reconsider the claim as provided in Subsection 703J. As claims against the insured are settled or barred, the insured or third party, as appropriate, shall be paid, from the amount withheld, the same percentage distribution as was paid on other claims of like priority, based on the lesser of the amount actually due from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or the amount allowed on the claims by the receivership court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed property of the insurer.

Drafting Note: The fact that a third party claim often remains unsettled for a long time should not prevent the insured from getting protection from his or her policy as others have received from theirs, so long as it does not unreasonably delay the liquidation. Each claim should be evaluated at the latest possible time and a distribution apportioned to it. In this case, however, the distribution should not be paid to the insured but withheld for future payment to the insured, after completion of the litigation and payment of the judgment. If the insured wins the litigation, the amount withheld would revert to the unallocated funds of the liquidator except for allowable defense costs. If the amount reverts at a time or in a sum that would make it uneconomic to distribute it, it would be distributed in accordance with Section 804.

D. (1) If several claims founded upon one policy are timely filed, whether by third parties or as claims by the insured under this section, and the aggregate amount of the timely filed allowed claims exceeds the aggregate policy limits, the liquidator may:

(a) Apportion the policy limits ratably among the timely filed allowed claims; or

(b) Give notice to the insured, known third parties and affected guaranty associations that the aggregate policy limits have been exceeded. Thirty (30) days after the date of the liquidator's notice, no further amounts shall be allowed, the policy limits shall be apportioned ratably among the timely filed allowed claims, and any additional claims shall be rejected.

(2) Claims by the insured shall be evaluated as in Subsection C. If any insured's claim is subsequently reduced under Subsection C, the amount thus freed shall be apportioned ratably among the claims that have been reduced under this subsection.

E. No claim may be allowed under this section to the extent it is covered by any guaranty association.

F. A claimant may withdraw a proof of claim with the liquidator's approval. The liquidator may approve the withdrawal after giving notice of the withdrawal to the insured and only upon a showing of good cause.

G. The filing of a proof of claim in connection with a claim against an insured shall have the following effect on the rights of the claimant and the insured:

(1) By filing a proof of claim, a claimant waives any right to pursue the personal assets of the insured with respect to the claim, to the extent of the coverage or policy limits provided by the insurer, and agrees that, to the extent of the coverage or policy limits provided by the insurer, the claimant shall seek satisfaction of the claim against the insured solely from distributions paid by the liquidator on the claim and from any payments that a guaranty association may pay on account of the claim, except as provided in this section.

(2) The waiver provided under this section is conditioned upon the cooperation of the insured with the liquidator in the defense of the claim and any applicable guaranty association in defense of the claim. The waiver provided under this section does not operate to discharge the guaranty association from any of its responsibilities and duties, or release the insured with respect to any claim in excess of the coverage or policy limits provided by the insurer, or any other responsible party or release the insured to the extent of the guaranty association's claim for reimbursement from the insured under a guaranty association act provision instituting a right to recover from high net worth insureds.

(3) The waiver provided under this section shall be void if:

(a) A claimant withdraws his or her proof of claim under Subsection F; or

(b) The liquidator avoids insurance coverage in connection with a proof of the claim.

(4) The liquidator shall provide, where applicable, notice of the election of remedies provision in this section on any proof of claim form it distributes. The notice shall be inserted above the claimant's signature line in typeface no smaller than the typeface of the rest of the notice and, in any event, no smaller than font size 14 and shall include a statement substantially similar to the following: "I understand by filing this claim in the estate of the insurer I am waiving any right to pursue the personal assets of the insured to the extent that there are policy limits or coverage provided by the now insolvent insurer."

Section 707. Disputed Claims

A. The liquidator may adopt, with the approval of the receivership court, procedures for the review, determination and appeal of claims that will be preliminary to review by the receivership court.

B. Whenever objections to the liquidator's proposed treatment of a claim are filed and the liquidator does not alter the determination of the claim as a result of the objections, the liquidator shall ask the receivership court for a hearing pursuant to Section 107.

C. The provisions of this section are not applicable to disputes with respect to coverage determinations by guaranty associations as part of their statutory obligations.

D. The final disposition by the receivership court of a disputed claim shall be deemed a final judgment for purposes of appeal.

Section 708. Liquidator's Recommendations to the Receivership Court

The liquidator shall present to the receivership court, for approval, reports of claims settled or determined by the liquidator under Section 703. The reports will be presented from time to time as determined by the liquidator. The reports shall include information identifying the claim and the amount and priority class of the claim.

Section 709. Claims of Co-debtors

If a creditor does not timely file a proof of the creditor's claim, an entity that is liable to the creditor together with the insurer, or that has secured the creditor, may file a proof of the claim.

Section 710. Secured Creditors' Claims

A. The value of a security held by a secured creditor shall be determined in one of the following ways:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to the creditor; or

(2) By agreement or litigation between the creditor and the liquidator.

B. (1) If a surety has paid any losses and loss adjustment expenses under its own surety instrument prior to any petition for a delinquency proceeding and the principal has posted collateral that remains available to reimburse the losses and/or loss adjustment expenses and at the time of the petition that collateral had not been credited against the payments made, then the receiver has the first priority to utilize the collateral to reimburse the pre-petition losses and expenses.

(2) If the principal under a surety bond or a surety undertaking has pledged any collateral (including, but not limited to, a guaranty or a letter of credit) to secure its reimbursement obligation to the insurer, the claims of any obligee [or, subject to the discretion of the receiver, completion contractor] under the surety bond or surety undertaking shall be satisfied first out of the collateral or its proceeds.

(3) In making any distribution to an obligee [or completion contractor], the receiver shall retain a sufficient reserve for any other potential claims against the collateral under Subsection B(2).

(4) If the collateral is insufficient to satisfy in full all potential claims against it under Subsection B(2) and B(6), the claims shall be paid on a pro rata basis and the obligees [or completion contractor] shall have claims, subject to allowance pursuant to Section 703, for any deficiency.

(5) If the time to assert claims against a surety bond or a surety undertaking has expired, and all the claims have been satisfied in full, any remaining collateral for the surety bond or surety undertaking shall be returned to the principal.

(6) To the extent that a guaranty association has made a payment relating to a claim against a surety bond, the guaranty association shall first be reimbursed for the payment and related expenses out of the available collateral or proceeds related to the surety bond. To the extent the collateral is sufficient; the guaranty association will be reimbursed for 100 per cent of its payment. If the collateral is insufficient to satisfy in full all potential claims against it under Subsection B(2) and under this paragraph, the guaranty associations that have paid claims on surety bonds shall be entitled to a pro rata share of the available collateral in accordance with Subsection B(4) and the guaranty association or associations shall have claims against the general assets of the estate in accordance with Section 703 for any deficiency. Any payments made to guaranty funds from the collateral shall not be deemed early access or otherwise considered distributions out of the general assets or property of the estate and the guaranty associations shall subtract any payment from the collateral from their final claims against the estate.

C. The amount determined pursuant to Subsection A shall be credited upon the secured claim, and the claimant may file a proof of claim, subject to all other provisions of this Act, for any deficiency, which shall be treated as an unsecured claim. If the claimant shall surrender the claimant's security to the liquidator, the entire claim shall be treated as if unsecured.

D. The liquidator may recover from property securing an allowed secured claim the reasonable, necessary costs and expenses of preserving, or disposing of, such property to the extent of any benefit to the holder of such claim.

Section 711. Qualified Financial Contracts

A. Notwithstanding any other provision of this Act, including any other provision of this Act permitting the modification of contracts, or other law of a state, no person shall be stayed or prohibited from exercising:

(1) A contractual right to cause the termination, liquidation, acceleration or close out of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

(a) The insolvency, financial condition or default of the insurer at any time, provided that the right is enforceable under applicable law other than this Act; or

(b) The commencement of a formal delinquency proceeding under this Act;

(2) Any right under a pledge, security, collateral, reimbursement or guarantee agreement or arrangement or any other similar security arrangement or arrangement or other credit enhancement relating to one or more netting agreements or qualified financial contracts;

(3) Subject to any provision of Subsection 609B, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office (SVO) of the NAIC as eligible for netting; or

(4) If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this Act terminates, liquidates, closes out or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, close out or acceleration. The amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with Subsection F below.

B. Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a non-defaulting party to an insurer against which an application or petition has been filed under this Act shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract. For purposes of this subsection, the term "walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a non-defaulting party. Any limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full two-way payment or second method provision as against the defaulting insurer. Any such property or amount shall, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, be a general asset of the insurer.

Drafting Note: This provision requires that, upon termination of a netting agreement, the non-defaulting party will be required to pay to the defaulting party (the insurer) any net or settlement amounts owed to the insurer, notwithstanding any provision in the netting agreement that provides that the non-defaulting party is not required to make payments to the defaulting party. In short, this provision renders "limited two-way payment" provisions in master swap agreements unenforceable against a defaulting insurer.

C. In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this Act, the receiver shall either:

(1) Transfer to one party (other than an insurer subject to a proceeding under this Act) all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(a) All rights and obligations of each party under each netting agreement and qualified financial contract; and

(b) All property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

(2) Transfer none of the netting agreements, qualified financial contracts, rights, obligations or property referred to in Paragraph (1) of this subsection (with respect to the counterparty and any affiliate of the counterparty).

D. If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, then the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12:00 noon (the receiver's local time) on the business day following the transfer. For purposes of this subsection, "business day" means a day other than a Saturday, Sunday or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

E. Notwithstanding any other provision of this Act, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract (or any pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract) that is made before the commencement of a formal delinquency proceeding under this Act. However, a transfer may be avoided under Section 606A if the transfer was made with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

F. (1) In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

(a) Disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

(b) Disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in Subparagraph (a) (with respect to the person or any affiliate of the person).

(2) Notwithstanding any other provision of this Act, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. The term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities or other market for the contract and agreement claims.

Drafting Note: The intended effect of this provision is that, except where the receiver has expressly affirmed a netting agreement or qualified financial contract, the claim of a counterparty against the estate of an insolvent insurer (after completion of the netting and setoff processes) will have no greater priority than the claim of a general creditor.

G. The term "contractual right" as used in this section includes any right set forth in a rule or bylaw of a derivatives clearing organization (as defined in the Commodity Exchange Act), a multilateral clearing organization (as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991), a national securities exchange, a national securities association, a securities clearing agency, a contract market designated under the Commodity Exchange Act, a derivatives transaction execution facility registered under the Commodity Exchange Act, or a board of trade (as defined in the Commodity Exchange Act) or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law, or under law merchant, or by reason of normal business practice.

H. The provisions of this section shall not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

I. All rights of counterparties under this Act shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

Section 712. Administration of Loss Reimbursement Policies

A. For purposes of this section:

(1) "Loss reimbursement policy" means any combination of one or more policies, endorsements, contracts or security agreements in which:

(a) The insured has agreed with the insurer to:

(i) Pay directly any portion of a loss or loss adjustment expense owed by the insurer under the policy up to a specified dollar amount; or

(ii) Reimburse the insurer for its payment of loss and loss adjustment expense under the policy up to a specified dollar amount; and

(b) Under which the insurer remains liable for payment of loss and loss adjustment expense under the policy regardless of whether the insured has met its obligations.

A loss reimbursement policy may provide for a specific dollar amount of loss reimbursement applicable to each claim, an aggregate dollar amount applicable to all claims under the policy, or both.

(2) "Loss reimbursement" means any payment made by the insured to or on behalf of the insurer for loss or loss adjustment expense pursuant to the terms of a loss reimbursement policy, to the extent that the insurer is responsible for payment regardless of whether the insured has met its obligations. Loss reimbursement includes any voluntary or involuntary application of loss reimbursement collateral to the loss reimbursement obligations of the insured. Loss reimbursement does not include:

(a) Payments made by the insured pursuant to a deductible arrangement under which the insurer has no obligation to pay or advance the amount of the deductible on behalf of the insured or a self-insurance arrangement under which the insurer has no payment obligation for the obligation of the self-insured;

(b) Retrospectively rated premium payments; or

(c) Reinsurance claim payments made by a captive reinsurer or other reinsurer affiliated with or funded by the insured or affiliated with the insurer.

(3) "Loss reimbursement claim" means any claim on a loss reimbursement policy that has been made against the estate, or that was previously paid by the insurer, to the extent that it is subject to an insured's loss reimbursement obligation. A loss reimbursement claim includes any loss adjustment expenses that are subject to reimbursement by the terms of the policy.

(4) "Loss reimbursement collateral" means any cash, letters of credit, surety bond or any other form of security provided by the insured to secure its loss reimbursement obligations, regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer, and regardless of whether the collateral also secures other obligations of the insured.

(5) "Uncovered loss reimbursement claim" means a loss reimbursement claim that is not defined as a covered claim under the relevant guaranty association statute.

(6) "Other secured obligations" means any obligations, such as reinsurance or retrospective premium obligations, that are payable by the insured to the insurer and which are secured by collateral that also secures a loss reimbursement obligation.

B. (1) Unless otherwise prohibited by law, the receiver may enter into agreements allowing the insured to fund or pay loss reimbursement claims directly or through a third party administrator.

(2) Unless otherwise prohibited by law, if the insurer allowed the insured to fund or pay loss reimbursement claims directly or through a third party administrator, the insured shall continue to fulfill its obligations, and the receiver may enforce the funding or payment agreements.

(3) The insured's payment of a loss reimbursement claim in whole or part, including any payment made by a third-party administrator on behalf of the insured, shall extinguish the obligation, if any, of the receiver or any guaranty association to pay that claim or that portion of the claim. Acceptance of the insured's payment by a claimant in full or final settlement of a claim shall bar the assertion of that claim in the delinquency proceeding.

(4) An agreement entered into or reaffirmed under this subsection may be terminated in the manner specified in the agreement.

C. Any loss reimbursements owed by an insured shall be administered as follows:

(1) The receiver shall bill an insured for reimbursement of a loss reimbursement claim when i) the insurer paid the claim prior to the commencement of delinquency proceedings; ii) the receiver is notified that a guaranty association has paid a loss reimbursement claim; iii) the receiver has paid a loss reimbursement claim; or iv) a loss reimbursement claim is allowed in liquidation proceedings. Notwithstanding the provisions of this subsection, a guaranty association which pays a loss reimbursement subject to recovery from the insured under statutory net worth provisions shall bill the insured directly and shall provide notice of said billing to the receiver as well as notice to the receiver of any reimbursements collected. Such recoveries pursuant to statutory net worth provisions shall not be general assets of the estate.

(2) All loss reimbursements paid to the receiver are general assets of the estate.

(3) Any loss reimbursement paid to the receiver that is allocable to a claim paid by a guaranty association shall be immediately distributed to that guaranty association as an early access payment in accordance with Section 803; provided, however, that notwithstanding the provisions of Section 803, receivership court approval shall not be required for early access distributions made pursuant to this section.

(4) If the insured does not make payment within the time specified in the loss reimbursement policy, or within sixty (60) days after receipt of the billing if no time is specified, the receiver is authorized to take all commercially reasonable actions necessary to collect any reimbursements owed.

(5) The insolvency of the insurer, the receiver's inability to perform any of the insurer's obligations under the loss reimbursement policy, or any allegation of improper handling or payment of a loss reimbursement claim by the receiver and/or any guaranty association shall not be a defense to the insured's reimbursement obligation under the loss reimbursement policy.

D. Any collateral held under a loss reimbursement policy issued by an insurer subject to a delinquency proceeding under this Act shall be maintained and administered in accordance with the loss reimbursement policy except where the loss reimbursement policy conflicts with this section.

E. If the loss reimbursement collateral, when combined with loss reimbursement payments that have been made by the insured, is insufficient to reimburse loss reimbursement claims already paid by the insurer, the receiver and guaranty associations, and to discharge all currently and past due loss reimbursement claims and other secured obligations, then the collateral shall be applied first to fully meet all early access obligations to the guaranty associations under paragraph (C)(3).

F. If the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured for a loss reimbursement claim and there is no available collateral, a guaranty association may, after notice to the receiver, seek to collect reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured. The guaranty association shall report any amounts so collected from each insured to the receiver. The receiver shall provide the guaranty association with available information needed to collect a reimbursement due from the insured. Whenever a guaranty association undertakes to collect reimbursements from an insured, it shall notify all other guaranty associations that have paid loss reimbursement claims on behalf of the same insured. Amounts collected by a guaranty association pursuant to this paragraph shall be treated as in accordance with subparagraph C(3) of this section. The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

G. The receiver is entitled to recover through billings to the insured or from loss reimbursement collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this Section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants.

H. [OPTIONAL] The provisions of this section shall be applied in all receiverships pending at the time of enactment.

Drafting Note: Attention should be drawn to whether Section 712 is adopted with IRMA or as a stand-alone. If it is adopted with IRMA, then the provisions in Section 111 of IRMA may apply. States may wish for this particular section to not apply retroactively even if electing to have the rest of IRMA so applied, or may wish to apply 712 retroactively while having the rest of IRMA applying prospectively.

ARTICLE VIII. DISTRIBUTIONS

Section 801. Priority of Distribution

Drafting Note: A state may choose Alternative 1 or Alternative 2 depending how it wishes to classify certain expenses of the guaranty associations. Alternative 1 places expenses of the guaranty associations, including defense and cost containment expenses of property and casualty guaranty associations, in Class 2. Alternative 2 places the defense and cost containment expenses of property and casualty guaranty association expenses in Class 3 with other general policyholder claims, while the remaining expenses of the guaranty associations are in Class 2.

Alternative 1]

The priority of payment of distributions on unsecured claims shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for their payment before the members of the next class receive payment. All claims within a class shall be paid substantially the same percentage. Except as provided in Subsections A(1)(e), K and M, subclasses shall not be established within a class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be:

A. Class 1.

(1) The costs and expenses of administration expressly approved or ratified by the liquidator, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the property of the insurer;

(b) Reasonable compensation for all services rendered on behalf of the administrative supervisor or receiver;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Unsecured loans obtained by the receiver. Any such obligation, unless by its terms otherwise provided, shall have priority over all other costs of administration. Absent agreement to the contrary, all claims in this sub-class shall share pro-rata; and

(f) Expenses approved by the conservator or rehabilitator of the insurer, if any, incurred in the course of the conservation or rehabilitation that are unpaid at the time of the entry of the order of liquidation.

(2) Except as expressly approved by the receiver, any expenses arising from a duty to indemnify the directors, officers or employees of the insurer are excluded from this class and, if allowed, are Class 7 claims.

Drafting Note: Implicit in the powers conferred on the liquidator under this Act, and explicitly in Section 504A(3), is the right, subject to approval by the receivership court, to pay Class 1 administrative costs to persons in any priority class where those Class 1 administrative cost payments assist or result in the collection or recovery of property of the insurer for the benefit of creditors of the estate. Payments of administrative costs in these circumstances do not constitute distributions so as to circumvent priority classes or establish subclasses within a class.

B. Class 2. The reasonable expenses of a guaranty association, including overhead, salaries and other general administrative expenses allocable to the receivership to include administrative and claims handling expenses and expenses in connection with arrangements for ongoing coverage, other than expenses incurred in the performance of duties under Section [insert citation to guaranty fund law detection and prevention powers] or similar duties under the statute governing a similar organization in another state. In the case of property and casualty guaranty associations, the expenses shall include, but not be limited to, loss adjustment expenses, which shall include adjusting and other expenses and defense and cost containment expenses.

Drafting Note: If appropriate, states may add to Class 2: "This class shall also include the reasonable expenses of any entity responsible for the payment of claims or continuation of coverage of an insolvent health maintenance organization."

C. Class 3. All claims under policies of insurance including third party claims, claims under annuity contracts and funding agreements, claims under non-assessable policies for unearned premium, claims of obligees (and, subject to the discretion of the receiver, completion contractors) under surety bonds and surety undertakings (not to include bail bonds, mortgage or financial guaranty or other forms of insurance offering protection against investment risk, or warranties), claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents, and claims incurred during the extension of coverage provided for in Section 502. All other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 2, including but not limited to indemnity payments on covered claims and, in the case of a life, health and annuity guaranty association, all claims as a creditor of the impaired or insolvent insurer for all payments of and liabilities incurred on behalf of covered claims or covered obligations of the insurer and for the funds needed to reinsure those obligations with a solvent insurer.

Notwithstanding any other provision of this Act, the following claims shall be excluded from Class 3 priority and paid as claims in Class 7, except as otherwise provided in this section:

Drafting Note: If appropriate, states may add to Class 3: "This class shall also include indemnity payments on covered claims, unearned premiums, and payments for the continuation of coverage made by any entity responsible for the payment of claims or continuation of coverage of an insolvent health maintenance organization."

(1) Obligations of the insolvent insurer arising out of reinsurance contracts;

(2) Obligations incurred pursuant to an occurrence policy, or reported pursuant to a claims made policy, after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this Act. Notwithstanding this subsection, unearned premium claims on policies, other than reinsurance agreements, shall not be excluded;

(3) Obligations to insurers, insurance pools or underwriting associations and their claims for contribution, indemnity or subrogation, equitable or otherwise, except for direct claims under policies where the insurer is the named insured;

(4) Any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy, which shall be paid as claims in Class 9;

Drafting Note: In some jurisdictions the courts have held that coverage for punitive or exemplary damages may not be excluded from liability policies.

(5) Tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices; and

(6) Claims of the guaranty associations for assessments not paid by the insurer.

D. Class 4. All claims under policies of insurance for mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risk, or warranties.

Drafting Note: If warranties are regulated as insurance, claims under those instruments should be afforded Class 4 priority. Otherwise, claims under warranties should not be included as Class 4 claims and should also be excluded from Class 3.

E. Class 5. Claims of the federal government not included in Classes 3 or 4.

F. Class 6. Debts due employees for services or benefits to the extent that they do not exceed $5,000 or two (2) months' salary, whichever is the lesser, and represent payment for services performed within one year before the entry of the initial order of receivership. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

G. Class 7. Claims of other unsecured creditors not included in Classes 1 through 6, including claims under reinsurance contracts, claims of guaranty associations for assessments not paid by the insurer, and other claims excluded from Classes 3 or 4 above, unless otherwise assigned to Classes 8 through 13.

Drafting Note: If appropriate, states may add to Class 7: "all other claims of any entity responsible for the payment of claims of an insolvent health maintenance organization."

H. Class 8. Claims of any state or local governments, except those specifically classified elsewhere in this section. Claims for services rendered and expenses incurred in opposing a formal delinquency proceeding. In order to prove the claim, the claimant must show that the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information and belief, formed after reasonable inquiry indicating opposition was in the best interests of the insurer, was well grounded in fact and was warranted by existing law or a good faith argument for the extension, modification or reversal of existing law, and that opposition was not pursued for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of the litigation.

I. Class 0. Claims for penalties, punitive damages or forfeitures, unless expressly covered under the terms of a policy of insurance.

J. Class 10. Except as provided in Subsections 701B and C, late filed claims that would otherwise be classified in Classes 3 through 9.

K. Class 11. Surplus notes, capital notes or contribution notes or similar obligations, and premium refunds on assessable policies, and any other claims specifically assigned to this class. Claims in this class shall be subject to any subordination agreements, related to other claims in this class, which existed prior to the entry of a liquidation order.

L. Class 12. Interest on allowed claims of Classes 1 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the liquidator and approved by the receivership court.

M. Class 13. Claims of shareholders or other owners arising out of their capacity as shareholders or other owners, or any other capacity except as they may be qualified in Class 3, 4, 7 or 12 above. Claims in this class shall be subject to any subordination agreements, related to other claims in this class, that existed prior to the entry of a liquidation order.

[Alternative 2]

The priority of payment of distributions on unsecured claims shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for their payment before the members of the next class receive payment. All claims within a class shall be paid substantially the same percentage. Except as provided in Subsections A(1)(e), K and M, subclasses shall not be established within a class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be:

A. Class 1.

(1) The costs and expenses of administration expressly approved or ratified by the liquidator, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the property of the insurer;

(b) Reasonable compensation for all services rendered on behalf of the administrative supervisor or receiver;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Unsecured loans obtained by the receiver. Any such obligation, unless by its terms otherwise provided, shall have priority over all other costs of administration. Absent agreement to the contrary, all claims in this sub-class shall share pro-rata; and

(f) Expenses approved by the conservator or rehabilitator of the insurer, if any, incurred in the course of the conservation or rehabilitation that are unpaid at the time of the entry of the order of liquidation.

(2) Except as expressly approved by the receiver, any expenses arising from a duty to indemnify the directors, officers or employees of the insurer are excluded from this class and, if allowed, are Class 7 claims.

Drafting Note: Implicit in the powers conferred on the liquidator under this Act, and explicitly in Section 504A(3), is the right, subject to approval by the receivership court, to pay as Class 1 administrative costs to persons in lower priority classes where those Class 1 administrative cost payments assist or result in the collection or recovery of property of the insurer for the benefit of creditors of the estate. Payments of administrative costs in these circumstances do not constitute distributions so as to circumvent priority classes or establish subclasses within a class.

B. Class 2. The reasonable expenses of the guaranty association, including overhead, salaries and other general administrative expenses and claims handling expenses and expenses in connection with arrangements for ongoing coverage that are of the type and nature that, but for the activities of the guaranty association, otherwise would have been incurred or allocable to the receiver. The expenses allowed under this subsection shall not include: (i) expenses incurred in the performance of duties under Section [insert citation to state guaranty fund law detection and prevention powers], (ii) expenses related to defense and cost containment, in accordance with the NAIC Statements of Statutory Accounting Principles as incorporated in this state by [cite state's insurance statute incorporating the NAIC Statements of Statutory Accounting Principles]; (iii) any other expenses required to be paid or incurred as direct policy benefits by the terms of a policy; (iv) expenses related to coverage issues between the guaranty association and the liquidator.

Drafting Note: If appropriate, states may add to Class 2: "This class shall also include the reasonable expenses of any entity responsible for the payment of claims or continuation of coverage of an insolvent health maintenance organization."

C. Class 3. All claims under policies of insurance including third party claims, claims under annuity contracts and funding agreements, claims under non-assessable policies for unearned premium, claims of obligees (and, subject to the discretion of the receiver, completion contractors) under surety bonds and surety undertakings (not to include bail bonds, mortgage or financial guaranty or other forms of insurance offering protection against investment risk, or warranties), claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents, and claims incurred during the extension of coverage provided for in Section 502. All other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 2, including but not limited to expenses related to defense and cost containment, in accordance with the NAIC Statements of Statutory Accounting Principles as incorporated in this state by [cite state's insurance statute incorporating the NAIC Statements of Statutory Accounting Principles]; expenses related to coverage issues between the guaranty association and the liquidator; indemnity payments on covered claims and, in the case of a life, health and annuity guaranty association, all claims as a creditor of the impaired or insolvent insurer for all payments of and liabilities incurred on behalf of covered claims or covered obligations of the insurer and for the funds needed to reinsure those obligations with a solvent insurer.

Notwithstanding any other provision of this Act, the following claims shall be excluded from Class 3 priority and paid as claims in Class 7, except as otherwise provided in this section:

Drafting Note: If appropriate, states may add to Class 3: "This class shall also include indemnity payments on covered claims, unearned premiums, and payments for the continuation of coverage made by any entity responsible for the payment of claims or continuation of coverage of an insolvent health maintenance organization."

(1) Obligations of the insolvent insurer arising out of reinsurance contracts;

(2) Obligations incurred pursuant to an occurrence policy, or reported pursuant to a claims made policy, after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this Act.

Notwithstanding this subsection, unearned premium claims on policies, other than reinsurance agreements, shall not be excluded;

(3) Obligations to insurers, insurance pools or underwriting associations and their claims for contribution, indemnity or subrogation, equitable or otherwise, except for direct claims under policies where the insurer is the named insured;

(4) Any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy, which shall be paid as claims in Class 9;

Drafting Note: In some jurisdictions the courts have held that coverage for punitive or exemplary damages may not be excluded from liability policies.

(5) Tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices; and

(6) Claims of the guaranty associations for assessments not paid by the insurer.

D. Class 4. All claims policies of insurance for mortgage guaranty, financial guaranty insurance or other forms of insurance offering protection against investment risk, or warranties.

Drafting Note: If warranties are regulated as insurance, claims under those instruments should be afforded Class 4 priority. Otherwise, claims under warranties should not be included as Class 4 claims and should also be excluded from Class 3.

E. Class 5. Claims of the federal government not included in Classes 3 or 4.

F. Class 6. Debts due employees for services or benefits to the extent that they do not exceed $5,000 or two (2) months' salary, whichever is the lesser, and represent payment for services performed within one year before the entry of the initial order of receivership. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

G. Class 7. Claims of other unsecured creditors not included in Classes 1 through 6, including claims under reinsurance contracts, claims of guaranty associations for assessments not paid by the insurer, and other claims excluded from Classes 3 or 4 above, unless otherwise assigned to Classes 8 through 13.

Drafting Note: If appropriate, states may add to Class 7: "all other claims of any entity responsible for the payment of claims of an insolvent health maintenance organization."

H. Class 8. Claims of any state or local governments, except those specifically classified elsewhere in this section. Claims for services rendered and expenses incurred in opposing a formal delinquency proceeding. In order to prove the claim, the claimant must show that the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information and belief, formed after reasonable inquiry indicating opposition was in the best interests of the insurer, was well grounded in fact and was warranted by existing law or a good faith argument for the extension, modification or reversal of existing law, and that opposition was not pursued for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of the litigation.

I. Class 9. Claims for penalties, punitive damages or forfeitures, unless expressly covered under the terms of a policy of insurance.

J. Class 10. Except as provided in Subsections 701B and C, late filed claims that would otherwise be classified in Classes 3 through 9.

K. Class 11. Surplus notes, capital notes or contribution notes or similar obligations, and premium refunds on assessable policies, and any other claims specifically assigned to this class. Claims in this class shall be subject to any subordination agreements, related to other claims in this class, which existed prior to the entry of a liquidation order.

L. Class 12. Interest on allowed claims of Classes 1 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the liquidator and approved by the receivership court.

M. Class 13. Claims of shareholders or other owners arising out of their capacity as shareholders or other owners, or any other capacity except as they may be qualified in Class 3, 4, 7 or 12 above. Claims in this class shall be subject to any subordination agreements, related to other claims in this class, that existed prior to the entry of a liquidation order.

Section 802. Partial and Final Distributions of Assets

A. With the approval of the receivership court, a liquidator may declare and pay one or more partial distributions on claims as those claims are allowed and a final distribution. All claims allowed within a priority class shall be paid at substantially the same percentage. Distributions under this section to guaranty associations are not advances under Section 803.

B. In determining the percentage of distributions to be paid on these claims, the liquidator may consider the estimated value of the insurer's property (including estimated reinsurance recoverables in connection with the insurer's estimated liabilities for unpaid losses and loss expenses and for incurred but not reported losses and loss expenses) and the estimated value of the insurer's liabilities (including estimated liabilities for unpaid losses and loss expenses and for incurred but not reported losses and loss expenses).

C. Distribution of property in kind may be made at valuations set by agreement between the liquidator and the creditor and as approved by the receivership court.

D. (1) Notwithstanding the provisions of Subsection A and Article VII, the liquidator is authorized to pay benefits under workers compensation policies after the entry of the liquidation order if:

(a) There has been an acceptance of liability by the insurer, and no bona fide dispute exists;

(b) Payments were commenced prior to the entry of the liquidation order; and

(c) Future or past indemnity or medical payments are due.

(2) Claim payments under this subsection may continue until the applicable guaranty association assumes responsibility for claim payments or determines the claim is not a covered claim under its guaranty association law. Any claim payments and related expenses made under this section may be treated as early access distributions under Section 803 in accordance with an agreement with the guaranty association responsible for the payments.

Section 803. Early Access Disbursements

A. (1) Early access payments to guaranty associations shall be made as soon as possible after the entry of a liquidation order and as frequently as possible thereafter, but at least annually if assets are available to be distributed to the guaranty associations ("distributable assets"), and shall be in amounts consistent with the provisions of this section. Amounts advanced to an affected guaranty association pursuant to this section shall be accounted for as advances against distributions to be made under Section 802.

(2) Distributable assets means all general assets of the liquidation estate less:

(a) Amounts reserved, to the extent necessary and appropriate, for the entire Section 801A expenses of the liquidation through and after its closure; and

(b) To the extent necessary and appropriate, reserves for distributions on claims other than those of the guaranty associations falling within the priority classes of claims established in Subsection 801C.

(3) Where sufficient distributable assets are available, amounts advanced need not be limited to the claims and expenses paid to date by the guaranty associations. However, the liquidator shall not distribute distributable assets to the guaranty associations in excess of the anticipated entire claims of the guaranty associations falling within the priority classes of claims established in Subsections 801B and C.

B. Within 120 days after the entry of an order of liquidation by the receivership court, and at least annually thereafter, the liquidator shall apply to the receivership court for approval to make early access payments out of the general assets of the insurer to any guaranty associations having obligations arising in connection with the liquidation or report that the liquidator has determined that there are no distributable assets at that time based on financial reporting as required in Section 117. The liquidator may apply to the receivership court for approval to make early access payments more frequently than annually based on additional information or the recovery of material assets.

C. Within sixty (60) days after approval by the receivership court of the applications in Subsection B, the liquidator shall make any early access payments to the affected guaranty associations as indicated in the approved application.

D. Notice of each application for early access payments, or of any report required pursuant to this section, shall be given in accordance with Section 107 to the guaranty associations that may have obligations arising from the liquidation. Notwithstanding the provisions of Section 107, the liquidator shall provide these guaranty associations with at least thirty (30) days actual notice of the filing of the application with a complete copy of the application prior to any action by the receivership court. Any guaranty association that may have obligations arising in connection with the liquidation shall have:

(1) The right to request additional information from the liquidator, who shall not unreasonably deny such request; and

(2) The right to object as provided in Section 107 to any part of each application or to any report filed by the liquidator pursuant to this section.

E. In each application regarding early access payments, the liquidator shall, based on the best information available to the liquidator at the time, provide at a minimum the following:

(1) To the extent necessary and appropriate, the amount reserved for the entire expenses of the liquidation through and after its closure and for distributions on claims falling within the priority classes of claims established in Section 801B and C;

(2) The calculation of distributable assets and the amount and method of equitable allocation of early access payments to each of the guaranty associations; and

(3) The most recent financial information filed with the National Association of Insurance Commissioners by the liquidator.

F. Each guaranty association that receives any payments pursuant to this section agrees, upon depositing the payment in any account to its benefit, to return to the liquidator any amount of these payments that may be required to pay claims of secured creditors and claims falling within the priority classes of claims established in Section 801A, B or C. No bond shall be required of any guaranty association.

G. Without the consent of the affected guaranty associations or an order of the receivership court, the liquidator may not offset the amount to be disbursed to any guaranty association by the amount of any special deposit or any other statutory deposit or asset of the insolvent insurer held in that state unless the association has actually received such deposit or asset.

Section 804. Unclaimed and Withheld Funds

[Alternative 1]

A. If any funds of the receivership estate remain unclaimed after the final distribution under Section 802, the funds shall be placed in a segregated unclaimed funds account held by the commissioner. If the owner of any of these funds presents proof of ownership satisfactory to the commissioner within two (2) years after the termination of the delinquency proceeding, the commissioner shall remit the funds to the owner. The interest earned on funds held in the unclaimed funds account may be used to pay any administrative costs related to the handling or return of unclaimed funds.

B. If any amounts held in the unclaimed funds account remain unclaimed for two (2) years after the termination of the delinquency proceeding, the commissioner may file a motion for an order directing the disposition of the funds in the court in which the delinquency proceeding was pending. Any costs incurred in connection with the motion may be paid from the unclaimed funds account. The motion shall identify the name of the insurer, the names and last known addresses of the persons entitled to the unclaimed funds, if known, and the amount of the funds. Notice of the motion shall be given as directed by the court. Upon a finding by the court that the funds have not been claimed within two (2) years after the termination of the delinquency proceeding, the court shall order that any claims for unclaimed funds, a interest earned thereon that has not been expended under Subsection A, are abandoned and the funds shall be disbursed under one of the following methods:

(1) The amounts may be deposited in the general receivership expense account under Subsection C;

(2) The amounts may be transferred to the State Treasurer, and deposited into the state general fund; or

(3) The amounts may be used to reopen the receivership in accordance with Section 903, and be distributed to the known claimants with approved claims.

C. The commissioner may establish an account for the following purposes:

(1) To pay general expenses related to the administration of receiverships; or

(2) To advance funds to any receivership that does not have sufficient cash to pay its operating expenses.

D. Any advance to a receivership estate under Subsection C(2) may be treated as a claim under Section 801 as may be agreed at the time the advance is made or, in the absence of such agreement, in a priority determined to be appropriate by the receivership court.

E. If the commissioner determines at any time that the funds in the account exceed the amount required, the commissioner may transfer the funds or any part thereof to the State Treasurer, and the transferred funds shall be deposited into the state general fund.

[Alternative 2]

If any funds of the receivership estate remain unclaimed after the final distribution under Section 802, the funds shall be handled in accordance with [cite to state's unclaimed property laws].

ARTICLE IX. DISCHARGE

Section 901. Condition on Release from Delinquency Proceedings

Until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all the payments and expenses, shall have been repaid to the guaranty associations unless otherwise provided in a plan approved by the guaranty association, an insurer that is subject to any formal delinquency proceedings shall not:

A. Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

B. Be returned to the control of its shareholders or private management; or

C. Have any of its assets returned to the control of its shareholders or private management.

Section 902. Termination of Liquidation Proceedings

When all property justifying the expense of collection and distribution have been collected and distributed under this Act, the liquidator shall apply to the receivership court for an order discharging the liquidator and terminating the proceeding. The receivership court may grant the application and make any other orders, including orders to transfer any remaining funds that are uneconomic to distribute or, pursuant to Subsection 802C, assign any assets that remain unliquidated, including claims and causes of action, as may be deemed appropriate.

Section 903. Reopening Liquidation

After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the court that was the receivership court to reopen the proceedings for good cause, including the discovery of additional property. If the court is satisfied that there is justification for reopening, it shall so order.

Section 904. Disposition of Records During and After Termination of Liquidation

A. Whenever it shall appear to the receiver that the records of the insurer in receivership are no longer useful, he or she may recommend to the receivership court, and the receivership court shall direct, what records shall be destroyed.

B. If the receiver determines that any records should be maintained after the closing of the delinquency proceeding, the receiver may reserve property from the receivership estate for the maintenance of the records. Any amounts so retained shall be administrative expenses of the estate under Section 801A. Any records retained pursuant to this subsection shall be transferred to the custody of the commissioner, and the commissioner may retain or dispose of the records as appropriate, at the commissioner's discretion. Any records of a delinquent insurer that are transferred to the commissioner shall not be considered as records of the Department of Insurance for any purposes, and the [reference applicable public records act] shall not apply to those records.

Drafting Note: The recommendation should conform to whatever general record destruction laws exist in the particular state.

Section 905. External Audit of the Receiver's Books

The receivership court may, as it deems desirable, order audits to be made of the books of the receiver relating to any receivership established under this Act, and a report of each audit shall be filed with the commissioner and with the receivership court. The books, records and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

ARTICLE X. INTERSTATE RELATIONS

Section 1001. Ancillary Conservation of Foreign Insurers

A. The commissioner may initiate an action against a foreign insurer pursuant to Section 201 on any of the grounds stated in that section or on the basis that:

(1) Any of its property has been sequestered, garnished or seized by official action in its domiciliary state, or in any other state;

(2) Its certificate of authority to do business in this state has been revoked or that none was ever issued and there are residents of this state with unpaid claims or in-force policies; or

(3) It is necessary to enforce a stay under [cite applicable guaranty fund acts].

B. If a domiciliary receiver has been appointed, the commissioner may initiate an action against a foreign insurer under this section only with the consent of the domiciliary receiver.

C. An order entered pursuant to this section shall appoint the commissioner as conservator. The conservator's title to assets shall be limited to the insurer's property and records located in this state.

D. Notwithstanding the provisions of Section 201D, the conservator shall hold and conserve the assets located in this state until the commissioner in the insurer's domiciliary state is appointed its receiver or until an order terminating conservation is entered under Subsection G. Once a domiciliary receiver is appointed, the conservator shall turn over to the domiciliary receiver all property subject to an order under this section.

E. The conservator may liquidate such property of the insurer as may be necessary to cover the costs incurred in the initiation or administration of a proceeding under this section.

F. The court in which an action under this section is pending may issue a finding of insolvency or an ancillary liquidation order. Any ancillary liquidation order shall be entered for the limited purposes of:

(1) Liquidating assets in this state to pay costs under Subsection E; or

(2) Activating applicable guaranty associations in this state to pay valid claims that are not being paid by the insurer.

G. The conservator may at any time petition the receivership court for an order terminating an order entered under this section.

Section 1002. Domiciliary Receivers Appointed in Other States

A. A domiciliary receiver appointed in another state shall be vested by operation of law with title to, and may summarily take possession of, all property and records of the insurer in this state. Notwithstanding any other provision of law regarding special deposits, special deposits held in this state for this state's guaranty association as the only beneficiary shall be, upon the entry of an order of liquidation with a finding of insolvency, distributed to the guaranty associations in this state as early access, subject to Section 803, in relation to the lines of business for which the special deposits were made. The holder of any special deposit shall account to the domiciliary receiver for all distributions from the special deposit at the time of the distribution. The statutory provisions of another state and all orders entered by courts of competent jurisdiction in relation to the appointment of a domiciliary receiver of an insurer and any related proceedings in another state shall be given full faith and credit in this state. For purposes of this Act, another state means any state other than this state. This state will treat all foreign states as reciprocal states.

B. Upon appointment of a domiciliary receiver in another state, the commissioner shall, unless otherwise agreed by the receiver, immediately transfer title to and possession of all property of the insurer under his or her control, including all statutory general or special deposits other than special deposits where that state's guaranty association is the only beneficiary, to the receiver.

C. Except as provided in Subsection A, the domiciliary receiver shall handle special deposits and special deposit claims in accordance with the statutes pursuant to which the special deposits were required and applicable federal law. All amounts in excess of the estimated amount necessary to administer the special deposit and pay the unpaid special deposit claims shall be deemed general assets of the estate. If there is a deficiency in any special deposit so that the claims secured thereby are not fully discharged from the deposit, the claimants may share in the general assets of the insurer to the extent of the deficiency at the same priority as other claimants in their class of priority under Section 801, but the sharing shall be deferred until the other claimants of their class have been paid percentages of their claims equal to the percentage paid from the special deposit. The intent of this provision is to equalize to this extent the advantage gained by the security provided by the special deposits.

ARTICLE XI. SEPARABILITY AND EFFECTIVE DATE

Section 1101. Separability

If any provision of this Act or its application to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of the provision to other persons or circumstances shall not be affected.

Section 1102. Effective Date

This Act shall take effect immediately and shall be applicable to ongoing delinquency proceedings in accordance with Section 111 of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2005 Proc. 4th Quarter 32,48-122 (adopted).
2007 Proc. 1st Quarter 291-297, 298-307,1303-1305, 1320-1321 (amended).

This model was designed to replace an earlier NAIC model.

1936 Proc. I 29, 30-32, 33 (adopted first liquidation statute).
1969 Proc. I 168, 241, 271 (recommended the adoption of the Wisconsin Liquidation Act by states).
1978 Proc. I 13, 15, 211, 238-241, 242-275 (adopted new model).
1986 Proc. II 410-411 (amendments adopted later are printed here).
1987 Proc. I 11, 18, 161, 420-421, 423-424 (amended).
1989 Proc. II 13, 23, 227-228, 338, 379-381 (amended).
1990 Proc. I 6, 26, 172, 398, 407-410 (amended).
1990 Proc. II 7, 14-15, 202-204, 224-251, 529-531 (amended and reprinted).
1991 Proc. II 25, 56-57, 322, 560, 577, 604 (amended).
1992 Proc. I 77, 78-79, 769 (amended at special plenary session in September 1991).
1993 Proc. I 8, 136, 277, 741, 746-748 (amended).
1994 Proc. 4th Quarter 14, 20, 593-594, 596-634 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 562, 565-566 (amended).
1996 Proc. 4th Quarter 9, 44, 938, 945, 953-955 (amended).
1997 Proc 2nd Quarter 25-26, 539-546 (amended).
1997 Proc. 3rd Quarter 25, 26, 1076, 1124, 1124-1126 (amended).
1999 Proc. 4th Quarter 15, 805, 812-814 (amended).

INSURER RECEIVERSHIP MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURER RECEIVERSHIP MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-32-1 to 7-32-41 (1971/2003).
Alaska		ALASKA STAT. §§ 21.78.010 to 21.78.330 (1966/2010).	
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-611 to 20-650 (1954/2011).
Arkansas			ARK. CODE ANN. §§ 23-68-101 to 23-68-135 (1959/2013).
California			CAL. INS. CODE §§ 1010 to 1062 (1935/2013); § 1063.6 (1999); §§ 1064.1 to 1064.13 (1988/2006).
Colorado		COLO. REV. STAT. §§ 10-3-401 to 10-3-559 (1992/2014).	
Connecticut		CONN. GEN. STAT. §§ 38a-903 to 38a-962j (1979/2014).	
Delaware			DEL. CODE ANN. tit. 18, §§ 5901 to 5944 (1953/2014).
District of Columbia		D.C. CODE §§ 31-1301 to 31-1357 (1993/2004.	

INSURER RECEIVERSHIP MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 631.001 to 631.401 (1982/2011).
Georgia		GA. CODE ANN. §§ 33-37-1 to 33-37-58 (1991/2000).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:15-101 to 431:15-411 (1988/2005).	
Idaho		IDAHO CODE ANN. §§ 41-3301 to 41-3360 (1981/1999).	
Illinois			215 ILL. COMP. STAT. 5/187 to 5/221 (1937/2013).
Indiana		IND. CODE §§ 27-9-1-1 to 27-9-4-10 (1979/2011).	
Iowa		IOWA CODE §§ 507C.1 to 507C.60 (1984/2014).	
Kansas		KAN. STAT. ANN. §§ 40-3605 to 40-3659 (1991/2014).	
Kentucky		KY. REV. STAT. ANN. §§ 304.33-010 to 304.33-600 (1970/2004).	
Louisiana			LA. REV. STAT. ANN. §§ 22:731 to 22:737 (1958/2001); §§ 22:2001 to 22:2045 (1958/2015).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 4351 to 4407 (1970/2011) (portions of model).		
Maryland			MD. CODE ANN., INS. §§ 9-201 to 9-232 (1933/2005).
Massachusetts			MASS. GEN. LAWS ANN. ch. 175 §§ 180A to 180L ½ (1939/2000).

INSURER RECEIVERSHIP MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS ch. 500, §§ 8101 to 8159 (1990/2012).	
Minnesota		MINN. STAT. §§ 60B.01 to 60B.61 (1969/2009).	
Mississippi		MISS. CODE ANN. §§ 83-24-1 to 83-24-117 (1991/2000).	MISS. CODE ANN.§§ 83-23-1 to 83-23-9 (1942).
Missouri	MO. REV. STAT. §§ 375.1150 to 375.1246 (1991/2010) (portions of model).		MO. REV. STAT. §§ 375.535 to 375.780 (1939/1996); §§ 375.950 to 375.990 (1976/1986).
Montana		MONT. CODE ANN. §§ 33-2-1301 to 33-2-1394 (1979/2013).	
Nebraska		NEB. REV. STAT. §§ 44-4801 to 44-4862 (1989/2013).	NEB. REV. STAT. §§ 44-120 to 44-133 (1913/1989).
Nevada		NEV. REV. STAT. §§ 696B.010 to 696B.570 (1971/2013).	
New Hampshire		N.H. REV. STAT. ANN. §§ 402-C:1 to 402-C:61 (1969/2005).	
New Jersey		N.J. STAT. ANN. §§ 17B:32-31 to 17B:32-92 (1992/2011) (life insurers).	N.J. STAT. ANN. §§ 17:30C-1 to 17:30C-31 (1975) (P/C Insurers).
New Mexico			N.M. STAT. ANN. §§ 59A-41-1 to 59A-41-57 (1985/2014).
New York			N.Y. INS. LAW §§ 7401 to 7437 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-30-1 to 58-30-310 (1989/2013).	
North Dakota		N.D. CENT. CODE §§ 26.1-06.1-01 to 26.1-06.1-59 (1991/2005).	
Northern Marianas	NO CURRENT ACTIVITY		

INSURER RECEIVERSHIP MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio		OHIO REV. CODE ANN. §§ 3903.01 to 3903.99 (1982/2013).	OHIO REV. CODE ANN. § 3901.045 (2002/2014); § 3901.36 (1971/2014).
Oklahoma	OKLA. STAT. tit. 36, § 1922 (2008/2013) (portions of model).	OKLA. STAT. tit. 36, §§ 1901 to 1938 (1957/2014) (rehabilitation and liquidation).	OKLA. STAT. tit. 36, §§ 1801 to 1811 (1975/2002) (supervision and conservatorship).
Oregon		OR. REV. STAT. §§ 734.014 to 734.440 (1967/2003).	
Pennsylvania		40 PA. STAT. ANN. §§ 221.1 to 221.63 (1979/2014).	
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 4001 to 4054 (1991).	
Rhode Island		R.I. GEN. LAWS §§ 27-14.3-1 to 27-14.3-65 (1993/2012).	R.I. GEN. LAWS §§ 27-14.4-1 to 27-14.4-23 (1994/1999).
South Carolina		S.C. CODE ANN. §§ 38-27-10 to 38-27-1000 (1988/2008).	
South Dakota		S.D. CODIFIED LAWS §§ 58-29B-1 to 58-29B-161 (1989/2005).	
Tennessee	TENN. CODE ANN. §§ 56-9-101 to 56-9-511 (1991/2012) (portions of model).		
Texas	TEX. INS. CODE ANN. §§ 443.001 to 443.402 (2005).		
Utah	UTAH CODE ANN. §§ 31A-27a-101 to 31A-27a-902 (1986/2014).		
Vermont		VT. STAT. ANN. tit. 8, §§ 7031 to 7100 (1991).	
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 1252 to 1286 (1968/1985).

INSURER RECEIVERSHIP MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia			VA. CODE ANN. §§ 38.2-1500 to 38.2-1522 (1986/2011).
Washington		WASH. REV. CODE ANN. §§ 48.31.010 to 48.31.435 (1947/2010).	WASH. REV. CODE ANN. §§ 48.99.010 to 48.99.900 (1947/1993).
West Virginia		W. VA. CODE §§ 33-10-1 to 33-10-41 (1957/2005).	
Wisconsin		WIS. STAT. §§ 645.01 to 645.90 (1967/2013).	
Wyoming			WYO. STAT. ANN. §§ 26-28-101 to 26-28-131 (1967/1983).

PROJECT HISTORY - 2007

INSURER RECEIVERSHIP MODEL ACT (#555)
(Section 801)

1. Description of the Project, Issues Addressed, etc.

The proposed amendments to Section 801 of the Insurer Receivership Model Act ("IRMA") focus on the priority status of claims made during receivership proceedings under warranties and policies of mortgage guaranty and financial guaranty insurance. As originally adopted, Section 801 excluded claims under policies of mortgage and financial guaranty insurance from the general policyholder class, Class 3. As a result of this exclusion, these claims were included in Class 6, the same priority as claims of unsecured creditors.

The amendments maintain the exclusion of claims under mortgage and financial guaranty insurance from Class 3 but elevate such claims from Class 6 to a new Class 4. The new Class 4 includes "claims under financial guaranty insurance or other forms of insurance offering protection against financial risk, mortgage guaranty insurance and warranties." The claims previously designated as Class 4 are renumbered to become Class 5, and the remaining classes are likewise renumbered. The amendments also include a drafting note highlighting that the priority treatment of claims under warranties depends on whether warranties are regulated as insurance.

2. Name of Group Responsible for Drafting the Model and States Participating

Receivership Model Act Revision (E) Working Group

States Participating:

Pennsylvania, Chair	Massachusetts
Arkansas, Vice Chair	Missouri
New Mexico	Nebraska
California	New York
Connecticut	Ohio
Delaware	Oklahoma
Florida	Tennessee
Illinois	Texas
Iowa	Utah

3. Project Authorized by What Charge and Date First Given to the Group

The 2006 charges of the Receivership and Insolvency (E) Task Force include responsibility to monitor the progress of IRMA through the adoption process and perform additional work as directed by the parent committee. The Receivership and Insolvency (E) Task Force delegated any additional work needed to amend or revise IRMA to the Receivership Model Act Revision (E) Working Group ("Working Group"). The need for this amendment was proposed directly to the Working Group by members and representatives of the affected industries.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

During the first quarter of 2006, representatives from the mortgage and financial guaranty insurance industry approached the Receivership Model Act Revision (E) Working Group seeking an amendment to improve the priority status of claims under the affected policies. This was prompted by a statement from FitchRatings that the financial strength ratings of mortgage insurers could be unfavorably affected by the priority treatment of claims under mortgage insurance policies. The priority status afforded by IRMA, as adopted, was considered to indicate a moderate possibility of policyholder recovery in the event of receivership proceedings.

Based on this information and further information from the financial guaranty insurance sector, the Working Group considered several options for rectifying what was an unintentional effect of extensive revisions to the receivership model. Working Group members responsible for the drafting of Section 801 stated that the original intent of excluding claims under policies of mortgage and financial guaranty insurance was not to create an unfavorable perception about the legitimacy of these types of insurance as compared to other insurance of Class 3 priority. It was also observed placing these claims in Class 6, as originally adopted, could create a conflict with federal priority as outlined by the Supreme Court in *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993).

The decision to place these claims in a separate class from the general policyholder class was intended to provide greater protection to policyholders of insurers that write only financial guaranty or mortgage guaranty insurance. If such a monoline writer were subject to receivership proceedings, no Class 3 claims would exist, thus the claimants would have *de facto* Class 3 status. The Working Group agreed to amend Section 801 to better protect individual policyholders of monoline writers of mortgage and financial guaranty insurance, while recognizing that these lines may not be regulated in a manner consistent with other lines.

Interested parties who participated in the drafting process were the Genworth Mortgage Insurance Corporation, the Mortgage Guaranty Insurance Corporation and the Association of Financial Guaranty Insurers. The interested parties reported that the amendments should provide a cure for the concerns expressed by FitchRatings.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group received comments these issues at the Spring 2006 and Summer 2006 National Meetings. Interim meetings allowed for further refinement of the proposed amendments. Written comments were accepted at the Working Group level in two intervals of at least 30 days. The amendments were unanimously adopted by the Working Group on July 11, 2006, and received by the Receivership and Insolvency (E) Task Force at the Fall 2006 National Meeting. No written comments were received at the Task Force level, and the Task Force adopted the amendment unanimously on October 23, 2006. The Financial Condition (E) Committee unanimously adopted the amendment at the Winter 2006 National Meeting.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The only issue garnering controversy at the Working Group level was the proposal by the financial guaranty insurance industry to remove the exclusion for claims under such policies from Class 3 and instead afford Class 3 status to claims by monoline financial guaranty insurers under reinsurance agreements with an insolvent monoline financial guaranty reinsurer. Working Group members expressed concern that this proposal would treat reinsurers in one line of business differently from reinsurers in all other lines. The proposal was offered because market consolidation in the financial guaranty sector has significantly reduced the separation between primary writers and reinsurers. Citing *Fabe* concerns about treating claims under reinsurance the same as claims of direct policyholders, the Working Group rejected the proposal. The proposed amendment does not recognize claims of reinsurers in these lines differently from reinsurers in any other line.

7. Any Other Important Information (e.g., amending an accreditation standard).

The amendment, if adopted, would become part of IRMA, which is currently being processed under the Financial Regulation Standards and Accreditation (F) Committee framework for consideration as an amendment to the existing receivership accreditation standard.

PROJECT HISTORY - 2007

INSURER RECEIVERSHIP MODEL ACT (#555)
(Section 712 - Administration of Loss Reimbursement Policies)

1. Description of the Project, Issues Addressed, etc.

The Insurer Receivership Model Act (IRMA) was originally adopted by the NAIC on December 4, 2005, but did not contain a provision on large deductible insurance policies. Large deductible policies are insurance policies, most common in the workers' compensation area, where the insurer has "first dollar" responsibility for payment of claims, regardless of whether a particular loss is within the deductible amount. In return, the policyholder promises to reimburse the insurer for all payments within the deductible amount. Large deductible policies are typically in excess of $100,000, and are often accompanied by collateral arrangements to secure the insured's deductible obligations. Section 712 – Administration of Loss Reimbursement Policies was added to IRMA to treat loss reimbursements in the receivership context as general assets of the insolvent estate. Section 712 also provides that any funds that come into the insolvency estate (either through repayments or through the draw down of collateral) that are allocable to claims that a guaranty association has paid shall be immediately remitted to the guaranty association. Such payments remitted to a guaranty fund are considered early access payments under Section 803 of IRMA. The term "large deductible policy" was changed to "loss reimbursement policy", and references to worker's compensation policies were removed, to reflect that Section 712 applies to all insurance policies regardless of the size of the deductible or the type of coverage provided.

2. Name of Group Responsible for Drafting the Model and States Participating

Receivership and Insolvency (E) Task Force (RITF)

States Participating:

New Jersey, Chair	Louisiana
Tennessee, Vice Chair	Massachusetts
Arkansas	New Mexico
California	New York
Connecticut	North Carolina
Delaware	Ohio
District of Columbia	Oklahoma
Florida	Pennsylvania
Hawaii	Rhode Island
Illinois	Texas
Indiana	Utah
Iowa	Washington
Kentucky	

3. Project Authorized by What Charge and Date First Given to the Group

The following charge was given to the RITF in 2006:

> Monitor progress of IRMA through adoption process, provide assistance as requested and perform additional work as directed by parent committee. *Essential*

The Financial Condition (E) Committee in its interim meeting dated November 7-8, 2005, gave the following charge:

> A charge to consider a large deductible provision in 2006.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

In the Fall of 2005, the Financial Condition (E) Committee asked the Model Act Revision Working Group (MARG) of the RITF to study the issue of large deductibles and, if advisable, draft model language. MARG met on January 12, 2006, to discuss the working group's charge to consider the development of a large deductible provision in IRMA by the Spring 2006 National Meeting. On February 14, 2006, MARG adopted a model provision to amend IRMA by adding a new section in Article VII, which was presented to the RITF on March 6, 2006. At this meeting the RITF indicated that written comments should be submitted by April 10, 2006, after which the RITF would hold an interim conference call to discuss the issue further. A subgroup was formed in April of 2006 to consider comments from receivers of the Reliance Insurance Company in Liquidation, who had significant practical experience with administering large deductible polices. This subgroup prepared a draft of IRMA Section 712 (the Arkansas Proposal) on May 10, 2006, which was presented to the RITF at its Summer National Meeting on June 12, 2006. Revisions to IRMA Section 712 were then submitted to the RITF, which were discussed on a conference call dated July 25, 2006. This version of Section 712 was again discussed on a conference call of the RITF dated August 23, 2006, at which time another subgroup was appointed to review an alternative proposal to Section 712 (the Delaware Proposal), which consisted of representatives from Delaware (Chair), Arkansas, Massachusetts and Ohio. On September 11, 2006, the RITF instructed the subgroup to prepare two alternative and conceptually different drafts of Section 712 addressing large deductibles. In a conference call dated October 23, 2006, the subgroup submitted a draft of Section 712 (the Delaware Proposal) to the RITF, which directed that comments be posted on the Delaware Proposal by November 23, 2006. The RITF and the Financial Conditions (E) Committee adopted the Delaware version of Section 712 at the NAIC's Winter National Meeting on December 11, 2006.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Both the Delaware and Arkansas Proposals for IRMA Section 712 were the subject of extensive exposure periods, public hearings and other means (e.g., conference calls) by which widespread input from industry, consumers and legislators were solicited, as discussed in paragraph 4 above. Beginning with the NAIC 2005 Winter National Meeting, drafts of the proposed revisions were reviewed and discussed at each National Meeting and during RITF and subgroup conference calls. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC web site and distributed by email to interested parties. Comments were received by numerous groups, including industry groups such as the National Conference of Insurance Guaranty Funds (NCIGF), Property Casualty Insurers Association of America (PCI), American Insurance Association (AIA), Western Guaranty Fund Services, Minnesota Property & Casualty Guaranty Association, Mississippi Insurance Guaranty Association, Oregon Insurance Guaranty Association, and Bingham McCutchen LLP.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The most significant issue and item of controversy during the due process were the alternative proposals to IRMA Section 712; i.e., the Delaware Proposal and the Arkansas Proposal. The Delaware Proposal, as eventually adopted by the RITF and previously discussed, would treat loss reimbursements as general assets of the insolvent estate, but would give guaranty funds the right to early access to these loss reimbursements. Alternatively, under the Arkansas Proposal the guaranty association, and not the receivership, directly receives reimbursements on the payment of large deductible claims. Many of the interested parties actively involved with the guaranty associations favored the Arkansas Proposal. In the Spring National Meeting of the RITF dated March 6, 2006, it was noted that the NAIC membership recently adopted a large deductible white paper (Workers' Compensation Large Deductible Study prepared by the NAIC/IAIABC Joint Working Group in March 2006), which took the position that the reimbursement on large deductible policies should be paid to the guaranty funds to the extent the guaranty funds advanced the funds to pay the claims. The Arkansas Proposal was drafted to reflect this position. However, it soon became evident that a majority of the RITF favored the Delaware approach, which was eventually approved by roll call vote of the RITF over the Arkansas Proposal, with 14 states in favor (Delaware, District of Columbia, Florida, Illinois, Iowa, Kentucky, Massachusetts, New Mexico, North Carolina, Ohio, Rhode Island, Texas, Utah and Washington), five opposed (Arkansas, Indiana, Louisiana, Oklahoma and Pennsylvania) and two abstentions (New Jersey and New York).

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2005

INSURER RECEIVERSHIP MODEL ACT (#555)

1. Description of the Project, Issues Addressed, etc.

The Insurer Receivership Model Act (IRMA) is intended to comprehensively address the administration of an impaired or insolvent insurer from conservation and rehabilitation to liquidation and winding up of an estate. This model serves as the foundation of modernization efforts in the receivership area called for in both the Insurance Regulatory Modernization Action Plan and the Framework for a National System of State-Based Regulation. IRMA was a collective effort of people dedicated to enhancing the efficiency and economy of receiverships.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership Model Act (E) Revision Working Group of the Financial Condition (E) Committee's Receivership And Insolvency Task Force drafted the Insurer Receivership Model Act. The drafting process started in 2001 and the following persons chaired the working group: Doug Hartz (MO) (2001), Diane Garber (MO) (2001 – 2003), Wayne Johnson (FL) (2003) and Frank Martin (PA) (2004 – 2005). The following states were members of the working group: Arkansas, Arizona, California, Connecticut; Delaware, Florida, Iowa, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The charge that was given to the working group was to "produce a revised Insurers Rehabilitation and Liquidation (Insurer Receivership) Model Act, using the current model act as a starting point and incorporating the Uniform Receivership Law, as adopted by the Interstate Insurance Receivership Commission, where appropriate, with a final revised Insurer Receivership Model Act to be delivered by the 2004 Winter National Meeting. Continue to update the Insurer Receivership Model Act annually to reflect current best practices for issues as identified by the NAIC in its other charges related to insurer receiverships." Excerpted from the 2004 Charges of the Receivership & Insolvency Task Force.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

IRMA was developed in an open and deliberative process at the working group level as well as the task force and committee levels. The devotion and expertise contributed to the development of this model law was tremendous as it involved input from regulators and others that have handled or been involved in multiple, complex, and at times, controversial receiverships. The major players in the area of receiverships had significant input into this model, including the guaranty associations for life & health and property & casualty and the reinsurers. Specifically, the following interested parties, among others, provided substantive input into the IRMA drafting process National Organization of Life & Health Insurance Guaranty Associations, National Conference of Insurance Guaranty Funds, Reinsurance Association of America, American Counsel of Life Insurers, American Insurance Association, Property Casualty Insurers Association of America, State Farm Insurance Company and representatives of the Home Receivership Estate. In addition, several attorneys in private practice with expertise in insurance receivership or bankruptcy contributed to the process without compensation.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The working group spent a great deal of time over the last four years in more than 70 two- to three-hour conference calls, in four- to eight-hour sessions at each NAIC quarterly meeting during that period, and at multiple two-day interim meetings in accelerated discussions on a new model law governing receiverships. Interested parties participated in every meeting or conference call. Since March 2004, more than 60 drafts of the model showing adopted sections and proposed revisions were provided to members of the working group, subgroups and drafting groups, interested regulators and interested parties for comment and review.

The Financial Condition (E) Committee received IRMA for consideration in May 2005. The committee had a special ninety-minute public hearing at the Summer 2005 National Meeting and received written comments prior to that meeting. The committee had a thirty-day exposure period and received comment letters from interested parties in mid-July. The committee conducted an interim meeting in Chicago, Illinois on August 2 - 3, 2005 and spent one full day receiving oral comments from interested parties including asking questions regarding areas of concern. The committee held two-hour conference calls on

August 17, 2005, and October 28, 2005, that were open to interested parties but limited to regulator-only discussion. On November 7 - 8, 2005, the committee held an interim meeting and spent eight hours receiving comments from and dialoguing with interested parties as well as voting on proposed changes to the model.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The two most controversial issues at the working group level and the committee level related to provisions affecting the guaranty associations and reinsurance collections.

Guaranty associations wanted the automatic right of intervention (Section 105I) and automatic party in interest status (Section 104S) in liquidation proceedings, both rights which are not included in the current model receivership law. Regulators were concerned that some states do not afford special treatment to guaranty associations by giving them an automatic right of intervention or party status. The Financial Condition Committee included three options for states to choose regarding intervention of guaranty associations: 1) silent on this issue; 2) intervention only upon application to and approval by receivership court; or 3) intervention as a matter of right. A guaranty association is not an automatic party in interest but rather must petition the court.

The notice and hearing provision (Section 107) modernizes the receiver's interaction with the court and is intended to increase the efficiency and economy of the receivership proceeding while protecting other parties' abilities to participate. This provision also provides that if the court determines that an objection to an action proposed by the receiver was frivolous, filed for delay or other improper purpose the court can award fees and costs to the receiver. Some interested parties objected to this provision citing fairness concerns but this "loser pays" provision only applies to actions the court determines to be frivolous or filed merely for delay, not to all unsuccessful objections and is consistent with state law in many instances.

The immunity and indemnification provision (section 115) is an enhancement to the existing model because conservators and rehabilitators, who are arguably subject to greater liability, are covered. The receiver's contractors such as attorneys and accountants are immune from liability to the same extent as the receiver. Immunity and indemnification do not extend to liability caused by intentional, willful or wanton misconduct. Gross negligence is not expressly excluded. Since any claim of misconduct by a contractor would accrue to the receiver, not to claimants or stakeholders of the receivership estate, the receiver maintains the ability to proceed against a contractor, and indemnification does not apply.

There are new provisions for addressing conservation (Article III). The purpose of this Article is to provide for a type of delinquency proceeding where it is not clear if the insurer can be rehabilitated. The intent is to avoid rehabilitation proceedings conducted merely for the purpose of preparing the estate for the entry of a liquidation order. Some interested parties complained that the powers of the conservator are too broad. The committee believed that the purpose of conservation was best served by the enumerated powers.

In Section 504A(3)(b), the model explicitly adds a power that many regulators believe has been implicit in the powers of the receiver. (Also see Drafting Note to Section 801A). This provision expressly allows the liquidator, upon approval of the receivership court, to pay administrative costs of the estate where the payment will assist or result in the collection or recovery of property of the insurer. An example is where a claimant of the estate is not going to prosecute a claim, but if the claim were pursued, the estate would realize a recovery of property. This provision recognizes the liquidator's power to incentivize the prosecution of the claim, provided there is a net benefit to all creditors of the estate by a resultant increase in the distributable assets. The payment does not constitute a violation of the priority of distribution because it has no effect on the amount or timing of any subsequent distribution on the underlying claim.

This model incorporates a procedure to enable liquidators to address estates with long-tail claim liabilities in order to minimize continuing administrative expenses (Sections 611 and 614/615). Under existing models, receivers have attempted to actuarially estimate the remaining liabilities and bill reinsurers based on those estimates – which may be higher or lower than actual liability. Reinsurance Association of America strongly opposed any language that would require reinsurers to commute and settle claims or that would include a component of incurred but not reported losses in the calculation of reinsurance balances. The committee voted to have one option in the model, that is, allowing the receiver to petition for arbitration of reinsurance receivables only when 75% of the estates' liabilities have been settled or if the reinsurer is in financial difficulty. The provision allows the liquidator or the reinsurer to reject the arbitration panel's decision, in which case the commutation payment would be placed into a trust for the benefit of the estate and funds would be withdrawn from the trust as claims are paid. The RAA told the committee that they were supportive of the provision that ended up in the model. They had objected to an additional option, which the committee removed.

The priority of distribution provision (Section 801A) adopted by the task force created a new Class 2 for administrative expenses including defense costs of the guaranty associations. At the working group and task force levels, this provision was a compromise between the receivers and the guaranty associations as guaranty associations wanted all of their expenses in Class 1 and receivers wanted defense costs and costs related to policyholder benefits included in Class 3, the general policyholder class. The committee included two options that a state may choose from: (1) create Class 2 and guaranty association administrative expenses are in this class; (2) create Class 2 and certain guaranty association administrative expenses are in this class, but P/C defense costs and other costs related to policyholder benefits are in the general policyholder class. This second option was added to address the concern that defense costs and cost containment costs of guaranty associations are more appropriately considered policyholder benefits and therefore deserve the same treatment as the policyholder benefits of policyholders not eligible for coverage by a guaranty association.

This model provides that early access payments (Section 803) shall be made to guaranty associations as soon and as frequently as possible, at least yearly if distributable assets exist and are treated as advances against distributions. It requires the liquidator to petition the court within 120 days of the liquidation order and annually thereafter for approval to make early access distributions or report that there are no distributable assets at that time. The model requires early access payments to be made within 60 days of receivership court approval. Guaranty associations have suggested requiring more frequent distributions, inclusion of a formula for determining early access distributions and a requirement that early access be reapplied for by the liquidator whenever significant new assets are recovered. At least one state contends that early access payments be based on actual claim payments by guaranty funds. This provision provides a simple rule that all assets not needed for administrative expenses be forwarded to guaranty associations and would simplify calculations and recovery of excess distributions if needed.

Two issues were referred to the Model Act Revision Working Group for further consideration: (1) provision to petition court for receiver to administer all claims, and (2) large deductible provision. A provision was proposed at the committee level to address concerns about a lack of coordination and cost efficiency when multiple guaranty associations are triggered in an insolvency or when complex claims are handled by the liquidator and also by the guaranty association. Some interested parties strongly opposed this provision and claimed it would conflict with guaranty fund laws and no evidence existed to support its inclusion in the model act. The committee agreed to defer the issue for consideration by the Receivership Model Act Revision Working Group during its ongoing review of the P/C insurance guaranty fund model. The resulting charge is to address the need for improvements in coordination among guaranty associations and the receiver's ability to control claims handling expenses in liquidation proceeding.

The large deductible provision was proposed very late in the working group's consideration and revived at the task force and committee levels. It addresses a type of policy, most common in the workers' compensation area, where the insurer has "first dollar" responsibility for payment of claims regardless of whether a particular loss is within the deductible amount. In return the policyholder promises to reimburse the insurer for all payments within the deductible amount. With the support of industry trade groups, guaranty funds propose that, in the event of insolvency, the reimbursement should be funneled to the guaranty fund responsible for paying claims under large deductible policies. This provision has been adopted in a few states but the provision has been universally difficult to apply. The committee deferred the issue for consideration at the working group level.

7. Any Other Important Information (e.g., amending an accreditation standard).

It is intended that selected portions of this model will be the basis for a revised accreditation standard.

ADMINISTRATIVE SUPERVISION MODEL ACT

Table of Contents

Section 1. Definitions

As used in this Act:

A. "Insurer" means and includes every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuities as limited to:

(1) Any insurer who is doing an insurer business, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future;

(2) Any fraternal benefit society which is subject to the provisions of [insert applicable statute];

(3) [List any other specialty type insurer not covered by the general law which should be covered by this Act].

B. "Exceeded its powers" means the following conditions:

(1) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the commissioner, his or her deputies, employees or duly commissioned examiners;

(2) A domestic insurer has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the insurer;

(3) The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto;

(4) The insurer has neglected or refused to observe an order of the commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus;

(5) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner;

(6) The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or has without first having obtained written approval of the commissioner if approval is required by law:

(a) Totally reinsured its entire outstanding business, or

(b) Merged or consolidated substantially its entire property or business with another insurer.

(7) The insurer engaged in any transaction in which it is not authorized to engage under the laws of this state;

(8) The insurer refused to comply with a lawful order of the commissioner.

C. "Consent" means agreement to administrative supervision by the insurer.

D. [The terms "commissioner" and "department" may need definitions].

Drafting Note: States may wish to compare these definitions with other definitions in their statutes and resolve any conflict.

Section 2. Applicability

The provisions of this Act shall apply to:

A. All domestic insurers, and

B. Any other insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of this Act as regards such insurer.

Section 3. Notice to Comply with Written Requirements of Commissioner; Noncompliance; Administrative Supervision

A. An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the commissioner's discretion that:

(1) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

(2) The insurer ["has" or "appears to have"] exceeded its powers granted under its certificate of authority and applicable law;

(3) The insurer has failed to comply with the applicable provisions of the insurance code;

(4) The business of the insurer is being conducted fraudulently; or

(5) The insurer gives its consent.

B. If the commissioner determines that the conditions set forth in Subsection A of this section exist, the commissioner shall:

(1) Notify the insurer of his or her determination;

(2) Furnish to the insurer a written list of the requirements to abate this determination; and

(3) Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of the Act. Action by the commissioner shall be subject to review pursuant to applicable state administrative procedures under [insert state's appropriate administrative appeals procedure statute].

C. If placed under administrative supervision, the insurer shall have sixty (60) days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of this Act.

D. If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the commissioner may extend the period.

E. If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

Section 4. Confidentiality of Certain Proceedings and Records

A. Notwithstanding any other provision of law and except as set forth in this section; proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the commissioner or the Department relating to the supervision of any insurer are confidential and shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action, except as provided by this section. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

B. The personnel of the Department shall have access to these proceedings, hearings, notices, correspondence, reports, records or information as permitted by the commissioner. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. The commissioner may share the notices, correspondence, reports, records or information with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States, and provided that the recipient agrees to maintain the confidentiality of the documents, material or other information. No waiver of any applicable privilege or claim of confidentiality shall occur as a result of the sharing of documents, materials or other information pursuant to this subsection.

D. The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors or the general public.

E. This section does not apply to hearings, notices, correspondence, reports, records or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

Drafting Note: States may want to consider changing this section to require proceedings and records to be public record unless the commissioner deems otherwise. Confidentiality of orders is not included in this section. Some states may want to protect orders from disclosure by including them in this section.

Section 5. Prohibited Acts During Period of Supervision

During the period of supervision, the commissioner or the commissioner's designated appointee shall serve as the administrative supervisor. The commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or the appointed supervisor:

A. Dispose of, convey or encumber any of its assets or its business in force;

B. Withdraw any of its bank accounts;

C. Lend any of its funds;

D. Invest any of its funds;

E. Transfer any of its property;

F. Incur any debt, obligation or liability;

G. Merge or consolidate with another company;

H. Approve new premiums or renew any policies;

I. Enter into any new reinsurance contract or treaty;

J. Terminate, surrender, forfeit, convert or lapse any insurance policy, certificate or contract, except for nonpayment of premiums due:

K. Release, pay or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate or contract;

L. Make any material change in management; or

M. Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

Section 6. Review and Stay of Action

During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to request a proceeding under [insert state's appropriate administrative appeals procedure statute].

Section 7. Administrative Election of Proceedings

Nothing contained in this Act shall preclude the commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under this Act against the insurer.

Section 8. Rules

The commissioner is empowered to adopt reasonable rules necessary for the implementation of this Act.

Section 9. Other Laws; Conflicts; Meetings Between the Commissioner and the Supervisor

Notwithstanding any other provision of law, the commissioner may meet with a supervisor appointed under this Act and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of this Act to carry out the commissioner's duties under this Act or for the supervisor to carry out his or her duties under this Act.

Section 10. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Insurance Commissioner or the Department of Insurance or its employees or agents for any action taken by them in the performance of their powers and duties under this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1990 Proc. I 6, 26, 173, 175-178 (adopted).
1999 Proc. 4th Quarter 15, 804, 811-812 (amended).

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What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ADMINISTRATIVE SUPERVISION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-2-33 to 27-2-39 (1977).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. INS. CODE §§ 1077 to 1077.95 (1992).		
Colorado			COLO. REV. STAT. §§ 10-3-401 to 10-3-414 (1963/1992).
Connecticut	CONN. GEN. STAT. §§ 38a-962 to 38a-962j (1992).		
Delaware			DEL. CODE ANN. tit. 18, § 5942 (1984/1995).
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. STAT. §§ 624.80 to 624.87 (1989).		FLA. ADMIN. CODE ANN. r. 69O-141.001 to 69O-141.006 (1991/1992).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. § 33-3-1 (1960); §§ 33-3-17 to 33-3-18 (1992); GA. COMP. R. & REGS. 120-2-55 (1993).		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431:15-101 to 431:15-411 (1987).
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	IND. CODE § 27-9-2-1 to 27-9-2-3 (2015) (portions of the model).		
Iowa			IOWA CODE §§ 507C.1 to 507C.60 (1984/2014).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. REV. STAT. ANN. §§ 22:731 to 22:737 (1991/1992).		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	MASS. GEN. LAWS ch. 175J, §§ 1 to 10 (1993).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. STAT. §§ 60G.01 to 60G.09 (1991).		
Mississippi	MISS. CODE ANN. §§ 83-1-151 to 83-1-169 (1991).		
Missouri	MO. REV. STAT. § 375.1160 (1991).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana			MONT. CODE ANN. §§ 33-2-1301 to 33-2-1394 (1979/2013).
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. §§ 402-M:1 to 402-M:11 (2016).		
New Jersey	N.J. STAT. ANN. §§ 17:51A-1 to 17:51A-10 (1993).		
New Mexico			N.M. STAT. § 59A-46-22 (HMO) (1993).
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. § 58-30-62 (1991).		
North Dakota	N.D. CENT. CODE §§ 26.1-06.2-01 to 26.1-06.2-10 (1993).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. STAT. tit. 36, §§ 1801 to 1811 (1975/1986) (portions of model).		
Oregon	OR. REV. STAT. §§ 734.043 to 734.047 (1993) (portions of model).		
Pennsylvania			40 PA. STAT. ANN. § 221.11 (1977).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-14.1-1 to 27-14.1-10 (1991/1999).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. §§ 38-26-10 to 38-26-110 (1991).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. CODE ANN. §§ 56-9-501 to 56-9-511 (1991/2004).		
Texas			TEX. INS. CODE ANN. §§ 441.001 to 441.008 (2005/2007).
Utah	NO CURRENT ACTIVITY		
Vermont			VT. STAT. ANN. tit. 8, §§ 7031 to 7100 (1991/1999).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE 48.31.400 to 48.31.435 (2005).		
West Virginia	W. VA. CODE §§ 33-34-1 to 33-34-10 (1990).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. STAT. ANN. § 26-34-123 (HMO) (1995).

GROUP LIFE INSURANCE DEFINITION AND GROUP LIFE INSURANCE STANDARD PROVISIONS MODEL ACT

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Section 1. Group Life Insurance Definitions

Except as provided in Section 2, no policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" may include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

Drafting Note: Last sentence of Paragraph (1) may be deleted if its content is covered by other statutes.

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in Paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured employees shall insure all eligible employees, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

B. A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

(a) Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction;

(b) The debtors of one or more subsidiary corporations; and

(c) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships or partnerships is under common control.

(2) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in Paragraph (3), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance shall insure all eligible debtors.

(3) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor, except that insurance written in connection with open-end credit having a credit limit exceeding $10,000 may be in an amount not exceeding the credit limit.

(5) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment and any excess of the insurance shall be payable to the estate of the insured.

(6) Notwithstanding the provisions of the above subsections, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a non-decreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which shall be deemed to be the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

(2) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in Paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance shall insure all eligible members, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

D. A policy issued to a trust or to the trustees of a fund established or adopted by two (2) or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy

may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in Paragraph (3), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance shall insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

E. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of btaining insurance; shall have been in active existence for at least two (2) years; and shall have a constitution and by-laws which provides that: (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations, collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(1) The policy may insure members of the association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

(2) The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

(3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance shall insure all eligible persons, except those who reject the coverage in writing.

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two (2) or more credit unions, which credit union, trustee, trustees or agent shall be deemed policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in Paragraph (3), shall insure all eligible members.

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Section 2. Limits of Group Life Insurance

Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than one described in Section 1 shall be subject to the following requirements:

A. A group life insurance policy shall not be delivered in this state unless the commissioner finds that:

(1) The issuance of the group policy is not contrary to the best interest of the public;

(2) The issuance of the group policy would result in economies of acquisition or administration; and

(3) The benefits are reasonable in relation to the premiums charged.

B. A group life insurance coverage may not be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in Subsection A(1), (2) and (3) has made a determination that the requirements have been met.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Section 3. Notice of Compensation

A. With respect to a program of insurance which, if issued on a group basis, would not qualify under Section 1 of this Act, the insurer shall cause to be distributed to prospective insureds a written notice that compensation will or may be paid, if compensation of any kind will or may be paid to;

(1) A policyholder or sponsoring or endorsing entity in the case of a group policy; or

(2) A sponsoring or endorsing entity in the case of individual, blanket or franchise policies marketed by means of direct response solicitation.

B. The notice shall be distributed:

(1) Whether compensation is direct or indirect; and

(2) Whether the compensation is paid to or retained by the policyholder or sponsoring or endorsing entity, or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity, or an entity affiliated therewith by way of ownership, contract or employment.

C. The notice required by this section shall be placed on or accompany an application or enrollment form provided to prospective insureds.

D. The following terms shall have the meanings indicated:

(1) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity through the mails, telephone or other mass communications media;

(2) "Sponsoring or endorsing entity" means an organization that has arranged for the offering of a program of insurance in a manner that communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

Section 4. Dependent Group Life Insurance

Except for a policy issued under Section 1B, a group life insurance policy may be extended to insure the employees or members against loss due to the death of their spouses and dependent children, or any class or classes thereof, subject to the following:

A. The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both. Except as provided in Subsection B, a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons shall insure all eligible employees or members with respect to their spouses and dependent children, or any class or classes thereof.

B. An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

C. The amounts of insurance for any covered spouse or dependent child under the policy may not exceed fifty percent (50%) of the amount of insurance for which the employee or member is insured.

Section 5. Group Life Insurance Standard Provision

No policy of group life insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the commissioner are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder. However, (i) Subsections F to K inclusive shall not apply to policies insuring the lives of debtors; (ii) the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and (iii) if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which, in the opinion of the commissioner, is or are equitable to the insured persons and to the policyholder. Nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

A. The policy shall contain a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder gives the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

B. The policy shall contain a provision that the validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for two (2) years from its date of issue; and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless it is contained in a written instrument signed by him or her. This provision shall not preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage.

C. The policy shall contain a provision that a copy of the application, if any, of the policy holder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of death or incapacity of the insured person, to his or her beneficiary or personal representative.

D. The policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

E. The policy shall contain a provision specifying an equitable adjustment of premiums or benefits, or both, to be made in the event the age of a person insured has been misstated. The provision to contain a clear statement of the method of adjustment to be made.

F. The policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that, where the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of the sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding $2,000 to any person appearing to the insurer to be equitably entitled to it by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

G. The policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, a statement as to any dependent's coverage included in the certificate, and the rights and conditions set forth in Subsections H, I, J and K following.

H. The policy shall contain a provision that, if the insurance, or any portion of it, on a person covered under the policy or on the dependent of a person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after termination and provided further that:

(1) The individual policy shall, at the option of the person, be on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

(2) The individual policy shall be in an amount not in excess of the amount of life insurance that ceases because of termination, less the amount of any life insurance for which the person becomes eligible under the same or any other group policy within thirty-one (31) days after termination, provided that any amount of insurance that shall have matured on or before the date of termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount that is considered to cease because of termination; and

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to the individual age attained on the effective date of the individual policy. Subject to the same conditions set forth above, the conversion privilege shall be available:

(a) To a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy that terminates by reason of the death; and

(b) To the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

I. The policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five (5) years prior to the termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by Subsection H above, except that the group policy may provide that the amount of the individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one (31) days after termination; or

(2) $10,000.

J. The policy shall contain a provision that, if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual policy issued in accordance with Subsection H or I above and before the individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued under the individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

K. Where active employment is a condition of insurance, the policy shall contain a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of six (6) months from the date on which the total disability started, but not beyond the earlier of:

(1) Approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain; or

(2) The discontinuance of the group insurance policy.

L. In the case of a policy insuring the lives of debtors, the policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the death benefit shall first be applied to reduce or extinguish the indebtedness.

Section 6. Supplementary Bill Relating to Conversion Privileges

If an individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of the policy to have an individual policy of life insurance issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in the policy, and if the individual is not given notice of the existence of the right at least fifteen (15) days prior to the expiration date of the period, then in that event the individual shall have an additional period within which to exercise the right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in the policy. This additional period shall expire fifteen (15) days next after the individual is given notice but in no event shall the additional period extend beyond sixty (60) days after the expiration date of the period provided in the policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this paragraph.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1917 Proc. (adopted).
1946 Proc. 334, 338-344, 352 (amended).
1948 Proc. 459-460 (amended).
1954 Proc. I 114, 117, 136 (amended).
1955 Proc. I 124, 128-129, 132 (amended).
1956 Proc. II 355, 358, 361-369, 394 (adopted new model).
1957 Proc. I 131, 134, 163 (amended).
1981 Proc. I 47, 51, 421, 516, 528-533 (amended and reprinted).
1983 Proc. I 6, 35, 447, 667, 678-683 (amended and reprinted).
1984 Proc. I 6, 31, 374, 377 (amended).
1985 Proc. I 19, 37, 550-551, 552-557 (amended).
1988 Proc. I 9, 21-22, 828, 851-852 (amended).

GROUP LIFE INSURANCE DEFINITION AND GROUP LIFE INSURANCE STANDARD PROVISIONS MODEL BILL

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GROUP LIFE INSURANCE DEFINITION AND GROUP LIFE INSURANCE STANDARD PROVISIONS MODEL BILL

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-18-1 to 27-18-16 (1971) (§ 5 of model).		
Alaska	ALASKA STAT. §§ 21.48.010 to 21.48.230 (1966/2006).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1251 to 20-1269 (1954/2005).		
Arkansas	ARK. CODE ANN. §§ 23-83-101 to 23-83-122 (1981/1987).		
California			CAL. INS. CODE §§ 10200 to 10214 (1935/2016).
Colorado	COLO. REV. STAT. §§ 10-7-201 to 10-7-207 (1963/2010) (§ 5 of model).		
Connecticut			CONN. GEN. STAT. §§ 38a-532 to 38a-537 (1958/2013).
Delaware	DEL. CODE ANN. tit. 18, §§ 3101 to 3128 (1987).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. CODE § 31-4711 (1981/2003).
Florida	FLA. STAT. §§ 627.551 to 627.575 (1959/1992).		
Georgia	GA. CODE ANN. §§ 33-27-1 to 33-27-9 (1960/2013).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:10D-201 to 431:10D-215 (1988/2008).		
Idaho	IDAHO CODE ANN. §§ 41-2001 to 41-2021 (1961/2005).		
Illinois	215 ILL. COMP. STAT. 5/230.1 to 5/231.1 (1982/1983).		
Indiana	IND. CODE §§ 27-1-12-37 to 27-1-12-42 (1985/1987).		
Iowa	IOWA CODE ANN. 509.1 to 509.2 (1947); 509.4 to 509.6 (1947/1987).		
Kansas	KAN. STAT. ANN. §§ 40-433 to 40-435 (1951/1997).		
Kentucky	KY. REV. STAT. ANN. §§ 304.16-010 to 304.16-230 (1970/2005).		
Louisiana	LA. REV. STAT. ANN. §§ 22:941 to 22:945 (1958/2008).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2601 to 2625 (1969/1987).		
Maryland	MD. CODE ANN., INS. §§ 17-101 to 17-311 (1955/1999).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ANN. ch. 175, §§ 133 to 134 (1918/2008).
Michigan			MICH. COMP. LAWS §§ 500.4400 to 500.4454 (1957/2014).
Minnesota	MINN. STAT. §§ 61A.09 to 61A.12 (1967/1989).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. REV. STAT. §§ 376.691 to 376.697 (1982/1987).		
Montana	MONT. CODE ANN. §§ 33-20-1101 to 33-20-1213 (1959/2005).		
Nebraska	NEB. REV. STAT. §§ 44-1601 to 44-1607 (1949/1974).		
Nevada	NEV. REV. STAT. §§ 688B.010 to 688B.190 (1971/1987) (§§ 5 and 6 of Model).		
New Hampshire	N.H. REV. STAT. ANN. §§ 408:15 to 408:16 (1947/2009).		
New Jersey	N.J. STAT. ANN. §§ 17B:27-68 to 17B:27-75 (2005).		
New Mexico	N.M. STAT. ANN. §§ 59A-21-1 to 59A-21-22 (1985).		
New York	N.Y. INS. LAW § 3220 (1984); § 4216 (1984/2010).		
North Carolina	N.C. GEN. STAT. §§ 58-58-135 to 58-58-140 (1925/1991).		
North Dakota	N.D. CENT. CODE §§ 26.1-33-11 to 26.1-33-12 (1985) (§§ 5 and 6 of model).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3917.01 to 3917.07 (1935/2006).		
Oklahoma	OKLA. STAT. tit. 36, §§ 4101 to 4104 (1957/2005).		
Oregon	OR. REV. STAT. §§ 743.303 to 743.345 (1967/1989).		
Pennsylvania	40 PA. STAT. ANN. §§ 532.1 to 532.9 (1949).		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1401 to 1411 (1960).
Rhode Island	R.I. GEN. LAWS §§ 27-4.8-1 to 27-4.8-6 (2009/2013).		
South Carolina	S.C. CODE ANN. §§ 38-65-10 to 38-65-210 (1988) (§ 5 of model).		
South Dakota			S.D. CODIFIED LAWS §§ 58-16-1 to 58-16-54 (1966/2004).
Tennessee	NO CURRENT ACTIVITY		
Texas	TEX. INS. CODE ANN. §§ 1131.051 to 1131.060 (2003).		TEX. INS. CODE ANN. §§ 1131.001 to 1131.007 (2003/2005); §§ 1131.451 to 1131.457 (2003/2005).
Utah			UTAH CODE ANN. §§ 31A-22-501 to 31A-22-521 (1986/2005).
Vermont	VT. STAT. ANN. tit. 8, §§ 3803 to 3823 (1968).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-3318.1 to 38.2-3339 (1986/1998).		
Washington	WASH. REV. CODE ANN. §§ 48.24.010 to 48.24.900 (1947/2005).		
West Virginia	W. VA. CODE §§ 33-14-1 to 33-14-20 (1957/2006).		
Wisconsin	WIS. STAT. §§ 632.56 to 632.57 (1975/1981).		
Wyoming	WYO. STAT. ANN. §§ 26-17-101 to 26-17-130 (1967/2009).		

MILITARY SALES PRACTICES MODEL REGULATION

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Section 1. Purpose

A. The purpose of this regulation is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Drafting Note: The language of Subsection B comes from the NAIC Unfair Trade Practices Act. If a state has adopted different language, it should be substituted for Subsection B.

Section 2. Scope

This regulation shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to an active duty service member of the United States Armed Forces.

Section 3. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.

Section 4. Exemptions

A. This regulation shall not apply to solicitations or sales involving:

1. Credit insurance;

2. Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;

3. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

4. Individual stand-alone health policies, including disability income policies;

5. Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 *et seq*.;

6. Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c) (23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

7. Contracts used to fund:

(a) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

(c) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(e) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(f) Prearranged funeral contracts.

B. Nothing herein shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 – PERSONAL COMMERCIAL SOLICITATION ON DOD INSTALLATIONS or successor directive.

C. For purposes of this regulation, general advertisements, direct mail and internet marketing shall not constitute "solicitation." Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided however, nothing in this subsection shall be construed to exempt an insurer or insurance producer from this regulation in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in this subsection.

Section 5. Definitions

A. "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

B. "Department of Defense (DoD) Personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

C. "Door to Door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

D. "General Advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

E. "Insurer" means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

F. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

G. "Known" or "Knowingly" means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited:

(1) Is a service member; or

(2) Is a service member with a pay grade of E-4 or below.

H. "Life Insurance" means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issued annuities.

I. "Military Installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

J. "MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

K. "Service Member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

L. "Side Fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(1) Accumulated value or cash value or secondary guarantees provided by a universal life policy;

(2) Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(3) A premium deposit fund which:

(a) Contains only premiums paid in advance which accumulate at interest;

(b) Imposes no penalty for withdrawal;

(c) Does not permit funding beyond future required premiums;

(d) Is not marketed or intended as an investment; and

(e) Does not carry a commission, either paid or calculated.

M. "Specific Appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.

N. "United States Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

Section 6. Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation

A. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

(1) Knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

(2) Soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.

(3) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(4) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

(5) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(6) Posting unauthorized bulletins, notices or advertisements.

(7) Failing to present DD Form 2885, *Personal Commercial Solicitation Evaluation*, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(8) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

Drafting Note: Currently, Army Regulation 210-7, which applies only to Army pay grades E-3 and below, requires that DA Form 2056, "Commercial Insurance Solicitation Record" be completed. At the time this Model Regulation was adopted, there were no similar requirements for other service branches, although it is anticipated that in the future there may be similar regulations adopted by other service branches.

B. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(2) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

Section 7. Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location

A. The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's "MyPay" account or other similar internet or electronic medium for such purposes. This subsection does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

(2) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(a) Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 *et seq*. and the regulations promulgated thereunder; and

(b) Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(3) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in subsection 7 (A)(2).

(4) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

(5) Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

(6) Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

(7) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

(8) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

B. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

(1) Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor." Nothing herein shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science In Financial Services (MSFS), or Masters of Science Financial Planning (MS).

(2) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

C. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs, or investment returns and are declared to be false, misleading, deceptive, or unfair:

(1) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(2) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free."

D. The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

(1) Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.

(2) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive.

(3) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the United States Armed Forces.

E. The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

(1) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

(2) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.

(3) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.

(4) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the "Military Personnel Financial Services Protection Act," Pub. L. No. 109-290, p.16.

(5) Excluding individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

(a) An explanation of any free look period with instructions on how to cancel if a policy is issued; and

(b) Either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of [insert reference to state's illustration or disclosure regulation] shall be deemed sufficient to meet this requirement for a written disclosure.

Drafting Note: In addition to the items enumerated above, states may wish to add other items required by their laws and regulations, for example, the NAIC Life Insurance Buyer's Guide.

F. The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

(1) Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

(2) Offering for sale or selling a life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(a) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.

(b) "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

(3) Excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund:

(a) Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(b) Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

(c) Which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.

(4) Excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

(5) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for an accidental death coverage, *e.g.*, double indemnity, which may be excluded.

Drafting Note: While the drafters are of the opinion that making it an unfair or deceptive trade practice to market and sell life insurance policies containing a war or military exclusion to active duty service members during a time of war is not inconsistent with statutes which permit those exclusions, others may disagree. Those states may either delete the subsection or seek to amend their statutes in order to protect service members under this subsection.

Section 8. Severability

If any provision of these sections or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of these sections are declared to be severable.

Section 9. Effective Date

This regulation shall become effective [January 1, 2008, or the effective date set in regulation] and shall apply to acts or practices committed on or after the effective date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2007 Proc. 2nd Quarter 147-159, 182-183 (adopted).

MILITARY SALES PRACTICES MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MILITARY SALES PRACTICES MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-140-.01 to 482-1-140-.09 (2007).		BULLETIN 7-9-2008 (2008).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.430 to 26.449 (2008/2011).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-2201 (2008).		
Arkansas	CODE ARK. R. 054.00.89 (2008).		BULLETIN 4-2008 (2008).
California	CAL. CODE REGS. tit. 10, §§ 2695.20 to 2695.28 (2008).		
Colorado	3 COLO. CODE REGS. 702-4:4-1-14 (2008/2012).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-819-70 to 38a-819-75 (2007).		
Delaware	18 DEL. ADMIN. CODE 1216-3.0 to 1216-9.0 (2008).		
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 5200 to 5299 (2007).		BULLETIN 2008-3 (2008).

MILITARY SALES PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69O-142.200 (2008).		
Georgia	GA. COMP. R. & REGS. 120-2-95-.01 to 120-2-95-.09 (2007).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-171-601 to 16-171-606 (2008/2012).		
Idaho			IDAHO CODE ANN. § 41-1302 (1961/2007); BULLETIN 2008-4 (2008).
Illinois	ILL. ADMIN. CODE tit. 50, § 2605 (2008).		
Indiana	760 IND. ADMIN. CODE 1-77-1 to 1-77-5 (2009).		
Iowa	IOWA ADMIN. CODE r. 191-25.1 to 191-25.9 (2007).		
Kansas	KAN. ADMIN. REGS. § 40-2-30 (2007) (adoption by reference).		
Kentucky	806 KY. ADMIN. REGS. 12:180 (2008).		KY. REV. STAT. ANN. § 304.12-257 (2010) (authority to promulgate regulations).
Louisiana	LA. ADMIN. CODE tit. 37, §§ 12501 to 12517 (2007).		
Maine	02-031 ME. CODE R. § 245 (2008).		BULLETIN 349 (2008).
Maryland	MD. CODE REGS. 31.09.13.01 to 13.09.13.09.		BULLETIN 9-2008 (2008).
Massachusetts	211 MASS. CODE REGS. 27.01 to 27.07 (2009).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. R. 2753.0100 to 2753.0600 (2009).		

MILITARY SALES PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	19 CODE MISS. R. PT. 1, R. 37 (2008-1) (2012).		
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 400-5.305 to 400:5.310 (2007).		
Montana	MONT. ADMIN. R. 6.6.907 (2008).		
Nebraska	NEB. ADMIN. R. & REGS. Tit. 210, Ch. 82 (2008).		BULLETIN CB-119 (2008).
Nevada	NEV. ADMIN. CODE §§ 686A.485 to 686A.4955 (2008).		BULLETIN 2008-008 (2008).
New Hampshire	N.H. CODE R. INS. 310 (2008).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-23A.1 to 11:2-23A.7 (2008).		
New Mexico	N.M. CODE R. §§ 13.9.17.1 to 13.9.17.13 (2008).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 223.1 to 223.7 (2008).		
North Carolina	N.C. GEN. STAT. ANN. §§ 58-58-320 to 58-58-350 (2007).		BULLETIN 2008-B-2 (2008).
North Dakota	N.D. ADMIN. CODE 45-04-14-01 to 45-04-14-04 (2008).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-1-08 (2007/2011).		BULLETIN 2008-3 (2008).
Oklahoma	OKLA. ADMIN. CODE §§ 365:25-27-1 to 365:25-27-8 (2007/2008).		BULLETIN 2-25-2008 (2008).
Oregon	OR. ADMIN. R. 836-080-0750 to 836-080-0775 (2007).		

MILITARY SALES PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	31 PA. CODE §§ 146d.1 to 146d.8 (2009).		NOTICE 8-2-2008 (2008); NOTICE 9-26-2009 (2009).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-25-11.1 to 20-25-11.8 (2011).		
South Carolina	S.C. CODE ANN. REGS. 69-65 (2007).		
South Dakota	S.D. CODIFIED LAWS §§ 58-33-117 to 58-33-130 (2008).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-89-.01 to 0780-1-89-.09 (2007).		
Texas	28 TEX. ADMIN. CODE §§ 21.4201 to 21.4207 (2008).		BULLETIN-0007-08 (2008).
Utah	UTAH ADMIN. CODE r. 590-242-1 to 590-242-11 (2007).		BULLETIN 2008-2 (2008).
Vermont	4-3 VT. CODE R. § 51 (2008).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-420-10 to 5-420-60 (2008).		ADMINISTRATIVE LETTER 2008-3 (2008).
Washington	WASH. ADMIN. CODE 284-30-850 to 284-30-872 (2008/2010).		
West Virginia	W. VA. CODE R. §§ 114-82-1 to 114-82-5 (2008).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 2.19 (2009).		
Wyoming	WY RULES AND REGULATIONS 044.0002.60 (2008).		

PROJECT HISTORY - 2007

MILITARY SALES PRACTICES MODEL REGULATION (#568)

1. Description of the Project, Issues Addressed, etc.

During the NAIC 2006 Winter National Meeting the, NAIC membership appointed a new Military Sales (EX) Working Group to assist state insurance regulators in achieving applicable directives set forth in the Military Personnel Financial Services Protection Act.

2. Name of Group Responsible for Drafting the Model and States Participating

Military Sales (EX) Working Group. The states of Georgia and Texas co-chaired the working group. The following states participated on the working group: Florida, Illinois, Iowa, Massachusetts, New York, North Carolina, North Dakota, Oklahoma and Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The working group was formed in December of 2006, through the NAIC's adoption of a resolution establishing the Military Sales (EX) Working Group. This resolution stated the following: "…the primary purpose of the new working group is to assist the organization in achieving those applicable directives set forth in the Military Personnel Financial Services Protection Act; and, furthermore, the new working group will coordinate with the Market Analysis Working Group regarding any further multi-state settlements against companies engaged in inappropriate sales practices specifically targeted to members of the Armed Forces."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Military Sales (EX) Working Group drafted the model regulation and solicited input from all interested parties. In addition to the working group members, the following states submitted comments on the model regulation: New Hampshire, Ohio, Pennsylvania and Virginia.

The working group worked very closely with the Department of Defense throughout the development of the model regulation. This coordination included a face-to-face meeting on March 5, 2007, between Commissioners John Oxendine (GA) and Roger Sevigny (NH) with Deputy Undersecretary of Defense Leslye Arsht and Colonel Michael Pachuta, Director of Moral, Welfare and Recreation Policy. The Department of Defense (DoD) submitted written comments on the model regulation on March 14, 2007.

The following interested parties submitted comments on the model regulation: (1) American Council of Life Insurers, (2) American Fidelity Life Insurance Company, (3) Financial Consulting, LLC, (4) Government Personnel Mutual Life Insurance Company, (5) Insurance Marketplace Standards Association, (6) Military Benefit Association, (7) National Association of Insurance & Financial Advisors, (8) Navy Mutual, (9) Prudential Insurance Company, (10) ReedSmith on behalf of Military Benefit Association, (11) State Farm Insurance Company, (12) Sonnenschein Nath & Rosenthal on behalf of Trans World Assurance and American Fidelity Life Insurance Company, (13) Trans World Assurance Company, and (14) United Services Automobile Association.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The drafting process followed the following timeline with an opportunity for all interested parties to comment:

The first draft of the model regulation dated February 2, 2007, was circulated for public comment on February 5, 2007. The working group received comments on the draft until February 13, 2007. The working group received comments from the following parties: (1) State of New Hampshire, (2) State of Pennsylvania, (3) American Council of Life Insurers, (4) National Association of Insurance & Financial Advisors, (5) American Fidelity Life Insurance Company, (6) Government Personnel Mutual Life Insurance Company, (7) Insurance Marketplace Standards Association, (8) Prudential Insurance Company, (9) State Farm Insurance Company, (10) Trans World Assurance Company and (11) United Services Automobile Association. The working group reviewed these comments and made numerous revisions to the model regulation.

The working group circulated a revised draft of the model regulation for public comment on March 29, 2007, in conjunction with the submission of the NAIC's report to Congress. The working group received comments on this draft until April 12, 2007. The working group received comments from the following parties: (1) State of Ohio, (2) State of Virginia, (3) American Council of Life Insurers, (4) National Association of Insurance & Financial Advisors, (5) Financial Consulting, LLC, (6) Government Personnel Mutual Life Insurance Company, (7) Military Benefit Association, (8) Navy Mutual, (9) ReedSmith on behalf of Military Benefit Association, (10) Sonnenschein Nath & Rosenthal on behalf of Trans World Assurance and American Fidelity Life Insurance Company. The working group reviewed these comments and made numerous revisions to the model regulation.

The working circulated a revised draft and held a conference call on April 19, 2007, with all interested parties.

Based upon the review of the comments and dialogue with all interested parties, the working group circulated a revised draft for comment on May 11, 2007. The working group received comments on the draft until May 18, 2007. The working group received comments from the following parties: (1) State of Washington and (2) American Council of Life Insurers.

The working held an open call with all interested parties on May 24, 2007 and made several revisions to the model act based upon the most recent comments submitted by the ACLI. The working group adopted the model act during this call.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Scope of the Model Regulation

Although Congress out of concerns for federalism or McCarran-Ferguson, or both, limited its Section 9 mandate in the Act to the development of standards to protect service members from "dishonest and predatory insurance sales practices" occurring on military installations, the Model is not so constrained. The Working Group found that many of the more egregious practices were not confined to military reservations but occurred off base as well. For example, the misuse and manipulation of the allotment system, which abrogated important rights guaranteed to certain service members, including the right to a cooling-off period and counseling, frequently occurred off base. Also, as installation commanders began to strictly enforce DoD on-base solicitation rules that prohibited solicitation in barracks or without an appointment, much of the actual sales activity moved off base, frequently to agents' offices. Young trainees were invited off base through various inducements, including "pizza parties." During these events, life insurance applications were frequently solicited. The DoD fully supports extending the scope of the Model Regulation to capture these and other prohibited practices occurring off base.

Section 6 of the model regulation addresses practices declared to be false, misleading, deceptive or unfair on a military installation while Section 7 of the model regulation addresses practices declared to be false, misleading, deceptive or unfair regardless of location.

Active Duty - Applicability to Reservist/National Guard Members

The Working Group found that most of the unlawful practices uncovered in the GAO Report to Congress and during the states' multi-state investigations (some of which are ongoing) occurred while service members were on active duty. Reservists and National Guard Members are covered by the model regulation if they are on full-time duty in the active military service. The model does not cover members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days. Thus, the Model would not cover solicitation or sales during weekend drills or "summer camp."

Suitability Standards

Some interested parties argued the suitability standards create a ban on certain classes of products and that the model regulation should focus instead on bad characteristics that might be associated with certain products. These parties indicated that military service members should be provided the same opportunity to purchase term insurance when they are younger just as people who are not members of the military are provided this opportunity.

On the other hand, the DoD in their comments to the first exposure draft questioned the wisdom of limiting a showing of suitability for the sale of combination products to those in pay grades E-4 or below and stated that it is "imperative" that this standard be applied to all pay grades sold these products. The Working Group disagreed. With the exception of combination products, offering inducements to attend off base sales presentations and giving certain tax advice, the Model Regulation

applies to all service members regardless of pay grade or rank. The Working Group's decision to limit combination product suitability to those in pay grades E-1 through E-4 was based on several considerations.

First, a careful review of the substantial documentation developed by state and federal authorities confirming abuses in the sale of life insurance to the military reveals that the victims of this abuse are overwhelmingly concentrated in the enlisted pay grades of E-4 and below. Investigations bore out that the E-1 to E-4 cohort was targeted by a very small group of insurers and their agents because, as a group, they are the most vulnerable and receptive to the deceptive sales pitches and questionable products proffered their way. They are vulnerable because they are young, financially inexperienced and, more often than not, recently separated from the security and comfort of civilian society. They are receptive because, in this new and unfamiliar environment in which they find themselves, loyalty and respect for authority are constant themes of their training and discipline. This deference and respect for authority were easily misappropriated by agents who were often retired military personnel and whose introduction and presence were far too frequently arranged and vouchsafed by their immediate superiors.

Second, the need for insurance in addition to the substantial coverage already provided to this group by the federal government is highly questionable. Service members in pay grades E-4 and below typically are young and unmarried with few financial obligations. Those in higher pay grades, on the other hand, are more likely to have a need for additional life insurance and, given their age and experience, are better prepared to make an informed decision regarding the need for additional insurance.

7. Any Other Important Information (e.g., amending an accreditation standard).

Federal Law Considerations

Responding to 30 years of documented abuse regarding the sale of life insurance to members of the military by a very small segment of the industry, Congress passed and President Bush signed on September 29, 2006, the *Military Personnel Financial Services Protection Act*, Congress found it imperative that members of the United States Armed Forces be shielded from "abusive and misleading sales practices" and protected from certain life insurance products that are "improperly marketed as investment products, providing minimal death benefits in exchange for excessive premiums that are front-loaded in the first few years, making them entirely inappropriate for most military personnel."

To address these concerns, Congress required that the "States collectively work with the Secretary of Defense to ensure implementation of appropriate standards to protect members of the Armed Forces from dishonest and predatory insurance sales practices while on a military installation," and that each state report to Congress by September 29, 2007, on the progress made regarding its adoption of the standards collectively developed. To insure that service members are offered only "first rate financial products" Congress also called on the NAIC in coordination with the Secretary to report to it on "ways of improving the quality of and sale of life insurance products by creating standards for products specifically designed to meet the particular needs of members of the Armed Forces, regardless of the sales location."

The Military Sales Practices Model Regulation was developed to meet these dual Congressional mandates. It makes actionable certain acts and practices which until now have not been declared to be false, misleading, deceptive or unfair under state trade practices statutes. Many of the practices identified incorporate DoD solicitation rules. For example, the Model Regulation, tracking DoD regulations, makes it a deceptive trade practice to solicit in barracks, day rooms and other restricted areas.

The Model Regulation also addresses Congressional concerns regarding suitability and product standards. In this regard, the Model Regulation makes it a deceptive or unfair trade practice to recommend the purchase of any life insurance product which includes a side fund to junior enlisted service members in pay grades E- 4 and below, unless the insurer has reasonable grounds for believing that the life insurance portion of the product, standing alone, is suitable.

Incorporation of DoD Regulations

The Model Regulation tracks or incorporates relevant DoD solicitation regulations in DoD Instruction 1344.07: *Personal Commercial Solicitation on DoD Installations,* and Army Regulation 210-7: *Commercial Solicitation on Army Installations*. These regulations identify sales practices directed at active-duty service members.

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

Section 2. Definitions

For the purpose of this regulation:

A. (1) "Advertisement" means material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy including:

Comment: See drafting note caveat immediately following the definition of "insurance producer" in this section.

(a) Printed and published material, audiovisual material and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television scripts, telemarketing scripts, billboards and similar displays, and the Internet or any other mass communication media.

(b) Descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers, or third parties, issued, distributed or used by the insurer or insurance producer; including but not limited to circulars, leaflets, booklets, web pages, depictions, illustrations and form letters;

(c) Material used for the recruitment, training and education of an insurer's insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;

(d) Prepared sales talks, presentations and materials for use by insurance producers.

(2) "Advertisement" for the purpose of this regulation shall not include:

(a) Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(b) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy; and

(c) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

B. "Determinable policy elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable policy elements only, or from both determinable and guaranteed policy elements.

C. "Guaranteed policy elements" means the premiums, benefits, values, credits or charges under a policy, or elements of formulas used to determine any of these that are guaranteed and determined at issue.

D. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

Drafting Note: Each jurisdiction may wish to revise the definition of "insurance producer" to reference the definition in that jurisdiction's licensing law. This definition from the NAIC Producer Licensing Model Act, which also defines the terms "sell," "solicit," and "negotiate," should be used. This term and words related thereto should not be included in life advertising regulations unless "insurance producer" also is statutorily defined and the definitions are identical.

E. "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the insurance code of this state or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

F. "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

G. "Policy" means any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider or endorsement which provides for life insurance or annuity benefits.

H. "Preneed funeral contract or prearrangement" means an arrangement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

I. "Registered product" means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered product includes, but is not limited to, contingent deferred annuities.

Section 3. Applicability

A. This regulation shall apply to any life insurance or annuity advertisement intended for dissemination in this state. In variable contracts and other registered products where disclosure requirements are established pursuant to federal regulation, this regulation shall be interpreted so as to eliminate conflict with federal regulation.

B. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer, as well as the producer who created or presented the advertisement. Insurers shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. A system of control shall include regular and routine notification, at least once a year, to agents, brokers and others authorized by the insurer to disseminate advertisements of the requirement and procedures for company approval prior to the use of any advertisements that is not furnished by the insurer and that clearly sets forth within the notice the most serious consequence of not obtaining the required prior approval.

Section 4. Form and Content of Advertisements

A. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

B. No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "deposit," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "private pension plan," "retirement plan" or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

Section 5. Disclosure Requirements

A. The information required to be disclosed by this regulation shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

B. An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied or that the policy or contract includes a "free look" period that satisfies or exceeds regulatory requirements, does not remedy misleading statements.

C. In the event an advertisement uses "non-medical," "no medical examination required," or similar terms where issue is not guaranteed, terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions set forth in the application.

D. An advertisement shall not use as the name or title of a life insurance policy any phrase that does not include the words "life insurance" unless accompanied by other language clearly indicating it is life insurance. An advertisement shall not use as the name or title of an annuity contract any phrase that does not include the word "annuity" unless accompanied by other language clearly indicating it is an annuity. An annuity advertisement shall not refer to an annuity as a CD annuity, or deceptively compare an annuity to a certificate of deposit.

E. An advertisement shall prominently describe the type of policy advertised.

F. An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no insurance producer or commission involved there will be a cost saving to prospective purchasers unless that is the fact. No cost savings may be stated or implied without justification satisfactory to the commissioner prior to use.

G. An advertisement for a life insurance policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, that fact shall be commonly disclosed. An advertisement of or for a life insurance policy under which the death benefit varies with the length of time the policy has been in force shall accurately describe and clearly call attention to the amount of minimum death benefit under the policy.

H. An advertisement for the types of policies described in Subsections F and G of this section shall not use the words "inexpensive," "low cost," or other phrase or words of similar import when the policies being marketed are guaranteed issue.

I. Premiums

(1) An advertisement for a policy with non-level premiums shall prominently describe the premium changes.

(2) An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.

(3) An advertisement shall not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

(4) An advertisement that represents that a pure endowment benefit has a "profit" or "return" on the premium paid, rather than a policy benefit for which a specified premium is paid is deemed to be deceptive and misleading and is prohibited.

(5) An advertisement shall not represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact.

(6) An advertisement shall not use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan using nonguaranteed elements to pay a portion of future premiums.

J. Analogies between a life insurance policy or annuity contract's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments shall be complete and accurate. An advertisement shall not emphasize the investment or tax features of a life insurance policy to such a degree that the advertisement would mislead the purchaser to believe the policy is anything other than life insurance.

K. An advertisement shall not state or imply in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or improper practice.

L. If nonforfeiture values are shown in any advertisement, the values must be shown either for the entire amount of the basic life policy death benefit or for each $1,000 of initial death benefit.

M. The words "free," "no cost," "without cost," "no additional cost, "at no extra cost," or words of similar import shall not be used with respect to any benefit or service being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor shall be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

N. No insurance producer may use terms such as "financial planner," "investment adviser," "financial consultant," or "financial counseling" in such a way as to imply that he or she is generally engaged in an advisory business in which compensation is unrelated to sales unless that actually is the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

O. Nonguaranteed Elements

(1) An advertisement shall not utilize or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead.

(2) An advertisement shall not state or imply that the payment or amount of nonguaranteed elements is guaranteed. Unless otherwise specified in [insert reference to the state law or regulation based on the NAIC Life Insurance Illustrations Model Regulation], if nonguaranteed elements are illustrated, they shall be based on the insurer's current scale and the illustration shall contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

Drafting Note: A state that has not adopted the Life Insurance Illustrations Model Regulation should delete the phrase referencing it.

(3) Unless otherwise specified in [insert reference to state equivalent to the NAIC Life Insurance Illustrations Model Regulation], an advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth, with equal prominence comparable illustrations or statements containing or based upon the guaranteed policy elements.

Drafting Note: A state that has not adopted the Life Insurance Illustrations Model Regulation should delete the phrase referencing it.

(4) An advertisement shall not use or describe determinable policy elements in a manner that is misleading or has the capacity or tendency to mislead.

(5) Advertisement may describe determinable policy elements as guaranteed but not determinable at issue. This description should include an explanation of how these elements operate, and their limitations, if any.

Drafting Note: Paragraphs (4) and (5) above contain references currently only applicable to equity indexed annuity products but could apply beyond such products. Additional requirements with respect to these products can be found in the Annuity Disclosure Model Regulation.

(6) If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way; such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation on the insurer's right.

(7) An advertisement shall not refer to dividends as "tax-free" or use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.

(8) An advertisement may not state or imply that illustrated dividends under either or both a participating policy or pure endowment will be or can be sufficient at any future time to assure without the future payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains the benefits or coverage provided at that time and the conditions required for that to occur.

P. An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

Q. Testimonials, Appraisals, Analysis, or Endorsements by Third Parties

(1) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective insureds as to the nature or scope of the testimonial, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis; the insurer or insurance producer makes as its own all the statements contained therein, and these statements are subject to all the provisions of this regulation.

(2) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the insurer or related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(4) When an endorsement refers to benefits received under a policy for a specific claim, the claim date, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of five (5) years after the discontinuance of its use or publication.

R. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any statistics used in advertisement shall be identified.

S. Policies Sold to Students

(1) The envelope in which insurance solicitation material is contained may be addressed to the parents of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student unless such is a correct and truthful statement.

(2) All advertisements including, but not limited to, informational flyers used in the solicitation of insurance shall be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities shall be clearly identified as such.

(3) The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.

T. Introductory, Initial or Special Offers and Enrollment Periods

(1) An advertisement of an individual policy or combination of policies shall not state or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not describe an enrollment period as “special” or “limited” or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(2) An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(3) An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. A reduced initial or first year premium may not be described as constituting free insurance for a period of time. When insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised.

Drafting Note: Some states prohibit a reduced initial premium. This section does not imply that a state that prohibits an initial premium is not in conformity with the NAIC model.

(4) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date on which the enrollment period is advertised for the first time. This regulation applies to all advertising media—i.e., mail, newspapers, radio, television, magazines and periodicals—by any one insurer or insurance producer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This regulation does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his or her request. It is also inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specified provisions of the insurance code for group, blanket or franchise insurance. In cases where insurance product is marketed on a direct mail basis to prospective insurance by reason of some common relationship with a sponsoring organization, this regulation shall be applied separately to each sponsoring organization.

U. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless that is the fact.

V. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.

W. For individual deferred annuity products or deposit funds, the following shall apply:

(1) Any illustrations or statements containing or based upon nonguaranteed interest rates shall likewise set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The nonguaranteed interest rate shall not be greater than those currently being credited by the company unless the nonguaranteed rates have been publicly declared by the company with an effective date for new issues not more than three (3) months subsequent to the date of declaration.

(2) If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it shall also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.

(3) If the contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning the contract shall prominently state that cash surrender benefits are not provided.

(4) Any illustrations, depictions or statements containing or based on determinable policy elements shall likewise set forth with equal prominence comparable illustrations, depictions or statements containing or based on guaranteed policy elements.

X. An advertisement of a life insurance policy or annuity that illustrates nonguaranteed values shall only do so in accordance with current applicable state law relative to illustrating such values for life insurance policies and annuity contracts.

Y. An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement as defined in Section 2F that is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

(1) The fact that a life insurance policy or annuity contract is being used to fund a prearrangement as defined in Section 2F; and

(2) The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise services, the administrator and any other person.

Section 6. Identity of Insurer

A. The name of the insurer shall be clearly identified in all advertisements about the insurer or its products, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. However, if an advertisement contains a listing of rates or features that is a composite of several different policies or contracts of different insurers, the advertisement shall so state, shall indicate, if applicable, that not all policies or contracts on which the composite is based may be available in all states, and shall provide a rating of the lowest rated insurer and reference the rating agency, but need not identify each insurer. If an advertisement identifies the issuing insurers, insurance issuer ratings need not be stated.

B. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, a reinsurer of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

C. An advertisement shall not use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with a governmental program or agency.

Section 7. Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement may state that an insurer or insurance producer is licensed in a particular state or states, provided it does not exaggerate that fact or suggest or imply that competing insurers or insurance producers may not be so licensed.

An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

Section 8. Statements About the Insurer

An advertisement shall not contain statements, pictures or illustrations that are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation including, but not limited to, the placement of insurer's rating in the hierarchy of the rating system cited.

Section 9. Enforcement Procedures

A. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies, hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to inspection by the department. All advertisements shall be maintained in the file for a period of five (5) years after discontinuance of its use or publication.

B. If the commissioner determines that an advertisement has the capacity or tendency to mislead or deceive the public, the commissioner may require an insurer or insurance producer to submit all or any part of the advertising material for review or approval prior to use.

C. Each insurer subject to the provisions of this regulation shall file with the commissioner with its annual statement a certificate of compliance executed by an authorized officer of the insurer stating that to the best of his or her knowledge, information and belief the advertisements that were disseminated by or on behalf of the insurer in this state during the preceding statement year, or during the portion of the year when these rules were in effect, complied or were made to comply in all respects with the provisions of these rules and the insurance laws of this state as implemented and interpreted by this regulation.

Drafting Note: In furtherance of efficient and effective use of scarce regulatory resources, the drafters recommend that any state requirements for review and pre-approval of life insurance and annuity advertisements be carefully examined and reconsidered. In particular it seems appropriate that generic or branding advertisements that are designed to create public interest in life insurance or annuities or in an insurer be exempt from such requirements.

Section 10. Penalties

An insurer or its officer, directors, producers or employees that violate any of the provisions of this regulation, or knowingly participate in or abet such violation, shall be subject to a fine up to $1000 for each violation and suspension or revocation of its certificate of authority or license.

Section 11. Conflict With Other Laws or Regulations

It is not intended that this regulation conflict with or supersede any regulations currently in force or subsequently adopted in this state governing specific aspects of the sale or replacement of life insurance including, but not limited to, laws or regulations dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance, replacement of life insurance policies, illustration of life insurance policies, and annuity disclosure. Consequently, no disclosure pursuant to or required under those regulations shall be deemed to be an advertisement within the meaning of this regulation.

Section 12. Severability

If any section, term or provision of this regulation shall be judged invalid for any reason, that judgment shall not affect, impair or invalidate any other section, term or provision of this regulation, and the remaining sections, terms and provisions shall be and remain in full force and effect.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1975 Proc. II 6, 9, 244, 325, 326-330 (adopted).
1976 Proc. II 15, 17, 342, 366, 373-374 (amended).
1988 Proc. I 9, 18, 88-91, 130-131, 138-144 (amended and reprinted).
1988 Proc. II 5, 12, 478, 490, 497-503 (amended).
2000 Proc. 1st Quarter 9, 26-27, 58, 110-117, 135 (amended and reprinted).
2015 Proc. 1st Quarter, Vol. I 117-118, 131-134, 337-342, 431 (amended).

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

What are the state pages?

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Who do I speak to if I have questions?

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ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

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Alabama		ALA. ADMIN. CODE r. 482-1-132 (1981/2004).	
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. ADMIN. CODE § R20-6-202 (1969/2007).
Arkansas		ARK. ADMIN. CODE §§ 054-00-99-1 to 054-00-99-14 (2011).	
California		CAL. ADMIN. CODE §§ 2547 to 2547.11 (1975).	
Colorado		3 COLO. CODE REGS. § 702-4:4-1-2 (1974/2014).	
Connecticut		CONN. AGENCIES REGS. §§ 38a-819-21 to 38a-819-31 (1976/1992).	
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

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Florida		FLA. ADMIN. CODE ANN. r. 69O-150.101 to 69O-150.122 (1973/2000).	FLA. ADMIN. CODE ANN. r. 69W-100.007 (1979/2014).
Georgia		GA. COMP. R. & REGS. 120-2-11 (1965/2007).	
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois		ILL. ADMIN. CODE tit. 50, §§ 909.10 to 909.120 (1976/2007).	
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. §§ 191-15.1 to 191-15.14 (1997/2011) (portions of health advertising regulation).
Kansas		KAN. ADMIN. REGS. §§ 40-9-118 (1977/2014) (adopted by reference).	BULLETIN 2014-1 (2014).
Kentucky			806 KY. ADMIN. REGS. 12:010 to 12:020 (1975/2007).
Louisiana		LA. ADMIN. CODE §§ 37:XIII.4101 to 37:XIII.4123 (Regulation 60) (1997/2018).	
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. §§ 31.15.01.01 to 31.15.01.10 (1970).
Massachusetts	NO CURRENT ACTIVITY		
Michigan		MICH. ADMIN. CODE r. 500.1371 to 500.1387 (1984/1997).	

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. R. 2790.0100 to 2790.2200 (1971/1989).
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-5.100 (1976/2016).		
Montana	NO CURRENT ACTIVITY		
Nebraska		210 NEB. ADMIN. CODE ch. 50, §§ 001 to 014 (1990/2008).	
Nevada	NO CURRENT ACTIVITY		
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. 2602.01 to 2602.11 (2008/2016).	
New Jersey		N.J. ADMIN. CODE §§ 11:2-23.1 to 11:2-23.10 (1985/2013).	
New Mexico	NO CURRENT ACTIVITY		
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 219.1 to 219.7 (Regulation 34-A) (1980/2006).	
North Carolina		11 N.C. ADMIN. CODE §§ 0424 to 0433 (1978/1992).	
North Dakota		N.D. ADMIN. CODE §§ 45-04-10-01 to 45-04-10-08 (1988/2006).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO ADMIN. CODE 3901-6-01 (1997/2018).
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-3-30 to 365:10-3-39 (1990/2015).	
Oregon			BULLETIN 2009-7 (2009).

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			31 PA. CODE §§ 51.1 to 51.43 (1973/1976).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		230 R.I. CODE R. §§ 20-25-5.1 to 20-25-5.13 (2009).	
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. ADMIN. R. 20:06:10 (1973/2012) (based on accident and health insurance model at page 40-1).
Tennessee		TENN. COMP. R. & REGS. 0780-1-33-.01 to 0780-1-33-.13 (1976).	
Texas			28 TEX. ADMIN. CODE §§ 21.101 to 21.122 (1981/2010).
Utah			UTAH ADMIN. CODE R590-130 (1989/2012) (based on accident and health insurance model at 40-1).
Vermont			VT. ADMIN. CODE. §§ 4-3-4:1 to 4-3-4:9; Appx. A to C (Regulation 77-2) (1978/1980).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		14 VA. ADMIN. CODE §§ 5-41-10 to 5-41-160 (2011).	
Washington		WASH. ADMIN. CODE 284-23-010 to 284-23-110 (1975/2010).	
West Virginia		W. VA. CODE R. §§ 114-11-1 to 114-11-11 (1974/20).	
Wisconsin			WIS. ADMIN. CODE INS. § 2.16 (1984/2015).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2015

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION (#570)

1. Description of the Project, Issues Addressed, etc.

The *Advertisements of Life Insurance and Annuities Model Regulation* (#570) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Adding to Section 2. Definitions: Registered product means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933, with a drafting note stating that registered products include, but are not limited to, CDAs.

- Adding a reference to "registered products" in Section 3. Applicability.

2. Name of Group Responsible for Drafting the Model and States Participating

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Ted Nickel, Chair	Wisconsin	Roger A. Sevigny/Keith Nyhan	New Hampshire
Robert Chester	Connecticut	Joseph Torti III/Elizabeth Dwyer	Rhode Island
Jim Mumford	Iowa	Michael Humphreys	Tennessee
Jason Lapham	Kansas	Tomasz Serbinowski	Utah
Bruce R. Ramge	Nebraska		

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions to the *Advertisements of Life Insurance and Annuities Model Regulation* (#570) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There were concerns that using the term "CDAs" when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and a drafting note to clarify that the terms are intended to include CDAs.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

LIFE AND HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION MODEL ACT

Table of Contents

Section 1. Title

This Act may be cited as the Life and Health Insurance Policy Language Simplification Act.

Drafting Note: The term "health" insurance where used in the Act should be changed to the proper statutory term in each state, e.g., "disability" or "accident and health."

Section 2. Purpose

The purpose of the Act is to establish minimum standards for language used in policies, contracts and certificates of life insurance, health insurance, credit life insurance and credit health insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.

This Act is not intended to increase the risk assumed by insurance companies or other entities subject to this Act or to supersede their obligation to comply with the substance of other insurance legislation applicable to life, health, credit life or credit health insurance policies. This Act is not intended to impeded flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

Drafting Note: In establishing minimum standards, it is recognized that certain terminology used in policies is difficult or impossible to restate in simplified language. This is because there are no suitable alternatives to necessary medical terminology, other insurance words of art, and statutory or regulatory language requirements. It is not the intention of this Act to preclude the use of such terminology or to penalize insurance companies for its continued use.

The purpose of this Act is to improve policy language in order to facilitate the insured's understanding of the coverages provided. The purpose is similar to that of the outline of coverage requirements found in Section 5 of the NAIC Model Individual Accident and Sickness Insurance Minimum Standards Act and in similar acts adopted in some jurisdictions. Consequently, any state adopting this Act may desire to review the continued necessity of other requirements such as the Outline of Coverage.

Section 3. Definitions

As used in this Act:

A. "Policy" or "policy form" means any policy, contract, plan or agreement of life or health insurance, including credit life insurance and credit health insurance, delivered or issued for delivery in this state by any company subject to this Act; any certificate, contract or policy issued by a fraternal benefit society; and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state.

B. "Company" or "insurer" means any life or health insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations.

Drafting Note: This Act is intended to apply to the certificates, policies or contracts of fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, dental care plans, vision care plans, pharmaceutical plans, health maintenance organizations, and all similar type organizations. In order to include such organizations, each state should properly identify them in accordance with that state's statutory terminology or by specific statutory citation.

Depending upon state law, insurance department jurisdiction, and other factors, separate legislation may be required. In any event, the proposed legislation should provide that the particular terminology used by these plans and organizations (e.g. contracts, certificates, subscribers, member) may be substituted for, or added to, the corresponding terms used in this Act.

C. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

Section 4. Applicability

A. This Act shall apply to all policies delivered or issued for delivery in this state by any company on or after the date the forms must be approved under this Act, but nothing in this Act shall apply to:

(1) Any policy which is a security subject to federal jurisdiction;

(2) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy; however, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state;

(3) Any group annuity contract which serves as a funding vehicle for pension, profit sharing or deferred compensation plans;

(4) Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this Act;

(5) The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under this Act.

Drafting Note: This Act is intended to apply to annuities except those annuities exempted by Section 4A(3). In those states where annuities are not included in the term "insurance," appropriate language should be added to include those contracts within the scope of the Act.

The words "approved or permitted to be issued" as used in this Act to describe policy forms are intended to include all policy forms whether they are affirmatively approved, deemed approved, or merely permitted to be issued after having been on file for a prescribed period of time.

B. No other statute of this state setting language simplification standards shall apply to any policy forms.

C. Any non-English language policy delivered or issued for delivery in this state shall be deemed to be in compliance with Section 5A(1) of this Act if the insurer certifies that the policy is translated from an English language policy which does comply with Section 5A(1) of this Act. [Optional provision for use in those states where non-English policies may be permitted or required.]

Section 5. Minimum Policy Language Simplification Standards

A. In addition to any other requirements of law, no policy forms, except as stated in Section 4, shall be delivered or issued for delivery in this state on or after the dates such forms must be approved under this Act, unless:

(1) The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in Subsection C of this section;

(2) It is printed, except for specification pages, schedules and tables, in not less than ten point type, one point leaded;

Drafting Note: This paragraph is not intended to include minor instructions concerning the preparation of an application within the type size requirement (e.g., "last name," "RFD or Box Number").

(3) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

(4) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on three (3) or fewer pages of text, or if the policy has more than three (3) pages regardless of the number of words.

B. For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:

(1) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two 200 word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(2) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(3) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(4) The sum of the figures computed under (2) and (3) subtracted from 206.835 equals the Flesch reading ease score for the policy form.

(5) For purposes of Section 5B(2), (3), and (4), the following procedures shall be used:

(a) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;

(b) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(c) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(6) The term "text" as used in this section shall include all printed matter except the following:

(a) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables; and

(b) Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the insurer identifies the language or terminology excepted by this paragraph and certifies, in writing, that the language or terminology is entitled to be excepted by this paragraph.

Drafting Note: A state adopting this Act may desire to review the necessity of including the Individual Accident and Sickness Uniform Policy Provision Law within the requirements of this Act until the NAIC has adopted a simplified uniform version of the UPPL.

C. Any other reading test may be approved by the commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

Drafting Note: While the Flesch "reading ease" test (Rudolph Flesch, the *Art of Readable Writing* 1949, as revised 1974) is the basic test set forth in this Act, it is recognized that other tests are also in wide use and should be permitted to be used under this Act. Subsection C is intended to permit the use by insurers of other tests approved by the commissioner for use as an alternative to the Flesch test, but is not intended to permit the adoption by the commissioner of another test to the exclusion of the Flesch test or as an addition thereto.

D. Filings subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with Section 7 of this Act. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

E. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

Section 6. Construction

Nothing in this Act shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.

Drafting Note: This provision is to be used only in those states having a provision in their statutes authorizing the use of policy forms which have been on file for a prescribed period.

Section 7. Powers of the Commissioner

The commissioner may authorize a lower score than the Flesch reading ease score required in Section 5A(1) whenever, in his sole discretion, he finds that a lower score:

A. Will provide a more accurate reflection of the readability of a policy form;

B. Is warranted by the nature of a particular policy form or type or class of policy forms; or

C. Is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation or agency interpretation.

Section 8. Approval of Forms

A policy form meeting the requirements of Section 5A shall be approved notwithstanding the provisions of any other laws which specify the content of policies, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

Section 9. Effective Dates

A. Except as provided in Section 4, this Act applies to all policy forms filed on or after [insert date 2 years after passage of Act]. No policy form shall be delivered or issued for delivery in this state on or after [insert date 5 years after passage of Act] unless approved by the commissioner or permitted to be issued under this Act. A policy form that has been approved or permitted to be issued prior to [insert date 5 years after passage of Act] and which meets the standards set by this Act need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the commissioner of a list of forms identified by form number and accompanied by a certificate as to each form in the manner provided in Section 5D.

B. The commissioner may, in his sole discretion, extend the dates in Subsection A.

Drafting Note: The time periods proposed are thought to accommodate most situations and are recommended for inclusion in the bill. Other effective dates may be inserted based upon the ability of the insurance department to process the work load and the ability of the industry to totally redraft its policy portfolio.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1978 Proc. II 31, 34, 295, 298-302 (adopted).

LIFE & HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
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Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-213 (1982).		
Arkansas	ARK. CODE ANN. §§ 23-80-201 to 23-80-208 (1979/2001).		
California			BULLETIN 79-4 (1979) (UPPL in simplified language).
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN GEN. STAT. §§ 38a-295 to 38a-300 (1979).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	D.C. CODE §§ 31-4725 to 31-4730 (1985).		
Florida	FLA. STAT. § 627.4145 (1983).		
Georgia	GA. COMP. R. & REGS. 120-2-10-.09 (1983).		GA. CODE ANN. § 33-3-25 (1987).
Guam	NO CURRENT ACTIVITY		

LIFE & HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	HAW. REV. STAT. §§ 431:10-101 to 431:10-109 (1988) (applies to all contracts).		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	IND. CODE 27-1-26-1 to 27-1-26-12 (1982).		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			KY. REV. STAT. ANN. §§ 304.14-420 to 304.14-450 (1988).
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2438 to 2445 (1979).		
Maryland	MD. CODE REGS. 31.10.02.01 to 31.10.02.05 (1992) (health only).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 2B (1979/1985).		
Michigan			MICH. COMP. LAWS § 500.2236 (1992/2014) (applies to all policies).
Minnesota			MINN. STAT. §§ 72C.01 to 72C.13 (1977).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	MONT. CODE ANN. §§ 33-15-321 to 33-15-329 (1983).		

LIFE & HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NEB. REV. STAT. §§ 44-3401 to 44-3408 (1979/1989).		
Nevada	NEV. REV. STAT. §§ 687B.122 to 687B.128 (1983).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. STAT. ANN. §§ 17B:17-17 to 17B:17-25 (1979).		
New Mexico	N.M. STAT. ANN. §§ 59A-19-1 to 59A-19-7 (1985).		
New York	N.Y. INS. LAW § 3102 (1984).		
North Carolina	N.C. GEN. STAT. §§ 58-38-1 to 58-38-40 (1979).		
North Dakota	N.D. CENT. CODE §§ 26.1-33-29 to 26.1-33-32 (1986).		
Ohio	OHIO REV. CODE ANN. §§ 3902.01 to 3902.08 (1979).		
Oklahoma	OKLA. STAT. tit. 36, §§ 3641 to 3651 (1987).		
Oregon	OR. REV. STAT. §§ 743.100 to 743.107 (1979).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS § 27-5-9.1 (1979); 230 R.I. CODE R. 20-30-5.5 (2010).
South Carolina	S.C. CODE ANN. REGS. 69-5.1 (1981).		
South Dakota	S.D. CODIFIED LAWS §§ 58-11A-1 to 58-11A-9 (1981).		

LIFE & HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	TENN. CODE ANN. §§ 56-7-1601 to 56-7-1609 (1981).		
Texas			28 TEX. ADMIN. CODE § 3.3092 (1977); §§ 3.3100 to 3.3102 (1977/1983); §§ 3.601 to 3.602 (1993) (health).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-3404 (1986) (authority to promulgate regulations).
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE §§ 33-29-1 to 33-29-9 (1983).		
Wisconsin	WIS. ADMIN. CODE INS. § 6.07 (1980).		WIS. STAT. § 631.22 (1980).
Wyoming	NO CURRENT ACTIVITY		

LIFE INSURANCE DISCLOSURE MODEL REGULATION

Table of Contents

Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

Drafting Note: Insert title of chief insurance regulatory official wherever the term "commissioner" appears.

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs and improve the buyer's understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 5B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

(1) Individual and group annuity contracts;

(2) Credit life insurance;

(3) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 *et seq.* as amended; or

(5) Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. "Buyer's Guide" means the current Life Insurance Buyer's Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. "Current scale of nonguaranteed elements" means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. "Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

D. "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

E. "Policy data" means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

F. "Policy summary" means a written statement describing the elements of the policy, including, but not limited to:

(1) A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION;

(2) The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the Policy Summary;

(3) The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

(4) The generic name of the basic policy and each rider;

(5) The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy;

(b) The annual premium for each optional rider;

(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;

(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider; and

(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;

(6) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the policy summary shall also indicate that the annual percentage rate will be

determined by the company in accordance with the provisions of the policy and the applicable law; and

(7) The date on which the policy summary is prepared.

G. "Preneed funeral contract or prearrangement" means an agreement by or for an individual before that individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer's Guide to all prospective purchasers, prior to accepting the applicant's initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer's Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a policy summary to prospective purchasers where the insurer has identified the policy form as one that will not be marketed with an illustration. The policy summary shall show guarantees only. It shall consist of a separate document with all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Section 4F(5) shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. Delivery of the policy summary shall be consistent with the time for delivery of the Buyer's Guide as specified in Paragraph (1).

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].

(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.

(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.

(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected

policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant's initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;

B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. The impact on the prearrangement:

(1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

(2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

(3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.

H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.

Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not

involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as "financial planner," "investment advisor," "financial consultant," or "financial counseling" in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company's current scale of nonguaranteed elements (use appropriate special term such as "current dividend" or "current rate" scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer's Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.

Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. I 7, 10-11, 381, 521, 523-527 (adopted).
1976 Proc. II 15, 17, 397, 542, 545-552 (reprinted with technical amendments and Buyer's Guide).
1978 Proc. I 13, 15, 348, 472 (corrected).
1984 Proc. I 6, 31, 375, 496, 497-510 (amended and named changed from Life Insurance Solicitation to Life Insurance Disclosure Model Regulation).
1988 Proc. I 9, 19-20, 599-600, 625-626 (amended).
1988 Proc. II 5, 12, 478, 490, 503-510 (amended, regulation reprinted).
1989 Proc. II 13, 23, 414-415, 419-422, 428-429, 430-442 (amended).
1990 Proc. I 6, 27, 438-439, 450-451, 453-463 (amended).
1991 Proc. I 9, 17, 540, 549-557, 558-559 (amended, regulation reprinted, Appendix E adopted).
1992 Proc. I 86, 94, 860, 868, 869-878 (amended and regulation reprinted).
1993 Proc. I 8, 136, 795-800 (amended).
1996 Proc. 3rd Quarter 9, 40, 907, 918, 931-936 (amended Buyer's Guide).
2000 Proc. 2nd Quarter 21, 22, 67, 99, 101-125 (amended and reprinted).
2000 Proc. 4th Quarter 16, 17, 105, 167-170 (Buyer's Guide amended).
2018 Proc. 3rd Quarter (Buyer's Guide removed).

The following have all been superseded by the model regulation above.)

a. Deceptive Practices in Life Insurance Model Regulation:
1973 Proc. II 18, 21, 471, 532-533, 541-543 (adopted).
1974 Proc. I 12, 14, 405, 440, 442-443 (amended).

b. Life Insurance Cost Comparison (Interest Adjusted Index) Model Regulation:
1973 Proc. II 18, 21, 471, 532-533, 538-540 (adopted).
1974 Proc. I 12, 14, 405, 440, 442 (corrected).

LIFE INSURANCE DISCLOSURE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIFE INSURANCE DISCLOSURE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-131 (2004).		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. ADMIN. CODE § R20-6-209 (1979/2007).	
Arkansas	ARK. ADMIN. CODE § 054-00-017 (2009).		
California			CAL. INS. CODE § 10509.975 (1996/1997) (requirement for buyer's guide).
Colorado	NO CURRENT ACTIVITY		
Connecticut		CONN. AGENCIES REGS. §§ 38a-819-32 to 38a-819-39 (1978/2013).	
Delaware		18 DEL. CODE REGS. § 1203 (1979/2003).	
District of Columbia	NO CURRENT ACTIVITY		
Florida		FLA. STAT. § 626.99 (1982/2013).	

LIFE INSURANCE DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia		GA. COMP. R. & REGS. 120-2-31 (1980/2007).	
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois		ILL. ADMIN. CODE tit. 50, §§ 930.10 to 930.90; Exs. A & B (1980/2009).	
Indiana		760 IND. ADMIN. CODE 1-24-1 to 1-24-9 (1979/2013).	
Iowa			IOWA ADMIN CODE. r. 191-15.4 (1997/2006).
Kansas		KAN. ADMIN. REGS. § 40-2-14 (1967/1988); § 40-2-23 (1993) (preneed funeral contracts).	
Kentucky	806 KY. ADMIN. REGS. 12:170 (2007/2011); 12:131 (1991/2007) (life insurance used to fund preneed funeral contracts).		806 KY. ADMIN. REGS. 12:020 (1975/2007).
Louisiana			LA. ADMIN. CODE tit. 37, § XIII.6901 (Regulation 21) (1962).
Maine		02-031 ME. CODE R. § 240 (1980/1999).	
Maryland	MD. CODE REGS. 31.15.03.01 to 31.15.03.08 (2009/2018).		
Massachusetts	211 MASS. CODE REGS. 31.00 to 31.10 (1980/2006).		
Michigan			MICH. ADMIN. CODE r. 500.4038 (1993/1998); BULLETIN 2000-02 (2000) (statement of Policy Information).
Minnesota	NO CURRENT ACTIVITY		

LIFE INSURANCE DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi	NO CURRENT ACTIVITY		
Missouri		MO. REV. STAT. §§ 376.700 to 376.714 (1979).	
Montana	MONT. ADMIN. R. §§ 6.6.201 to 6.6.209 (1978/2016).		
Nebraska	210 NEB. ADMIN. CODE § 33 (1978/2008).		
Nevada		NEV. ADMIN. CODE §§ 686A.410 to 686A.455 (1978/2006).	
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 301.01 to 301.10 (1983/2018).		N.H. CODE ADMIN. R. ANN. INS. 312.01 to 312.05 (2011/2019).
New Jersey	N.J. ADMIN. CODE §§ 11:4-11.1 to 11:4-11.7 (1976/2008).		
New Mexico	N.M. CODE R. §§ 13.9.5 (1981/2004)		
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 53-1.1 to 53-1.6; §§ 53-2.1 to 53-2.6; Appendix 24A; (Regulation 74) (1999/2003).	N.Y. INS. LAW § 3209 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-60-1 to 58-60-30 (1979/2005).	
North Dakota		N.D. ADMIN. CODE §§ 45-04-01-01 to 45-04-01-07 (1980/1997).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE § 3901-6-03 (1997/2018).	
Oklahoma	NO CURRENT ACTIVITY		
Oregon		OR. ADMIN. R. 836-051-0005 to 836-051-0020 (1979/2006).	

LIFE INSURANCE DISCLOSURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			31 PA. CODE §§ 83.1 to 83.57 (1974/1980).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R. I. CODE R. §§ 20-25-3.1 to 20-25-3.7 (2018).		
South Carolina	S.C. CODE ANN. REGS. 69-30 (1979/2010).		
South Dakota			S.D. ADMIN. R. § 20:06:10 (2012).
Tennessee		TENN. COMP. R. & REGS. 0780-01-40 (1979).	
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE §§ R590-79-1 to R590-79-10 (1978/2009).		
Vermont		VT. CODE R. §§ 4-3-4:1 to 4-3-4:9 (1977/1980).	BULLETIN 124 (1999).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington		WASH. ADMIN. CODE §§ 284-23-200 to 284-23-250 (1975/2012).	
West Virginia	W. VA. CODE R. §§ 114-11A-1 to 114-11A-6; App. A (1974/2008).		
Wisconsin			WIS. ADMIN. CODE INS. § 2.14 (1984/2015).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2018

LIFE INSURANCE DISCLOSURE MODEL REGULATION (#580)

REVISED LIFE INSURANCE BUYER'S GUIDE

1. Description of the Project, Issues Addressed, etc.

The *Life Insurance Buyer's Guide* (Buyer's Guide) was removed as Appendix A to the *Life Insurance Disclosure Model Regulation* (#580). An updated stand-alone Buyer's Guide was drafted.

2. Name of Group Responsible for Drafting the Model and States Participating

The Life Insurance Buyer's Guide (A) Working Group was responsible for drafting the revisions to the Buyer's Guide.

States Participating:

Missouri (Chair), Georgia, Nebraska, New York, Ohio, Pennsylvania and Rhode Island.

3. Project Authorized by What Charge and Date First Given to the Group

In fall 2016, the Life Insurance and Annuities (A) Committee adopted a charge for the Working Group to "review and revise, as necessary, the *Life Insurance Buyer's Guide* in conjunction with Appendix A of the *Life Insurance Disclosure Model Regulation* (#580)."

At the 2017 Summer National Meeting, a Request for NAIC Model Law Development to remove the Buyer's Guide as an appendix to Model #580 was adopted by the Executive (EX) Committee and Plenary.

On April 9, 2017, the Working Group finalized a revised Buyer's Guide for consideration by the Life Insurance and Annuities (A) Committee.

The Life Insurance and Annuities (A) Committee met July 19, 2018, via conference call to adopt the revisions to Model #580 and the revised Buyer's Guide.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Working Group agreed to remove the Buyer's Guide as an appendix to Model #580 on Feb. 27, 2017. The Working Group based the removal on efficiency and precedent with other NAIC buyer's guides. Like the annuity buyer's guides, which were removed as appendices from the *Annuity Disclosure Model Regulation* (#245) in 2011, there is no need to reopen Model #580 to update the Buyer's Guide. The existing definition in Model #580 states: "Buyer's Guide" means the current *Life Insurance Buyer's Guide* adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner. No additional changes to this or any other language in the model are necessary."

The Working Group met via conference call 15 times to draft the revised Buyer's Guide. Drafts were distributed via email and posted to the Working Group's page on the NAIC website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group's decision to remove the Buyer's Guide as an appendix was swift. The Working Group met via conference call on the following dates to determine its course of action and draft the content of the revised Buyer's Guide: Nov. 29, 2016; Feb. 7, 2017; Feb 27, 2017; March 13, 2017; March 27, 2017; July 10, 2017; July 31, 2017; Nov. 6, 2017; Nov. 20, 2017; Jan. 29, 2018; Feb. 5, 2018; Feb 26, 2018; March 12, 2018; March 19, 2018; and April 9, 2018.

All drafts and comments were posted to the Working Group's page on the NAIC website.

6. Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

The Working Group struggled with developing a Buyer's Guide that would be both succinct and sufficiently informative, to be provided to consumers in accordance with Model #580. A final guide in a question-and-answer format was agreed-upon, along with the decision to recommend that the Life Insurance and Annuities (A) Committee consider a charge for the Working Group to develop an online, interactive tool where more comprehensive information in an accessible format on the NAIC website could be developed.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

LIFE INSURANCE ILLUSTRATIONS MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

Section 2. Authority

This regulation is issued based upon the authority granted the commissioner under Section [cite any enabling legislation and state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

Drafting Note: Insert the title of the chief insurance regulatory official whenever the term "commissioner" appears.

Section 3. Applicability and Scope

This regulation applies to all group and individual life insurance policies and certificates except:

A. Variable life insurance;

B. Individual and group annuity contracts;

C. Credit life insurance; or

D. Life insurance policies with no illustrated death benefits on any individual exceeding $10,000.

Section 4. Definitions

For the purposes of this regulation:

A. "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

B. "Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

C. "Currently payable scale" means a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five (95) days.

D. "Disciplined current scale" means a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

(1) Are consistent with all provisions of this regulation;

(2) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(3) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(4) Do not permit assumed expenses to be less than minimum assumed expenses.

E. "Generic name" means a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

F. "Guaranteed elements" and "non-guaranteed elements"

(1) "Guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

(2) "Non-guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

G. "Illustrated scale" means a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(1) The disciplined current scale; or

(2) The currently payable scale.

H. "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years and that is one of the three (3) types defined below:

(1) "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

(2) "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this regulation, and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

(3) "In force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

I. "Illustration actuary" means an actuary meeting the requirements of Section 11 who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

J. "Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting as defined in this regulation, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 percent policy persistency thereafter.

K. (1) "Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(a) Fully allocated expenses;

(b) Marginal expenses; and

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the [National Association of Insurance Commissioners or by the commissioner].

(2) Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

L. "Non-term group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative;

(2) Some portion of the premium is paid by the group or through payroll deduction; and

(3) Group underwriting or simplified underwriting is used.

M. "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

N. "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

O. "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

Section 5. Policies to Be Illustrated

A. Each insurer marketing policies to which this regulation is applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this regulation, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this regulation, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

B. If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

Drafting Note: The prohibition in Section 5B may need to be modified if required by the state's replacement regulation.

C. If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this regulation is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

D. Potential enrollees of non-term group life subject to this regulation shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this regulation, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it.

Section 6. General Rules and Prohibitions

A. An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this regulation, be clearly labeled "life insurance illustration" and contain the following basic information:

(1) Name of insurer;

(2) Name and business address of producer or insurer's authorized representative, if any;

(3) Name, age and sex of proposed insured, except where a composite illustration is permitted under this regulation;

(4) Underwriting or rating classification upon which the illustration is based;

(5) Generic name of policy, the company product name, if different, and form number;

(6) Initial death benefit; and

(7) Dividend option election or application of non-guaranteed elements, if applicable.

B. When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

(1) Represent the policy as anything other than a life insurance policy;

(2) Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(3) State or imply that the payment or amount of non-guaranteed elements is guaranteed;

(4) Use an illustration that does not comply with the requirements of this regulation;

(5) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

(6) Provide an applicant with an incomplete illustration;

(7) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

(8) Use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;

(9) Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or

(10) Use an illustration that is not "self-supporting."

C. If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

Drafting Note: States may wish to replace disclosure requirements under the state's version of the Universal Life Insurance Model Regulation with the basic illustration as contained in this regulation.

Section 7. Standards for Basic Illustrations

A. Format. A basic illustration shall conform with the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared.

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (*e.g.,* the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").

(3) The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

(5) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

(6) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(7) If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed.

(8) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (*e.g.*, "see page one for guaranteed elements.")

(9) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

(10) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

(11) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

(12) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be more or less favorable.

(13) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

(14) If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

B. Narrative Summary. A basic illustration shall include the following:

(1) A brief description of the policy being illustrated, including a statement that it is a life insurance policy;

(2) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

(3) A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

(4) Identification and a brief definition of column headings and key terms used in the illustration; and

(5) A statement containing in substance the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

C. Numeric Summary.

(1) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10) and twenty (20) and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).

(a) Policy guarantees;

(b) Insurer's illustrated scale;

(c) Insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

(i) Dividends at fifty percent (50%) of the dividends contained in the illustrated scale used;

(ii) Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(iii) All non-guaranteed charges, including but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

(2) In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three (3) bases.

D. Statements. Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this regulation.

(1) A statement to be signed and dated by the applicant or policy owner reading as follows: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."

(2) A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

E. Tabular Detail.

(1) A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(a) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(b) The corresponding guaranteed death benefit, as provided in the policy; and

(c) The corresponding guaranteed value available upon surrender, as provided in the policy.

(2) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(3) Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

Section 8. Standards for Supplemental Illustrations

A. A supplemental illustration may be provided so long as:

(1) It is appended to, accompanied by or preceded by a basic illustration that complies with this regulation;

(2) The non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(3) It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed; and

(4) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

B. The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

Section 9. Delivery of Illustration and Record Retention

A. (1) If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this regulation, shall be submitted to the insurer at the time of policy application. A copy also shall be provided to the applicant.

(2) If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of this regulation, shall be labeled "Revised Illustration" and shall be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

B. (1) If no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

(2) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

C. If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

D. A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued.

Section 10. Annual Report; Notice to Policy Owners

A. In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(1) For universal life policies, the report shall include the following:

(a) The beginning and end date of the current report period;

(b) The policy value at the end of the previous report period and at the end of the current report period;

(c) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(d) The current death benefit at the end of the current report period on each life covered by the policy;

(e) The net cash surrender value of the policy as of the end of the current report period;

(f) The amount of outstanding loans, if any, as of the end of the current report period; and

(g) For fixed premium policies:

If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(h) For flexible premium policies:

If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

Drafting Note: For states that have adopted the NAIC Universal Life Model Regulation, this paragraph could be replaced with a reference to the equivalent of Section 9 of the model regulation.

(2) For all other policies, where applicable:

(a) Current death benefit;

(b) Annual contract premium;

(c) Current cash surrender value;

(d) Current dividend;

(e) Application of current dividend; and

(f) Amount of outstanding loan.

(3) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

B. If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently: "**IMPORTANT POLICY OWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

C. Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of Section 6A, 6B, 7A and 7E. No signature or other acknowledgment of receipt of this illustration shall be required.

D. If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

Section 11. Annual Certifications

A. The board of directors of each insurer shall appoint one or more illustration actuaries.

B. The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this regulation.

C. The illustration actuary shall:

(1) Be a member in good standing of the American Academy of Actuaries;

(2) Be familiar with the standard of practice regarding life insurance policy illustrations;

(3) Not have been found by the commissioner, following appropriate notice and hearing to have:

(a) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(d) Resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

(4) Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that under Paragraph (3) above;

(5) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification; and

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(a) Fully allocated expenses;

(b) Marginal expenses; or

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the [National Association of Insurance Commissioners or by the commissioner].

D. (1) The illustration actuary shall file a certification with the board and with the commissioner:

(a) Annually for all policy forms for which illustrations are used; and

(b) Before a new policy form is illustrated.

(2) If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the commissioner promptly.

E. If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly of his or her inability to certify.

F. A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(1) That the illustration formats meet the requirements of this regulation and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in Subsection C(6) of this section.

G. The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

H. If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change.

Section 12. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Section [cite state's unfair trade practices act].

Section 13. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 14. Effective Date

This regulation shall become effective [January 1, 1997 or effective date set in regulation, whichever is later] and shall apply to policies sold on or after the effective date.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 4th Quarter 11, 19, 779, 781-789 (adopted).

LIFE INSURANCE ILLUSTRATION MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIFE INSURANCE ILLUSTRATION MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-2-114 (1996).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.800 to 28.849 (1998/2011)		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. INS. CODE §§ 10509.950 to 10509.965 (1996).		CAL. INS. CODE § 10127.11 (1993/2013) (illustrations for seniors).
Colorado	3 COLO. CODE REGS. § 702-4:4-1-8 (1997/2000).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-819-58 to 38a-819-69 (1998).		
Delaware	18 DEL. CODE REGS. § 1210 (1997/2003).		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

LIFE INSURANCE ILLUSTRATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. ANN. §§ 431:10D-401 to 431:10D-411 (2000/2004).		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1406.10 to 1406.110 (1998).		
Indiana	760 IND. ADMIN. CODE 1-62-1 to 1-62-11 (2006).		
Iowa	IOWA ADMIN. CODE r. 191-14.1 to 191-14.14 (1996).		
Kansas	KAN. ADMIN. REGS. § 40-2-25 (1997/1998) (adopted by reference).		
Kentucky	806 KY. ADMIN. REGS. 12:140 (2007).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.3301 to XIII.3323 (Regulation 55) (1996).		
Maine	02-031 ME. CODE R. § 910 (1999).		
Maryland	MD. CODE REGS. 31.09.09.01 to 31.09.09.13 (1997).		
Massachusetts	211 MASS. CODE REGS. 28.01 to 28.14 (2006).		
Michigan			BULLETIN 2000-02 (2000).
Minnesota	MINN. STAT. 61A.70 to 61A.745 (2007).		
Mississippi	19 CODE MISS. R. Pt. 2, R. 13.01 to 13.14 (2012).		
Missouri	MO. REV. STAT. §§ 375.1500 to 375.1530 (1998/1999).		

LIFE INSURANCE ILLUSTRATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. ADMIN. R. 6.6.701 to 6.6.718 (2002).		
Nebraska	210 NEB. ADMIN. CODE ch. 72 (1997).		
Nevada	NEV. ADMIN. CODE §§ 686A.460 to 686A.479 (1998).		
New Hampshire	N.H. CODE R. INS. 309.01 to 309.12 (2000/2002).		
New Jersey	N.J. ADMIN. CODE §§ 11:4-52.1 to 11:4-52.11 (1998/2007).		
New Mexico	N.M. CODE R. 13.9.14.1 to 13.9.14.31 (1998).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 53-1.1 to 53-3.7 (Regulation 74) (1997/2003).		
North Carolina	11 N.C. ADMIN. CODE 4.0501 to 4.0509 (1996).		
North Dakota	N.D. ADMIN. CODE 45-04-01.1-01 to 45-04-01.1-10 (1996).		BULLETIN 96-2 (1996); BULLETIN 97-2 (1997).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-6-04 (1997/2013).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-3-50 to 365:10-3-62 (1997).		
Oregon	OR. ADMIN. R. 836-051-0500 to 836-051-0600 (1997/2005).		
Pennsylvania	40 PA. STAT. ANN. §§ 625-7 to 625-8 (1996) (covers annuities).		
Puerto Rico	NO CURRENT ACTIVITY		

LIFE INSURANCE ILLUSTRATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS §§ 27-62-1 to 27-62-11 (1999); 230 R.I. CODE R. 20-25-14 (2009).		
South Carolina	S.C. CODE ANN. REGS. 69-40 (1997).		
South Dakota	S.D. ADMIN. R. 20:06:38:01 to 20:06:38:35 (1997/2006).		
Tennessee	NO CURRENT ACTIVITY		
Texas	21 TEX. ADMIN. CODE §§ 2201 to 2210 (1998/2000).		
Utah	UTAH ADMIN. CODE r. 590-177 (1996/2009).		
Vermont	4-3 VT. CODE R. § 35 (Regulation I-98-1) (1998).		BULLETIN 124 (1999).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE ANN. § 48.23A (1997).		
West Virginia	W. VA. CODE R. §§ 114-11C-1 to 114-11C-11 (2008).		
Wisconsin	WIS. ADMIN. CODE INS. § 2.17 (1997).		
Wyoming	NO CURRENT ACTIVITY		

UNIVERSAL LIFE INSURANCE MODEL REGULATION

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Section 1. Authority

This regulation is promulgated under the authority of Section [insert applicable section], of the Insurance Laws of [insert state], and is effective [insert date].

Section 2. Purpose

The purpose of this regulation is to supplement existing regulations on life insurance policies in order to accommodate the development and issuance of universal life insurance plans.

Drafting Note: It is the position of the drafters of this regulation that universal life insurance is simply another competing type of life insurance which should be treated, to the extent possible, in the same regulatory manner as other life insurance products. This regulation is designed to address those areas where universal life insurance does not "fit" into the existing regulatory framework. This regulation does not supersede existing requirements relating to filing, solicitation, advertising, etc., but is supplementary to them.

Section 3. Definitions

As used in this regulation:

A. "Cash surrender value" means the net cash surrender value plus any amounts outstanding as policy loans.

B. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy.

D. "Flexible premium universal life insurance policy" means a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance.

E. "Interest-indexed universal life insurance policy" means any universal life insurance policy where the interest credits are linked to an external referent.

Drafting Note: This definition is not intended to include those policies which only have a variable policy loan interest rate provision, but have no other link to an external referent. This regulation presently addresses only the indexing of interest credits. The regulation does not preclude the indexing of other factors, e.g., mortality or expenses. Should other products be developed which involve the indexing of factors other than interest credits, this regulation may require modification. The regulation does not preclude insurance departments from adding requirements regarding the indexing of such other factors.

F. "Net cash surrender value" means the maximum amount payable to the policyowner upon surrender.

G. "Policy value" means the amount to which separately identified interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

Drafting Note: Universal life insurance policies may use designated amounts for different purposes. These include the following: the base upon which interest credits are calculated; the amount subtracted from the policy's face value to determine net amount at risk for calculation of mortality charges, and the amount paid upon surrender. These amounts may all be the same or may be different. For purposes of this regulation, these amounts do not define policy value, although they may be coincidentally equal to that amount as defined above.

Care should be taken not to place undue emphasis on the policy or "account" value. Very often the policy value is not directly available to the policyowner. Instead, the policy value is an intermediate step used to determine benefits actually available to the policyowner such as cash surrender values, net cash surrender values, death benefits, or maturity values. The benefits actually provided the policyowner should be considered in establishing valuation and nonforfeiture standards.

H. "Universal life insurance policy" means a life insurance policy where separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

Drafting Note: This regulation is specifically designed for individual life insurance policies. It is not intended, however, to prohibit the issuance of group universal life insurance policies. States are free to adopt whatever portions of this regulation which are appropriate for group insurance and which are in accordance with state law.

Unlike the unitary nature of traditional whole life insurance, a distinguishing feature of universal life insurance is the existence of an indeterminate policy value from which specified periodic charges are deducted and to which specified periodic interest is credited at a rate not determined at issue. This indeterminate policy value feature with separately identified charges and credits may or may not have a premium pattern predetermined by the insurer at issue. Valuation and nonforfeiture treatment of these products varies depending upon the nature of the premium pattern. To distinguish these treatments, a definitional distinction has been made between "flexible" and "fixed" premium policy forms.

Section 4. Scope

This regulation applies to all individual universal life insurance policies except variable universal life.

Section 5. Valuation

A. Requirements

The minimum valuation standard for universal life insurance policies shall be the Commissioners Reserve Valuation Method, as described below for such policies, and the tables and interest rates specified below. The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and less (D), where:

Reserves by the net level premium method shall be equal to ((A)-(B))r where (A), (B) and "r" are as defined below:

(A) is the present value of all future guaranteed benefits at the date of valuation.

(B) is the quantity $\frac{\text{PVFB}}{a_x} a_{x+t}$

where PVFB is the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer.

a_x and a_{x+t} are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and x+t, respectively, and continuing until the highest attained age at which a premium may be paid under the policy. The letter "x" is defined as the issue age and the letter "t" is defined as the duration of the policy.

The guaranteed maturity premium for flexible premium universal life insurance policies shall be that level gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy (otherwise at the highest age in the valuation mortality table), for an amount which is in accordance with the policy structure.[1] The guaranteed maturity premium is calculated at issue based on all policy guarantees at issue (excluding guarantees linked to an external referent). The guaranteed maturity premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees.[2]

The letter "r" is equal to one, unless the policy is a flexible premium policy and the policy value is less than the guaranteed maturity fund, in which case "r" is the ratio of the policy value to the guaranteed maturity fund.

The guaranteed maturity fund at any duration is that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue.

(C) is the quantity ((a)-(b))$\frac{a_{x+t}}{a_x}$ r where (a)-(b) is as described

in [insert reference to Section 4 of the Standard Valuation Law] for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer.

a_{x+t} and a_x are defined in (B) above.

(D) is the sum of any additional quantities analogous to (C) which arise because of structural changes[3] in the policy, with each such quantity being determined on a basis consistent with that of (C) using the maturity date in effect at the time of the change.

The guaranteed maturity premium, the guaranteed maturity fund and (B) above shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the descriptions above.

Future guaranteed benefits are determined by (1) projecting the greater of the guaranteed maturity fund and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and (2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

All present values shall be determined using (i) an interest rate (or rates) specified by [insert reference to the Standard Valuation Law] for policies issued in the same year; (ii) the mortality rates specified by the [insert reference to the Standard Valuation Law] for policies issued in the same year or contained in such other table as may be approved by the Commissioner for this purpose; and (iii) any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

Drafting Note: To the extent that the insurer declares guarantees more favorable than those in the policy (contractual guarantees), such declared guarantees shall be applicable to the determination of future guaranteed benefits.

The mortality and interest bases for calculating present values are the minimum standards in the Standard Valuation Law.

Ever since the adoption of the original Standard Valuation Law (SVL) in 1942, provision has been made for valuation calculations on the basis of substandard mortality. (See Section 4G of SVL). While this provision has been used infrequently in the past, it is anticipated that substandard mortality will be more frequently utilized in universal life insurance, given its flexible nature, to reflect the mortality classification assigned to the policy by the insurer.

In effecting structural changes, consistent methods are prescribed when calculating reserves. Several such methods are possible, but perhaps the simplest such method would be that of maintaining proportionality between the Guaranteed Maturity Fund and Guaranteed Maturity Premium values and the current face amount. In applying this method, Guaranteed Maturity Fund and Guaranteed Maturity Premium values could be calculated per dollar of face amount and simply multiplied by the new face amount. This would eliminate much of the complexity involved in other methods.

B. Alternative Minimum Reserves

If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of (1) or (2).

(1) The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

(2) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the Guaranteed Maturity Premium in each policy year for which the valuation net premium exceeds the Guaranteed Maturity Premium.

For universal life insurance reserves on a net level premium basis, the valuation net premium is $\frac{PVFB}{a_x}$

and for reserves on a Commissioners Reserve Valuation Method, the valuation net premium is $\frac{PVFB}{a_x} + \frac{(a)-(b)}{a_x}$

Section 6. Nonforfeiture

A. Minimum Cash Surrender Values for Flexible Premium Universal Life Insurance Policies Minimum cash surrender values for flexible premium universal life
policies shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to the accumulation to that date of the premiums paid minus the accumulations to that date of (i) the benefit charges, (ii) the averaged administrative expense charges for the first policy year and any insurance-increase years, (iii) actual administrative expense charges for other years, (iv) initial and additional acquisition expense charges not exceeding the initial or additional expense allowances, respectively, (v) any service charges actually made (excluding charges for cash surrender or election of a paid-up nonforfeiture benefit) and (vi) any deductions made for partial withdrawals; all accumulations being at the actual rate or rates of interest at which interest credits have been made unconditionally to the policy (or have been made conditionally, but for which the conditions have since been met), and minus any unamortized unused initial and additional expense allowances.

Interest on the premiums and on all charges referred to in items (i)-(vi) above shall be accumulated from and to such dates as are consistent with the manner in which interest is credited in determining the policy value.

The benefit charges shall include the charges made for mortality and any charges made for riders or supplementary benefits for which premiums are not paid separately. If benefit charges are substantially level by duration and develop low or no cash values, then the Commissioner shall have the right to require higher cash values unless the insurer provides adequate justification that the cash values are appropriate in relation to the policy's other characteristics.[4]

The administrative expense charges shall include charges per premium payment, charges per dollar of premium paid, periodic charges per thousand dollars of insurance, periodic per policy charges, and any other charges permitted by the policy to be imposed without regard to the policyowner's request for services.

The averaged administrative expense charges for any year shall be those which would have been imposed in that year if the charge rate or rates for each transaction or period within the year had been equal to the arithmetic average of the corresponding charge rates which the policy states will be imposed in policy years two through twenty in determining the policy value.

The initial acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in the first policy year over the averaged administrative expense charges for that year. Additional acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in an insurance-increase year over the averaged administrative expense charges for that year. An insurance-increase year shall be the year beginning on the date of increase in the amount of insurance by policyowner request (or by the terms of the policy).

Service charges shall include charges permitted by the policy to be imposed as the result of a policyowner's request for a service by the insurer (such as the furnishing of future benefit illustrations) or of special transactions.

The initial expense allowance shall be the allowance provided by [insert reference to Section 5 or 5cA of the Standard Nonforfeiture Law for Life Insurance] for a fixed premium, fixed benefit endowment policy with a face amount equal to the initial face amount of the flexible premium universal life insurance policy, with level premiums paid annually until the highest attained age at which a premium may be paid under the flexible premium universal life insurance policy, and maturing on the latest maturity date permitted under the policy, if any, otherwise at the highest age in the valuation mortality table. The unused initial expense allowance shall be the excess, if any, of the initial expense allowance over the initial acquisition expense charges as defined above.

If the amount of insurance is subsequently increased upon request of the policyowner (or by the terms of the policy), an additional expense allowance and an unused additional expense allowance shall be determined on a basis consistent with the above and with [Section 5cE of the Standard Nonforfeiture Law for Life Insurance], using the face amount and the latest maturity date permitted at that time under the policy.

The unamortized unused initial expense allowance during the policy year beginning on the policy anniversary at age x+t (where "x" is the same issue age) shall be the unused initial expense allowance multiplied by $a_{\underline{x+t}}$ where

$$a_{\underline{x}}$$

a_{x+t} and a_x are present values of an annuity of one per year payable on policy anniversaries beginning at ages $\underline{x+t}$ and $\underline{x}$, respectively, and continuing until the highest attained age at which a premium may be paid under the policy, both on the mortality and interest bases guaranteed in the policy. An unamortized unused additional expense allowance shall be the unused additional expense allowance multiplied by a similar ratio of annuities, with a_x replaced by an annuity beginning on the date as of which the additional expense allowance was determined.

Drafting Note: The drafters chose a whole life initial expense allowance for several reasons. Although highly flexible, universal life insurance is generally considered a permanent life insurance plan. Most companies encourage a premium level which will provide lifetime insurance protection. Every universal life insurance policy of which the drafters are aware has a "net level premium" that could be computed which would guarantee permanent protection. As a result, it is expected that most universal life insurance policies will be sold as permanent plans.

Traditional whole life insurance, which is accorded a permanent plan expense allowance by the Standard Nonforfeiture Law (SNFL), is much more flexible than is often realized. Premiums may be stopped with term coverage resulting, policy loans can result in "stop and go" premiums, or an arrangement to use available dividends to pay premiums can be effected, all without the permanent plan expense allowance being affected. The SNFL does not require cash values for many forms of term insurance. All other permanent plans develop an expense allowance greater than that for whole life insurance under the SNFL.

The alternative of basing the initial expense allowance on a policyowner's "planned premium" was considered but rejected as artificial and subject to substantial manipulation by agents and/or insurers.

B. Minimum Cash Surrender Values for Fixed Premium Universal Life Insurance Policies

For fixed premium universal life insurance policies, the minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to [(A)-(B)-(C)-(D)], where:

(A) is the present value of all future guaranteed benefits.

(B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in [Sections 5 and 5-a or in paragraph (1) of Section 5-c], as applicable, of [the Standard Nonforfeiture Law for Life Insurance, as amended in 1980]. If Section 5-c, paragraph (l) is applicable, the nonforfeiture net level premium is equal to the quantity $\frac{\text{PVFB}}{a_x}$,

where PVFB is the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer.

a_x is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(C) is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy. a_x shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration.

(D) is the sum of any quantities analogous to (B) which arise because of structural changes[5] in the policy.

Future guaranteed benefits are determined by (1) projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and (2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

All present values shall be determined using (i) an interest rate (or rates) specified by [the Standard Nonforfeiture Law for Life Insurance, as amended in 1980] for policies issued in the same year and (ii) the mortality rates specified by [the Standard Nonforfeiture Law for Life Insurance, as amended in 1980] for policies issued in the same year or contained in such other table as may be approved by the Commissioner for this purpose.

Drafting Note: The types of quantities included in Subsection C are increased current interest rate credits guaranteed for a future period, decreased current mortality rate charges guaranteed for a future period, or decreased current expense charges guaranteed for a future period.

C. Minimum Paid-Up Nonforfeiture Benefits

If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as (1) in the case of a flexible premium universal life insurance policy, the mortality and interest basis guaranteed in the policy for determining the policy value, or (2) in the case of a fixed premium policy the mortality and interest standards permitted for paid-up nonforfeiture benefits by [the Standard Nonforfeiture Law for Life Insurance, as amended in 1980]. In lieu of the paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits, or, if applicable, a greater amount or earlier payment of endowment benefits.

Drafting Note: it is possible that policies will have secondary guarantees. Such guarantees should be taken into consideration when computing minimum paid-up nonforfeiture benefits.

To preserve equity between policies on a premium paying basis and on a paid-up basis, present values must comply with Section 6A for flexible premium universal life insurance policies and with Section 6B for fixed premium policies.

Ever since the adoption of the original Standard Nonforfeiture Law (SNFL) in 1942, provision has been made for nonforfeiture calculations on the basis of substandard mortality. (See Sections 5, 5-a, and 5-c of SNFL.) While this provision has been used infrequently in the past, it is anticipated that substandard mortality will be more frequently utilized in universal life insurance, given its flexible nature, to reflect the mortality classification assigned to the policy by the insurer.

A charge may be made at the surrender of the policy provided that the result after the deduction of the charge is not less than the minimum cash surrender value required by this section.

Section 7. Mandatory Policy Provisions

The policy shall provide the following:

A. Periodic Disclosure to Policyowner

The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy. The end of the current report period must be not more than three months previous to the date of the mailing of the report. Specific requirements of this report are detailed in Section 9.

Drafting Note: Fixed premium universal life insurance policies may be required to contain a table of cash surrender or nonforfeiture values, by law. Such a table of values is of little use for a flexible premium policy, since the premiums cannot be determined, and therefore, such table should not be required to be included in the policy. Periodic disclosure to the policyowner is designed to fulfill the purpose of such a table of values, which, because of the nature of universal life insurance, cannot be determined at issue for a flexible premium policy.

B. Current Illustrations

The annual report shall provide notice that the policyholder may request an illustration of current and future benefits and values.

C. Policy Guarantees

The policy shall provide guarantees of minimum interest credits and maximum mortality and expense charges. All values and data shown in the policy shall be based on guarantees. No figures based on nonguarantees shall be included in the policy.

Drafting Note: Minimum and maximum guarantees are in addition to any index guarantees. If "guaranteed" credits and/or charges are also the "current" credits and/or charges, such amounts may be included in the policy if clearly labeled. The maturity date is not considered a guarantee for purposes of this section.

D. Calculation of Cash Surrender Values

The policy shall contain at least a general description of the calculation of cash surrender values including the following information:

(1) The guaranteed maximum expense charges and loads.

(2) Any limitation on the crediting of additional interest. Interest credits shall not remain conditional for a period longer than twenty-four months.

(3) The guaranteed minimum rate or rates of interest.

(4) The guaranteed maximum mortality charges.

(5) Any other guaranteed charges.

(6) Any surrender or partial withdrawal charges.

E. Changes in Basic Coverage

If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

F. Grace Period and Lapse

The policy shall provide for written notice to be sent to the policyowner's last known address at least thirty (30) days prior to termination of coverage.

A flexible premium policy shall provide for a grace period of at least thirty (30) days (or as required by state statute) after lapse. Unless otherwise defined in the policy, lapse shall occur on that date on which the net cash surrender value first equals zero.

Drafting Note: Fixed premium policies shall contain a provision providing for a standard grace period as required by state law.

G. Misstatement of Age or Sex

If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The commissioner may approve other methods which are deemed satisfactory.

H. Maturity Date

If a policy provides for a "maturity date," "end date," or similar date, then the policy shall also contain a statement, in close proximity to that date, that it is possible that coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner, if such is the case.

Section 8. Disclosure Requirements

Disclosure of information about the policy being applied for shall follow the standards in [insert citation to state equivalent of the Life Insurance Illustrations Model Regulation].

Section 9. Periodic Disclosure to Policyowner

A. Requirements

The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy. The end of the current report period shall be not more than three (3) months previous to the date of the mailing of the report.

B. The report shall include the following:

(1) The beginning and end of the current report period;

(2) The policy value at the end of the previous report period and at the end of the current report period;

(3) The total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(4) The current death benefit at the end of the current report period on each life covered by the policy;

(5) The net cash surrender value of the policy as of the end of the current report period;

(6) The amount of outstanding loans, if any, as of the end of the current report period;

(7) For fixed premium policies:

If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report;

(8) For flexible premium policies:

If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

Drafting Note: These are the same standards as required in the Life Insurance Illustrations Model Regulation. A state could refer to that regulation instead of including the standards here.

Section 10. Interest-Indexed Universal Life Insurance Policies

A. Initial Filing Requirements

The following information shall be submitted in connection with any filing of interest-indexed universal life insurance policies ("interest-indexed policies"). All such information received shall be treated confidentially to the extent permitted by law.

(1) A description of how the interest credits are determined, including:

(a) A description of the index;

(b) The relationship between the value of the index and the actual interest rate to be credited;

(c) The frequency and timing of determining the interest rate; and

(d) The allocation of interest credits, if more than one rate of interest applies to different portions of the policy value;

(2) The insurer's investment policy, which includes a description of the following:

(a) How the insurer addressed the reinvestment risks;

(b) How the insurer plans to address the risk of capital loss on cash outflows;

(c) How the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities;

(d) How the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy;

(e) The amount and type of assets currently held for interest indexed policies;

(f) The amount and type of assets expected to be acquired in the future;

(3) If policies are linked to an index for a specified period less than to the maturity date of the policy, a description of the method used (or currently contemplated) to determine interest credits upon the expiration of such period.

(4) A description of any interest guarantee in addition to or in lieu of the index.

(5) A description of any maximum premium limitations and the conditions under which they apply.

B. Additional Filing Requirements

(1) Annually, every insurer shall submit a Statement of Actuarial Opinion by the insurer's actuary similar to the example contained in Section 10C.

(2) Annually, every insurer shall submit a description of the amount and type of assets currently held by the insurer with respect to its interest-indexed policies.

(3) Prior to implementation, every domestic insurer shall submit a description of any material change in the insurer's investment strategy or method of determining the interest credits. A change is considered to be material if it would affect the form or definition of the index (i.e., any change in the information supplied in Section A above) or if it would significantly change the amount or type of assets held for interest-indexed policies.

Drafting Note: Interest-indexed products present unique aspects which, due to the unknown future values of the index, are not precisely addressed by current valuation laws. The drafters have considered and rejected approaches to valuation which would require the setting of arbitrary reserves and/or the arbitrary dedication of specific amounts of surplus as being neither logical nor workable. In requiring the filing and evaluation of the above items, together with an annual actuarial opinion, the drafters have attempted to preserve the basic principle of the valuation laws, which is to maintain the ability of the insurer to meet its future contractual obligations.

It is assumed that the evaluation of the information provided in this Section together with the experience of insurers in writing indexed forms will lead to a more scientific approach to valuation in the future.

The drafters believe that by focusing attention on cash flows and the quality and quantity of assets supporting indexed policy liabilities, most of the risks associated with indexed products can be addressed by insurers and regulators in a manner which will provide adequate protection to the public while permitting experimentation and diversity in minimizing the uncertainty associated with the valuation of these products.

C. Statement of Actuarial Opinion for Interest-Indexed Universal Life Insurance Policies

I,_____, am _____
(Name) (position or relationship to Insurer)
for the XYZ Life Insurance Company (The Insurer) in the state of _____.
(State of Domicile of Insurer)

I am a member of the American Academy of Actuaries (or if not, state other qualifications to sign annual statement actuarial opinions).

I have examined the interest-indexed universal life insurance policies of the Insurer in force as of December 31, 20XX, encompassing _____ number of policies and $_____ of insurance in force.

I have considered the provisions of the policies. I have considered any reinsurance agreements pertaining to such policies, the characteristics of the identified assets and the investment policy adopted by the Insurer as they affect future insurance and investment cash flows under such policies and related assets. My examination included such tests and calculations as I considered necessary to form an opinion concerning the insurance and investment cash flows arising from the policies and related assets.

I relied on the investment policy of the Insurer and on projected investment cash flows as provided by _____, Chief Investment Officer of the Insurer.[6]

The tests were conducted under various assumptions as to future interest rates, and particular attention was given to those provisions and characteristics that might cause future insurance and investment cash flows to vary with changes in the level of prevailing interest rates.

In my opinion, the anticipated insurance and investment cash flows referred to above make good and sufficient provision for the contractual obligations of the Insurer under these insurance policies.

_____
Signature of Actuary

Drafting Note: The American Academy of Actuaries has offered to prepare appropriate guidelines which will delineate the various responsibilities of the actuary in signing the Statement of Actuarial Opinion included in this regulation. Upon publication, these guidelines will become a part of the body of actuarial literature which describes Generally Accepted Actuarial Principles and Practice.

If the actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force, an appropriate statement of such reliance should be included here.

Endnotes:

1. The maturity amount shall be the initial death benefit where the death benefit is level over the lifetime of the policy except for the existence of a minimum-death-benefit corridor, or shall be the specified amount where the death benefit equals a specified amount plus the policy value or cash surrender value except for the existence of a minimum-death-benefit corridor.

2. The Guaranteed Maturity Premium for both flexible and fixed premium policies shall be adjusted for death benefit corridors provided by the policy. The Guaranteed Maturity Premium may be less than the premium necessary to pay all charges. This can especially happen in the first year for policies with large first year expense charges.

3. Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyholder and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period. For valuations on or after January 1, 1987, for fixed premium universal life policies with redetermination of all credits and charges no more frequently than annually, on policy anniversaries, structural changes also include changes in guaranteed benefits, or in fixed premiums, unanticipated by the guaranteed maturity premium for such policies at the date of issue, even if such changes arise from automatic workings of the policy. The recomputation of (B) above, for fixed premium universal life structural changes, shall exclude from PVFB, the present value of future guaranteed benefits, those guaranteed benefits which are funded by the excess of the insurer's declared guarantees of interest, mortality and expenses, over the guarantees contained in the policy at the date of issue.

4. Because this product is still developing, it is recommended that benefit charges not be restricted and regulatory treatment of cash values be limited to that contained in this section for several reasons. First, further restrictions would limit the development of the product. Second, added restrictions would discourage insurers from reducing non-guaranteed current benefit charges because such reductions could require reduced future benefit charges that could be financially unsound for the insurer. Third, market pressures will encourage insurers to limit benefit charges.

5. See footnote 3.

6. If the actuary does not choose to rely on an investment officer for the projected investment cash flows, this statement should be modified to show the extent of the actuary's reliance.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1984 Proc. I 6, 31, 376, 514, 515-526 (adopted).
1988 Proc. I 9, 19-20, 494, 599-600, 627 (adopted change to footnote 3).
1989 Proc. II 13, 23, 414-415, 428-429, 431-442 (amended to include consumer disclosure requirement).
1990 Proc. I 6, 27, 438-439, 450-451, 453-463 (amended).
2000 Proc. 3rd Quarter 13, 14, 88, 116, 119-135 (amended and reprinted).

UNIVERSAL LIFE INSURANCE MODEL REGULATION

What are the state pages?

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American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE R. 34 (1985).		
California	CAL. CODE REGS. tit. 10, §§ 2544 to 2544.6 (1991/2016) (portions of model).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-164.010 (1994/2003) (portions of model).		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

UNIVERSAL LIFE INSURANCE MODEL REGULATION

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Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1411.10 to 1411.60 (2004).		
Indiana	BULLETIN 137 (April 10, 2006) (adopted by reference).		
Iowa	IOWA ADMIN. CODE r. 191-92.1 (508) to 191-92.10 (508) (2005).		
Kansas	KAN. ADMIN. REGS. § 40-15b-1 (1985/1998).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.8501 to XIII.8517 (Regulation 36) (1985).		
Maine	NO CURRENT ACTIVITY		
Maryland	MD. CODE REGS. 31.09.15.01 to 31.09.15.13 (2010).		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. COMP. LAWS § 500.837 (1993); § 500.2236a (1993); § 500.4001 (1993); §§ 500.4037 to 500.4038 (1993); § 500.4061 (1993); BULLETIN 2000-02 (2000).		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	19 MISS. ADMIN. CODE PT. 2, R. 9 (84-106) (1984).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.100 (1985/2001).		
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE § 40 (1984/2008).		
Nevada	NO CURRENT ACTIVITY		

UNIVERSAL LIFE INSURANCE MODEL REGULATION

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New Jersey	NO CURRENT ACTIVITY		
New Mexico	N.M. Admin. Code 13.9.7 (1985).		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. ADMIN. CODE §§ 45-04-05-01 to 45-04-05-09 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-6-07 (1997/2013).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-80 to 365:10-5-86 (1985/1992).		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			CIRCULAR LETTER No. AV-100-2009 (2009).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		

UNIVERSAL LIFE INSURANCE MODEL REGULATION

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Virginia			VA. CODE ANN. § 38.2-3117 (authority to establish universal life standards) (1986).
Washington	WASH. ADMIN. CODE 284-84-010 to 284-84-110 (1985).		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	WY. RULES AND REGULATIONS 044.0002.40 (1984/1985).		

MODEL POLICY LOAN INTEREST RATE BILL
AN ACT TO REGULATE INTEREST RATES ON LIFE INSURANCE POLICY LOANS

Table of Contents

Section 1. Purpose

The purpose of this Act is to permit and set guidelines for life insurers to include in life insurance policies issued after the effective date of this Act a provision for periodic adjustment of policy loan interest rates.

Section 2. Definitions

For purposes of this Act the "published monthly average" means:

A. The Moody's Corporate Bond Yield Average—Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor thereto; or

B. In the event that the Moody's Corporate Bond Yield Average—Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the commissioner.

Section 3. Maximum Rate of Interest of Policy Loans

A. Policies issued on or after the effective date of this Act shall provide for policy loan interest rates as follows:

(1) A provision permitting a maximum interest rate of not more than eight percent (8%) per annum; or

(2) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

B. The rate of interest charged on a policy loan made under Subsection A(2) shall not exceed the higher of the following:

(1) The published monthly average for the calendar month ending two (2) months before the date on which the rate is determined; or

(2) The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

C. If the maximum rate of interest is determined pursuant to Subsection A(2), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

D. The maximum rate for each policy must be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any three-month period. At the intervals specified in the policy:

(1) The rate being charged may be increased whenever an increase determined under Subsection B would increase that rate by one-half percent (1/2%) or more per annum;

(2) The rate charged must be reduced whenever a reduction as determined under Subsection B would decrease that rate by one-half percent (1/2%) or more per annum.

E. The life insurer shall:

(1) Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(2) Notify the policyholder with respect to the premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in Paragraph (3);

(3) Send to policyholders with loans reasonable advance notice of any increase in the rate; and

(4) Include in the notices required above the substance of the pertinent provisions of Subsections A and C.

F. [The loan value of the policy shall be determined in accordance with Section ____, but] no policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

G. The substance of the pertinent provisions of Subsections A and C shall be set forth in the policies to which they apply.

H. For purposes of this section:

(1) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(2) The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.

(3) The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(4) The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

I. No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

Section 4. Applicability to Existing Policies

The provisions of this Act shall not apply to any insurance contract issued before the effective date of this Act unless the policyholder agrees in writing to the applicability of such provisions.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1981 Proc. I 47, 51, 421, 517, 534, 535-536 (adopted).

MODEL POLICY LOAN INTEREST RATE BILL

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Alabama	ALA. CODE 27-15-8.1 (1981).		
Alaska			ALASKA STAT. § 21.45.080 (1982).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1209 to 20-1209.01 (1978/1982).		
Arkansas	ARK. CODE ANN. § 23-81-109 (1981).		
California	CAL. INS. CODE §§ 1230 to 1239.5 (1982).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. GEN. STAT. § 38a-444 (1981).		
Delaware	DEL. CODE ANN. tit. 18, § 2911 (1983).		
District of Columbia	D.C. CODE § 31-4703(a)(6) (1985).		
Florida	FLA. STAT. § 627.4585 (1981).		
Georgia	GA. CODE ANN. § 33-25-3.1 (1983).		

MODEL POLICY LOAN INTEREST RATE BILL

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:10D-103 (1988/2004).		
Idaho	IDAHO CODE ANN. § 41-1909 (1981).		
Illinois	215 ILL. COMP. STAT. 5/229.5 (1982/1983).		
Indiana	IND. CODE §§ 27-1-12.3-1 to 27-1-12.3-6 (1981).		
Iowa	IOWA CODE § 511.36 (1984).		
Kansas	KAN. STAT. ANN.§§ 40-420a to 40-420d (1982).		
Kentucky	KY. REV. STAT. ANN. § 304.15-115 (1984).		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2552 to 2554 (1982).		
Maryland	MD. CODE ANN., INS. § 16-208 (1983/1997).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 142 (1981).		
Michigan	MICH. COMP. LAWS § 500.4023 (1982).		
Minnesota	MINN. STAT. § 61A.03 (1984).		
Mississippi	MISS. CODE ANN. § 83-7-26 (1984).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.090 (1982).		
Montana			MONT. CODE ANN. § 33-20-131 (1959/1985).

MODEL POLICY LOAN INTEREST RATE BILL

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NEB. REV. STAT. §§ 44-502.01 to 44-502.04 (1981).		
Nevada			NEV. REV. STAT. § 688A.110 (1971).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 401.05 (1983).		
New Jersey			N.J. STAT. ANN. § 17B:25-8 (1971).
New Mexico	N.M. STAT. ANN. § 59A-20-10 (1985).		
New York	N.Y. INS. LAW § 3206 (1984).		
North Carolina	N.C. GEN. STAT. §§ 58-61-1 to 58-61-15 (1981).		
North Dakota	N.D. ADMIN. CODE 45-04-03-01 to 45-04-03-04 (1982/1986).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE § 3915.051 (1982/1984).		
Oklahoma	OKLA. STAT. tit. 36, § 4008 (1982).		
Oregon	OR. REV. STAT. § 743.187 (1981).		
Pennsylvania	40 PA. STAT. ANN. § 510e (1982).		
Puerto Rico	P.R. LAWS ANN. tit. 26, § 1346 (2007).		
Rhode Island	R.I. GEN. LAWS § 27-4-13.1 (1982).		
South Carolina	S.C. CODE ANN. §§ 38-63-240 to 38-63-280 (1988).		

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South Dakota	S.D. CODIFIED LAWS §§ 58-15-15.5 to 58-15-15.12 (1982).		
Tennessee	TENN. CODE ANN. § 56-7-2309 (1982).		
Texas	TEX. INS. CODE ANN. §§ 1110.001 to 1110.008 (2003).		
Utah	UTAH CODE ANN. § 31A-22-420 (1986).		
Vermont	VT. STAT. ANN. tit. 8, § 3731(7) (1982).		
Virgin Islands			V.I. CODE ANN. tit. 22, § 958 (1968).
Virginia	VA. CODE ANN. § 38.2-3308 (1986).		
Washington	WASH. REV. CODE ANN. § 48.23.085 (1981).		
West Virginia	W. VA. CODE § 33-13-8a (1983).		
Wisconsin	WIS. STAT. § 632.475 (1981).		
Wyoming	WYO. STAT. ANN. § 26-16-108 (1983).		

GUIDELINES ON GIFTS OF LIFE INSURANCE TO CHARITABLE INSTITUTIONS

These Guidelines have been prepared for use by state insurance department personnel who may be presented with questions or concerns regarding charitable gifts of life insurance. Of course, each state's laws on the issues discussed may differ, and the following discussion should be read with that in mind.

Q. What is meant by a gift of life insurance?

A. As a general principle, the gift of a life insurance policy to any recipient, whether such recipient is a charity or other third party, involves the same considerations and characteristics as a gift of any other property owned by the donor. Once the transaction is made, the ownership of the policy and all ownership rights under the policy, including the ability to change the beneficiary, are forever transferred from the donor to the recipient.

Q. What is meant by "charitable institutions?"

A. Charitable institutions are typically non-profit, tax-exempt organizations such as corporations or foundations organized and operated exclusively for religious, charitable, scientific, literary or educational purposes or to foster amateur sports or for the prevention of cruelty to children or animals.

Q. How is a gift of life insurance to a charity accomplished?

A. A gift of life insurance to a charity is generally accomplished in one of two ways, although there are varying alternatives within these two categories. The gift may be either of an existing policy, in the form of an irrevocable assignment to the charity, or it may be the purchase of a new policy by the insured, or with the consent of the insured, by the charity on the life of the insured, to the benefit of the charity.

Q. Why has there been an increased interest and attention focused on gifts of life insurance to charitable institutions?

A. This stems primarily from a private letter ruling issued by the Internal Revenue Service dated December 6, 1990 which indicated that federal income, gift and estate tax charitable deductions may not be allowed for gifts of life insurance to charities if the law in the donor's state did not recognize that charities have an insurable interest in the life of their donors. The ruling was based on the IRS's interpretation of New York law. Following an amendment made to New York law which specifically authorized insureds to transfer life insurance policies to charities, the IRS issued another letter ruling on November 27, 1991 revoking its earlier ruling. As a result of the revocation, much of the concern over charitable giving of life insurance has subsided.

Q. What is insurable interest?

A. Insurable interest can generally be described as an interest on the part of the applicant or owner of the policy in the continuance of the life of the insured. Everyone has an insurable interest in his or her own life and where the applicant is the insured, he or she can generally make the proceeds payable to whomever he or she wants, including a favorite charity. Where someone other than the insured is the applicant, insurable interest is typically based on a family relationship or a reasonable expectation of deriving financial or economic benefits from the continuance of the insured's life. Some states require beneficiaries to have an insurable interest in the insured. For life insurance to be enforceable, an insurable interest must exist at the time the policy is being applied for.

Q. How is the insurable interest requirement met in the context of gifts of life insurance to charitable institutions?

A. The statutory definition of insurable interest in many states specifically includes charities. In other states, charities who have an ongoing relationship with a donor may qualify under the general definition of insurable interest by demonstrating an expectation of benefit or advantage from the continuance of the life of the insured as a result of the insured's previous donation patterns, whether they be of money, other gifts or volunteer time. Other state statutes simply authorize charities to own or purchase life insurance on an insured who consents to the ownership or purchase of the insurance. The primary protection against abuse in the charitable ownership of life insurance is the requirement that the insured consent to the ownership. Many state laws require that consent to be in writing.

Q. What other considerations are involved?

A. There are various considerations which may help the donor determine the method he or she should use to make a gift of life insurance to a charity. Among these is whether the assignment of an existing policy would exclude from the donor's estate insurance coverage needed for more immediate family or business needs. The donor's state of health and ability to obtain other coverage should also be considered. The type of coverage in force and/or being considered for purchase may also be of significance. In that the donation may be made as part of a donor's estate or tax plan or have varying tax ramifications depending on how the transaction is structured, the donor should seek the advice of a tax expert in connection with any transaction of this nature.

The prospective donor may well find it entirely appropriate to ascertain the longevity of the charitable institution to which he or she is considering making a donation. The length of time which the charity has been in existence and its avowed goals regarding its own future activities could be significant in determining whether or not the charity will still be a viable institution when the life insurance benefit is paid.

Q. If a state contemplates statutory or regulatory language to clarify the existence of an insurable interest in charitable organizations, what are the main items that should be considered for inclusion in the statue or rule?

A. 1. Its purpose should be to acknowledge the existence of the insurable interest in the charity and to clarify how the law applies to charitable interest in life insurance and annuities;

2. It should clearly state that it does not abridge or limit the insurable interest currently existing in common law or by statute;

3. It should make clear that any specific requirements for an insurable interest to exist (e.g., written consent of the insured) are to be applicable only to insurance applied for and assignments made subsequent to enactment or promulgation of the law or rule; and

4. It should define "nonprofit organization" to include charitable, religious, scientific, literary, educational or other legitimate institutions or entities, reasonably anticipated to be the genuine object of a donor's charitable intent. (This would include institutions or entities described in the Internal Revenue Code Sections 170, 501, 2055 and 2522).

Q. What are some examples of statutory language states have used to respond to concerns over charitable ownership of life insurance?

A. Two examples of statutory responses to such concerns are Colorado House Bill 1031 enacted in 1992 adding Section 114 to Article 7 of Title 10, Colorado revised statutes and Tennessee Senate Bill No. 2336, also enacted in 1992 adding Section ___ to Title 56, Chapter 7, Part 3 of the Tennessee Code Annotated.

The Colorado Law provides:

Notwithstanding any other provision of law, any organization that meets the requirements of Section 170(c) of the Federal "Internal Revenue Code of 1986," as amended, may own or purchase life insurance of an insured who gives written consent to the ownership or purchase of that insurance. The provisions of this section do not limit or abridge any insurable interest or right to insure now existing at common law or by statute, shall be construed liberally to sustain the existence of an insurable interest, and shall stand as a declaration of existing law applicable to all life insurance policies whenever issued, in existence on or after the effective date of this section.

The Tennessee Law provides:

If an organization described in either Section 501(c)(3) or Section 170(c) of the Internal Revenue Code of 1986, as amended, purchases or receives by assignment, before, on or after the effective date if this section, life insurance on an insured who consents to the purchase or assignment, the organization is deemed to have had an insurable interest in the insured person's life on the date of purchase or assignment. This section does not limit or abridge any insurable interest now existing at common law or by statute.

Citations to statutory provisions of other states dealing with charitable ownership of life insurance may be obtained by contacting the NAIC Legal Department.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. I 8, 136, 801, 804, 805-807 (adopted).

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Alabama	ALA. CODE § 27-14-3 (1971/1994).		
Alaska	ALASKA STAT. § 21.42.020 (1996/2002).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-1104 (1954/1989).		
Arkansas	ARK. CODE ANN. § 23-79-103 (1959/2003).		
California	CAL. INS. CODE § 10110.1 (1990/1994).		
Colorado	COLO. REV. STAT. § 10-7-115 (1992).		
Connecticut	CONN. GEN. STAT. § 38a-450 (1949).		
Delaware	DEL. CODE ANN. tit. 18, § 2705 (1953).		
District of Columbia	D.C. CODE ANN. § 31-4716 (1934/1995).		
Florida	FLA. STAT. § 627.404 (1959/1992).		

GUIDELINES ON GIFTS OF LIFE INSURANCE TO CHARITABLE INSTITUTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. § 33-24-3 (1933/1995).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:10-202 (1987/1988).		
Idaho	IDAHO CODE ANN. § 41-1805 (1961).		
Illinois	215 ILL. COMP. STAT. § 5/245(1937/1991).		
Indiana	IND. CODE §§ 27-8-18-1 to 28-8-18-6 (1992).		
Iowa	IOWA CODE § 511.39 (1992).		
Kansas	KAN. STAT. ANN. § 40-450 (1991).		
Kentucky	KY. REV. STAT. ANN. § 304.14-050 (1970).		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2405 (1969/1993).		
Maryland	MD. CODE ANN., INS. § 12-201 (1957/2001).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 123A (1996).		
Michigan	MICH. COMP. LAWS § 500.2212 (1956/1997).		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	MISS. CODE ANN. § 83-5-251 (1992/1993).		
Missouri	MO. REV. STAT. §§ 376.562 (1992/1997); 377.080 (1939/1987).		

GUIDELINES ON GIFTS OF LIFE INSURANCE TO CHARITABLE INSTITUTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. CODE ANN. § 33-15-201 (1959/1991).		
Nebraska	NEB. REV. STAT. § 44-704 (1913/1995).		
Nevada	NEV. REV. STAT. § 687B.050 (1971).		
New Hampshire	N.H. REV. STAT. ANN. § 408:2-a (1993).		
New Jersey	N.J. STAT. ANN. § 17B:24-1.1 (1991/1992).		
New Mexico	N.M. STAT. ANN. § 59A-18-5 (1984).		
New York	N.Y. INS. LAW § 3205 (1984/2001).		
North Carolina	N.C. GEN. STAT. § 58-58-86 (1991).		
North Dakota	N.D. CENT. CODE § 26.1-29-09.1 (1985/1995).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN § 3911.09 (1953/1992).		
Oklahoma	OKLA. STAT. tit. 36, § 3604 (1957/1999).		
Oregon	OR. REV. STAT. § 743.044 (1953).		
Pennsylvania	40 PA. STAT. ANN. § 512 (1921/1992).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. § 38-63-100 (1992).		

GUIDELINES ON GIFTS OF LIFE INSURANCE TO CHARITABLE INSTITUTIONS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	S.D. CODIFIED LAWS § 58-10-4 (1966/2000).		
Tennessee	TENN. CODE ANN. 56-7-314 (1992).		TENN. COMP. R. & REGS. 0780-01-70-.01 to 0780-01-70-.11 (2009).
Texas	TEX. INS. CODE ANN. § 1103.005 (2003).		
Utah	UTAH CODE ANN. § 31A-21-104(6) (1985/2002).		BULLETIN 2006-3 (2006).
Vermont	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-301(4) (1986/1993).		
Virgin Islands	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE ANN. § 48.18.030 (1947/1992).		
West Virginia	W. VA. CODE § 33-6-2(4) (1957/1992).		
Wisconsin	WIS. STAT. § 631.07 (1975/2002); WIS. ADMIN. CODE INS. § 2.45 (1994).		
Wyoming	WYO. STAT. ANN. § 26-15-103 (1967/1983).		

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

Corporate Owned Life Insurance (COLI) is life insurance a corporate employer buys covering one or more employees. With COLI, the employer is generally the applicant, owner, premium payer and beneficiary of the policy. COLI can be acquired on an individual or group basis and can take many forms. For example, it can be used to indemnify the employer for the loss of earnings or costs of replacing a key employee who becomes disabled or dies, or to finance the cost of a stock redemption agreement or a deferred compensation plan. COLI has also increasingly been used as a financing vehicle for broad-based welfare benefit plans, such as health benefit plans.

This relatively new application of the principals of corporate owned life insurance to retiree health benefits is largely attributable to the promulgation of Statement 106 by the Financial Accounting Standards Board (FASB). Under FASB 106, post-retirement benefits, including retiree health benefits, are required to be accrued as they are earned over the working lifetime of the employee, rather than as they are paid after retirement. Unfunded accrued benefits create a growing balance sheet liability. COLI or a variation thereof, Trust Owned Life Insurance (TOLI), where the insurance is purchased by a trust, typically a VEBA trust established under Section 501(c)(9)IRC, create a balance sheet asset which the employer can use to finance the cost of the benefit.

COLI and TOLI are attractive methods of financing liabilities such as an employer's obligations under a retiree health benefit plan. When for example, retiree health benefits are provided through an insured health benefit plan, the policy's cash values can be used to finance the after-tax cost of the health insurance premiums for the retired employees. When an insured retired employee dies, the policy death benefit allows the company to recover part or all of the costs of the plan. The policy values and death benefit also represent a source of funds which can be used to pay premiums for other employees who are covered under the plan.

When an employer provides health benefits to retired employees on a self-insured basis, the cash values and death benefits of the coverage are used to finance the coverage. Moreover, contributions to the VEBA Trust may, within well defined limits, be deductible to the employer.

Because of COLI's and TOLI's attractiveness in financing an employer's obligation under a plan established to provide broad-based welfare benefits to retirees, there has been increased interest in the use of COLI and TOLI for this purpose. There has also been increased interest in assuring that COLI and TOLI arrangements satisfy insurable interest requirements.

Business entities traditionally have been found to have insurable interests in the lives of their officers, managers and key employees. This is because the business may reasonably expect to benefit from the continuance of their lives or to suffer a loss if these individuals die. Many states have also recognized an insurable interest in the lives of non-key employees, particularly in the context of financing broad-based welfare benefit plans.

Some states have enacted laws that either specifically recognize an insurable interests in a COLI-TOLI arrangement, including those whose purpose is the financing of broad based welfare plan arrangements. Other states have found such insurable interests in their common law; in interpretations of existing statutes and case law without specific COLI-TOLI enabling language.

Citations to state statutes relating to insurable interests of employers in their employees can be obtained by contacting the Legal Division of the NAIC.

States considering a legislative response to insurable interest concerns regarding employers and their employees should consider the following elements for inclusion in their law:

1. The law should recognize that employers have a lawful and substantial economic interest in the lives of key employees and in other employees who have a reasonable expectation of benefiting from an employee welfare benefit plan.

2. Employers should be required to notify eligible employees of their proposed participation in the plan and the employees should be given an opportunity to refuse to participate. On a prospective basis, employers should obtain written consent of each individual being insured. Consent would include an acknowledgement that the employer may maintain the life insurance coverage even after the insured individual's employment has terminated.

3. An employer shall not retaliate in any manner against an employee or a retired employee for refusing consent to be insured.

4. For non-key or non-managerial employees, the amount of coverage should be reasonably related to the benefits provided to the employees.

5. With respect to employer provided pension and welfare benefit plans, the life insurance coverage purchased to finance the plans should only be allowed on the lives of those employees and retirees who, at the time their lives are first insured under the plan, would be eligible to participate in the plan.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. I 7, 10, 780, 782-783 (adopted).
2002 Proc. 3rd Quarter 12, 13, 116, 118, 119 (amended and reprinted).

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE § 27-14-3 (1971/1994).		
Alaska	ALASKA STAT. § 21.42.020 (1966/2002).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-1104 (1954/1989).		
Arkansas	ARK. CODE ANN. § 23-79-103 (1959/2003).		
California	CAL. INS. CODE § 10110.1 (1990/1994).		
Colorado	COLO. REV. STAT. ANN. § 10-7-704 (2011).		
Connecticut	CONN. GEN. STAT. § 38a-291 (1992/2004).		
Delaware	DEL. CODE ANN. tit. 18, § 2704 (1953/2002).		
District of Columbia	D.C. CODE ANN. § 31-4716 (1934/1995).		
Florida	FLA. STAT. § 627.404 (1959/1992).		

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. § 33-24-3(c) (1933/2003).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:10-202 (1987/1988).		
Idaho	IDAHO CODE ANN. § 41-1804 (1961).		
Illinois	215 ILL. COMP. STAT. § 5/224.1 (1937/1992).		
Indiana	IND. CODE §§ 27-1-12-17 to 27-1-12-17.1 (1935/1995).		
Iowa	IOWA CODE ANN. § 511.40 (2003).		
Kansas	KAN. STAT. ANN. § 40-452 (1993).		
Kentucky	KY. REV. STAT. § 304.14-040 (1970).		
Louisiana	LA. REV. STAT. ANN. § 22.901 (1953/1995).		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2404(D) (1969/2003).		
Maryland	MD. CODE ANN., INS. § 12-201 (1957/2001).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 123A (1996).		
Michigan	MICH. COMP. LAWS § 500.2210 (1956/1997).		
Minnesota	MINN. STAT. § 61A.0783 (1992/1994).		
Mississippi	MISS. CODE ANN. § 83-5-251 (1992/1993).		
Missouri	MO. REV. STAT. § 376.531 (1992/1994).		

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. CODE ANN. § 33-15-201 (1959/1991).		
Nebraska	NEB. REV. STAT. § 44-373 (1927).		
Nevada	NEV. REV. STAT. § 687B.040 (1971/1997)		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. STAT. ANN. § 17B:24-1.1 (1991/1992).		
New Mexico	N.M. STAT. ANN. § 59A-18-4 (1984).		
New York	N.Y. INS. LAW § 3205 (1984/2001).		
North Carolina	N.C. GEN. STAT. §§ 58-58-75 to 58-58-85 (1951).		
North Dakota	N.D. CENT. CODE § 26.1-29-09.1 (1985/2003).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3911.091 (1995).		
Oklahoma	OKLA. STAT. tit. 36, § 3604 (1957/1999).		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	40 PA. STAT. ANN. § 512 (2004).		
Puerto Rico	PR. LAWS. ANN. tit. 26, § 1104 (2011).		
Rhode Island	R.I. GEN. LAWS § 27-4-27(3) (1990/1992).		

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. CODIFIED LAWS §§ 58-10-4 to 58-10-6 (1966/2000).		
Tennessee	TENN. CODE ANN. § 56-7-314 (1992).		
Texas	TEX. INS. CODE ANN. § 1103.053 (2003/2005).		
Utah	UTAH CODE ANN. § 31A-21-104 (1985/2002).		
Vermont	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-301 to 38.2-302 (1986/1993).		
Virgin Islands	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE ANN. §§ 48.18.030 to 48.16.060 (1947/1992).		
West Virginia	W. VA. CODE § 33-6-2(2) (1957/1992).		
Wisconsin	WIS. STAT. § 631.07 (1975/2002).		
Wyoming	WYO. STAT. ANN. § 26-15-102 (1967); § 26-15-106 (1967/1983).		

PROJECT HISTORY – 2002

GUIDELINES ON CORPORATE OWNED LIFE INSURANCE (#602)

1. Description of the project, issues addressed, etc.

The Life Insurance and Annuities (A) Committee was charged to review issues related to corporate owned life insurance and make recommendations.

2. Name and membership of group responsible for draft the model:

The membership of the COLI Working Group is**:**

North Dakota, Chair
Iowa
Michigan
Missouri
Ohio
Utah

3. Project authorized by what charge and date first given to the group:

The A Committee was charged in May 2002 to "Identify consumer protection issues related to the sale of corporate owned life insurance and make recommendations. Report by September 2002."

4. A general description of the drafting process. Include any parties outside the members that participated.

The revisions were drafted by the working group and discussed over the course of several conference calls. Representatives from the life insurance industry participated extensively in the discussion.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means) by which widespread input from industry, consumers and legislators was solicited.

Comments were solicited from interested parties who participated in the conference calls and the draft was posted on the NAIC website.

6. A discussion of the significant issues raised during the drafting process and the group's response.

The working group members considered whether to require a written affirmative consent (opt-in) or whether an opt-out provision would provide adequate protection. In addition, the working group discussed the benefits of requiring a retroactive notification of existing policyholders. The group also considered adding a requirement for notification of the spouses of insured employees.

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this Act is to establish rules that ensure meaningful information is provided to the purchasers of small face amount policies.

Section 2. Definition

"Small face amount policy" means a life insurance policy or certificate with an initial face amount of $15,000 or less.

Drafting Note: The face amount specified does not prohibit states from using a different monetary face amount.

Section 3. Exemptions

This Act applies to all group and individual life insurance policies and certificates except:

A. Variable life insurance;

B. Individual and group annuity contracts;

C. Credit life insurance;

D. Group or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative;

(2) Some portion of the premium is paid by the group or through payroll deduction; and

(3) Group underwriting or simplified underwriting is used; or

E. Policies and certificates where an illustration has been provided pursuant to the requirements of [insert reference to state equivalent to the Life Insurance Illustrations Model Regulation].

Section 4. Disclosure Requirements

A. An insurer issuing a small face amount policy, where over the term of the policy the cumulative policy premiums paid may exceed the face amount of the policy, shall clearly and prominently disclose, on or before policy delivery, the length of time until the cumulative policy premiums paid may exceed the face amount of the policy.

B. If an insurer is required to provide a disclosure under Subsection A of this section, the insurer shall clearly and prominently disclose, on or before policy delivery, available premium payment plan and product alternatives. If no alternatives exist, the insurer shall clearly and prominently disclose that there are no such alternatives.

C. Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

Drafting Note: This disclosure assumes that a state has a free-look period requirement that allows a consumer to examine and cancel without penalty a policy for at least ten days following policy delivery. If a state does not have such a requirement applicable to all small face policies that may be subject to the disclosure requirement in this model act, the state should add the following language to the legislation containing this disclosure model:

D. Each policy subject to the disclosure requirements of this section shall contain a provision that allows the policyholder to cancel the policy within ten (10) days following the delivery of the policy with full premium refund to the consumer and with no charge or penalty. The free-look period shall be clearly and prominently disclosed to the consumer.

Section 5. Insurer Duties

The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement.

Section 6. Effective Date

This Act shall become effective [insert date] and shall apply to insurance policies and certificates issued on or after the effective date.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2001 Proc. 4th Quarter 6, 14, 164, 186, 187-188 (adopted).
2005 Proc. 2nd Quarter 338 (amendments adopted by parent committee).
2005 Proc. 3rd Quarter 26, 30-32 (reprinted, adopted by Plenary).

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT

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DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. § 33-26-6.2 (1960/2002) (may not collect premiums exceeding 150% of face value).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. §§ 191-15.51 to 191-15.55 (2003).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NEV. ADMIN. CODE § 688A.300 (2003); § 688B.100 (2003).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-60-90 to 58-60-105 (2005).		

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. ADMIN. CODE § 284-23-550 (1989) (may not sell small policies where face amount is exceeded by premium as specified).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2005

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT (#605)

1. Description of the Project, Issues Addressed, etc.

In 2002 the NAIC adopted this model to address concerns that consumers did not understand the possibility that they might pay more in premiums than the face amount of the life insurance policy that had been purchased. The working group that drafted the disclosure model considered how they might do more: could a way be found so that the premiums would not exceed the face amount? The working group was not able to fulfill its charge because it could not come to consensus on other approaches to this issue.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2004 chair of the A Committee appointed a study group to make a recommendation to the entire Committee. That small group consisted of former Iowa Insurance Commissioner Terri Vaughan, Commissioner Walter Bell (AL), Commissioner Tim Wagner (NE), Rich Robleto (FL) and Commissioner Jim Poolman (ND) representing the insurance regulators, Stacey Boyer (Monumental Life), Sharon Roberson (American General), Jerry Krauss (Investors Life), Rob Hardy (Investors Life), and Rick Campbell (Mitchell Williams Law Firm) representing the small face amount industry and Birny Birnbaum (Center for Economic Justice) representing consumer interests.

3. Project Authorized by What Charge and Date First Given to the Group

The first charge to review small face amount life insurance issues was given to the Life Insurance and Annuities (A) Committee in 2000. The charge was continued each year, as consensus had not yet been reached. The 2005 charge was: Complete a regulatory analysis of the small face amount (less than $15,000 face value) life insurance business, in all its various distribution forms, with an emphasis in this analysis on the overriding goal of fair policyholder treatment, not only in terms of market conduct, such as appropriate disclosures and sales of multiple policies, but also addressing the issue of fair value for the premiums paid and any other related issues.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The study group looked at all aspects of the problem; no possible solutions were off the table. The group looked at caps on premiums, rates, disclosure, and more. The solution settled upon by the group was to recommend changes to the Disclosure for Small Face Amount Life Insurance Policies Model Act to strengthen the disclosure, to require disclosure of alternative products if they existed, and to be sure that every small face amount policy was subject to a free look period. The draft prepared was circulated to the Life Insurance and Annuities (A) Committee for comment and discussion.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The proposed draft was distributed to interested parties and posted on the NAIC website. At the 2005 Summer National Meeting a hearing was held to solicit comment on the proposed revisions to the Disclosure for Small Face Amount Life Insurance Policies Model Act. Representatives from the life insurance industry and consumer advocates testified in support of the amendments.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was consensus on the proposed changes.

PROJECT HISTORY - 2001

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES MODEL ACT (#605)

1. Project Description

One of the problems identified in the sale of small face amount life insurance policies is that consumers often do not understand that the premiums on the policy may exceed the face amount of the policy. The consumer is better able to make an informed decision with more information.

2. Group Responsible for Drafting Model and States Participating

The Small Face Amount Working Group developed the model. The members of that working group are, South Carolina, Chair, Arkansas, Co-Chair, Alabama, California, Delaware, District of Columbia, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New York, North Carolina, Ohio, Oklahoma, Texas, Utah, and Virginia.

3. Charge Authorizing Project

The charge to the Small Face Amount (A) Working Group was, "to complete a regulatory analysis of the small face amount (less than $15,000 face value) life insurance business, in all its various distribution forms, with an emphasis in this analysis on the overriding goal of fair policyholder treatment, not only in terms of market conduct, such as appropriate disclosures and sales of multiple policies, but also addressing the issue of fair value for the premiums paid and any other related issues." The model regulation is the first step in fulfilling this charge.

4. General Description of Drafting Process

The Small Face Amount Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group received and reviewed numerous comments from interested parties on each draft of the model, which was posted on the NAIC website and attached to the minutes of the meetings.

5. Significant Issues Raised

The most significant issues raised and discussed by the working group and interested parties included whether to make the disclosure specific to each policy or whether to provide a generic disclosure. While the working group would have liked a specific disclosure, they were unwilling to mandate what could be a very costly requirement. In addition, there were lengthy discussions about whether to make the disclosure apply to new policies only or whether to require companies also to send the disclosure to their existing policyholders. The group ultimately decided against the second approach because of the concern that policyholders might lapse policies they had paid premiums on for many years.

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

Table of Contents

Section 1. Purpose and Scope

A. The purpose of this regulation is:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.

(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

(a) Assure that purchasers receive information with which a decision can be made in his or her own best interest;

(b) Reduce the opportunity for misrepresentation and incomplete disclosure; and

(c) Establish penalties for failure to comply with requirements of this regulation.

B. Unless otherwise specifically included, this regulation shall not apply to transactions involving:

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of Section 7;

(3) Group life insurance and annuities used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) (a) Policies or contracts used to fund (i) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (ii) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer; (iii) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(b) Notwithstanding Subparagraph (a), this regulation shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(7) Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five (5) years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this regulation; or

(10) Structured settlements.

C. Registered contracts shall be exempt from the requirements of Sections 5A(2) and 6B with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

Section 2. Definitions

A. "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

B. "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

C. "Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

D. "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it will be deemed *prima facie* evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This *prima facie* standard is not intended to increase or decrease the monitoring obligations contained in Section 4A(5) of this regulation.

E. "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in [insert reference to state law equivalent to the NAIC Life Insurance Illustrations Model Regulation].

F. "Policy summary," for the purposes of this regulation;

(1) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan.

(2) For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

G. "Producer," for the purpose of this regulation, shall be defined to include agents, brokers and producers.

H. "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

I. "Registered contract" means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered contracts include, but are not limited to, contingent deferred annuities.

J. "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

K. "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

Section 3. Duties of Producers

A. A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no," the producer's duties with respect to replacement are complete.

B. If the applicant answered "yes" to the question regarding existing coverage referred to in Subsection A, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the commissioner. However, no approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant.

C. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

D. In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

E. Except as provided in Section 5C, in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 4. Duties of Insurers that Use Producers

Each insurer shall:

A. Maintain a system of supervision and control to ensure compliance with the requirements of this regulation that shall include at least the following:

(1) Inform its producers of the requirements of this regulation and incorporate the requirements of this regulation into all relevant producer training manuals prepared by the insurer;

(2) Provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(3) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Paragraph (2) above;

(4) Procedures to confirm that the requirements of this regulation have been met; and

(5) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance with this regulation may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

B. Have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Insurance Department. The capacity to monitor shall include the ability to produce records for each producer's:

(1) Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(2) Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(3) Annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(4) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Subsection A(5) of this section; and

(5) Replacements, indexed by replacing producer and existing insurer;

C. Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

D. Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in Appendix A;

E. When the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material required by Section 3E, the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five (5) years after the termination or expiration of the proposed policy or contract;

F. Ascertain that the sales material and illustrations required by Section 3E of this regulation meet the requirements of this regulation and are complete and accurate for the proposed policy or contract;

G. If an application does not meet the requirements of this regulation, notify the producer and applicant and fulfill the outstanding requirements; and

H. Maintains records in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Section 5. Duties of Replacing Insurers that Use Producers

A. Where a replacement is involved in the transaction, the replacing insurer shall:

(1) Verify that the required forms are received and are in compliance with this regulation;

(2) Notify any other existing insurer that may be affected by the proposed replacement within five (5) business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five (5) business days of a request from an existing insurer;

(3) Be able to produce copies of the notification regarding replacement required in Section 3B, indexed by producer, for at least five (5) years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(4) Provide to the policy or contract owner notice of the right to return the policy or contract within thirty (30) days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract; such notice may be included in Appendix A or C.

B. In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases, the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

C. If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to Section 3E, the insurer may:

(1) Require with each application a statement signed by the producer that:

(a) Represents that the producer used only company-approved sales material; and

(b) States that copies of all sales material were left with the applicant in accordance with Section 3D; and

(2) Within ten (10) days of the issuance of the policy or contract:

(a) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with Section 3D;

(b) Provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(c) Stress the importance of retaining copies of the sales material for future reference; and

(3) Be able to produce a copy of the letter or other verification in the policy file for at least five (5) years after the termination or expiration of the policy or contract.

Section 6. Duties of the Existing Insurer

Where a replacement is involved in the transaction, the existing insurer shall:

A. Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five (5) years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

B. Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five (5) business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five (5) business days of receipt of the request from the policy or contract owner.

C. Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

Section 7. Duties of Insurers with Respect to Direct Response Solicitations

A. In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in Appendix B, or other substantially similar form approved by the commissioner.

B. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) Provide to applicants or prospective applicants with the policy or contract a notice, as described in Appendix C, or other substantially similar form approved by the commissioner. In these instances the insurer may delete the references to the producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(2) Comply with the requirements of Section 5A(2), if the applicant furnishes the names of the existing insurers, and the requirements of Sections 5A(3), 5A(4) and 5B.

Section 8. Violations and Penalties

A. Any failure to comply with this regulation shall be considered a violation of [cite twisting section of state's unfair trade practices act]. Examples of violations include:

(1) Any deceptive or misleading information set forth in sales material;

(2) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) The intentional incorrect recording of an answer;

(4) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

B. Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed *prima facie* evidence of the producer's intent to violate this regulation.

C. Where it is determined that the requirements of this regulation have not been met the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in Appendix A or C.

D. Violations of this regulation shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred. In addition, where the commissioner has determined that the violations were material to the sale, the insurer may be required to make restitution, restore policy or contract values and pay interest at [insert reference to a rate set by an applicable statute or regulation] on the amount refunded in cash.

Drafting Note: States should consider whether they have the authority to adopt the provisions of Subsection D.

Section 9. Severability

If any section or portion of a section of this regulation, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this regulation, or the applicability of its provisions to other persons, shall not be affected.

Section 10. Effective Date

This regulation shall be effective [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 301, 345-350, 379 (adopted).
1972 Proc. I 15, 16, 555, 606-607 (amended).
1979 Proc. I 44, 47, 373, 554-555, 557-569 (revised and reprinted).
1984 Proc. II 9, 19-20, 502, 502-506 (amended, renamed and reprinted).
1998 Proc. 2nd Quarter 10-11, 13, 654, 725, 726-735 (replaced with new regulation).
2000 Proc. 1st Quarter 9, 27, 59, 138-147 (amended and reprinted).
2006 Proc. 2nd Quarter 39, 51-54, 321 (amended).
2015 Proc. 1st Quarter, Vol. I 117-118, 131-134, 328, 344-350 (amended).
Fall 2021 (technical edit).

APPENDIX A

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

Life Insurance and Annuities Replacement Model Regulation

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

APPENDIX B

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

APPENDIX C

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
   ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

***Model Adoption refers to the 2000 version of the model. States that have citations identified in the Model Adoption column have laws substantially similar to the NAIC's 2000 version of the model regulation.**

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-133-.01 to 482-1-133-.11 (2005/2008).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.790 to 26.819 (2008) (portions of model).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1241 to 20-1241.09 (2003/2010); ARIZ. ADMIN. CODE § 20-6-212 (1983/2007) (adopted NAIC replacement forms by reference).		
Arkansas	054.00.97 ARK. CODE R. §§ 1 to 11; Apps. A to C (2010).		ARK. CODE ANN. § 23-66-307 (1987/2009); BULLETIN 8-2004 (2004); BULLETIN 8-2009 (2009); BULLETIN 1-2010 (2010).
California		CAL. INS. CODE §§ 10509 to 10509.9 (1990/2017).	
Colorado	3 COLO. CODE REGS. §§ 702-4:4-1-4; Apps. A to C (1972/2019).		

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut	CONN. AGENCIES REGS. §§ 38A-435-1 to 435-8 (2013).		
Delaware		DEL. CODE REGS. tit. 18, § 1204 (1984/2003).	
District of Columbia	NO CURRENT ACTIVITY		
Florida		FLA. ADMIN. CODE ANN. r. §§ 69B-151.001 to 69B-151.202 (1981/2018).	MEMORANDUM 2010-007 (2010).
Georgia		GA. COMP. R. & REGS. 120-2-24 (1972/2007.	
Guam	NO CURRENT ACTIVITY		
Hawaii	HAWAII. REV. STAT. §§ 431:10D-501 to 431:10D-509 (2001/2008).		
Idaho		IDAHO ADMIN. CODE r.18.01.41 (1983/1993).	
Illinois		ILL. ADMIN. CODE tit. 50, §§ 917.20 to 917.110 (1970/2002).	
Indiana		760 IND. ADMIN. CODE 1-16.1-1 to 1-16.1-13.5 (2007/2013).	
Iowa	IOWA ADMIN. CODE r. 191-16.21 to 191-16.30 (1983/2002).	BULLETIN 2009-4 (2009).	
Kansas		KAN. ADMIN. REGS. § 40-2-12 (1971/1993).	
Kentucky	806 KY. ADMIN. REGS. 12:080 (1983/2005).	KY. REV. STAT. ANN. § 304.12-030 (1970/2010).	ADVISORY OPINION 2014-2 (2014).
Louisiana	LA. ADMIN. CODE §§ 37:XIII.8901 to 37:XIII.8925 (Regulation 70) (2000/2002).		
Maine	02-031 ME. CODE R. ch. 919, §§ 1 to 10 (2007).		

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland	MD. CODE REGS. 31.09.05.01 to 31.09.05.12 (1962/2018).		
Massachusetts		211 MASS. CODE REGS. 34.01 to 34.09 (1987).	
Michigan		MICH. ADMIN. CODE r. 500.601 to 500.606 (1971/1984).	
Minnesota		MINN. STAT. §§ 61A.53 to 61A.60 (1996/2009) (different replacement notice).	
Mississippi	19-2:14 MISS. CODE R. § 01-13 (2012).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-5.400 (1979/2016) (includes 2015 amendment).		
Montana	MONT. ADMIN. R. 6.6.301 to 6.6.313 (1978/2017).		MONT. ADMIN. R. 33-20-105 (1959/2005).
Nebraska	210 NEB. CODE R. § 19 (1984/2008).		BULLETIN CB-56 (Amended #2) (2010).
Nevada		NEV. ADMIN. CODE §§ 686A.510 to 686A.577 (1980/2006).	BULLETIN 2008-007 (2008).
New Hampshire	N.H. CODE R. INS. 302.01 to 302.10; Apps. A to C (2001/2017).		
New Jersey	N.J. ADMIN. CODE §§ 11:4-2.1 to 11:4-2.9; Apps. A to C (1972/2019).		
New Mexico	N.M. CODE R. §§ 13.9.6.1 to 13.9.6.16 (1997/2016).		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 51.1 to 51.8; Apps. 10A, 10B, 10C and 11 (Regulation 60) (1998/2015); GEN. COUNSEL OPINION 5-30-2006 (2006).

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	11 N.C. ADMIN. CODE 12.0601 to 12.0612 (1985/2004).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-6-05 (1983/2019).		
Oklahoma			OKLA. STAT. ANN. tit. 36, §§ 4031 to 4038 (1983/1984).
Oregon	OR. ADMIN. R. 836-80-0001 to 836-80-0043 (1968/2008).		
Pennsylvania		31 PA. CODE §§ 81.1 to 81.9; Apps. A to B (1986).	40 PA. STAT. ANN. § 625-9 (1921/1996).
Puerto Rico			P.R. RULE XLII (1957).
Rhode Island	230 R.I. CODE R. §§ 20-25-4.1 to 20-25-4.11 (2018) (includes 2015 amendment).		
South Carolina	S.C. CODE ANN. REGS. 69-12.1 (1986/2009).		
South Dakota		S.D. ADMIN. R. 20:06:08:49 to 20:06:08:65 (1989/2012).	
Tennessee		TENN. COMP. R. & REGS. 0780-1-24 (1985).	
Texas		TEX. INS. CODE ANN. §§ 1114.001 to 1114.007 (2007/2011).	28 TEX. ADMIN. CODE §§ 3.9501 to 3.9506 (2007) (notice).
Utah	UTAH ADMIN. CODE r. 590-93-1 to 590-93-12 (1984/2013).		
Vermont	VT. ADMIN. CODE §§ 4-3-43:1 to 4-3-43:10 (Regulation I-2001-03); Apps. A to C (1989/2002).		

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-30-10 to 5-30-90 (1982/2008).		
Washington		WASH. ADMIN. CODE 284-23-400 to 284-23-485 (1980/2010).	
West Virginia	W. VA. CODE R. §§ 114-8-1 to 114-8-9; Apps. A to C (1970/2008).		
Wisconsin	WIS. ADMIN. CODE INS. § 2.07 (1972/2009).		BULLETIN 9-29-2009 (2009).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2015

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION (#613)

1. Description of the Project, Issues Addressed, etc.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Deleting the reference to "variable" in the definition of "registered contract" so that it reads "an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933" and adding a drafting note stating that registered contracts include, but are not limited to, CDAs.

2. Name of Group Responsible for Drafting the Model and States Participating

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Ted Nickel, Chair	Wisconsin	Roger A. Sevigny/Keith Nyhan	New Hampshire
Robert Chester	Connecticut	Joseph Torti III/Elizabeth Dwyer	Rhode Island
Jim Mumford	Iowa	Michael Humphreys	Tennessee
Jason Lapham	Kansas	Tomasz Serbinowski	Utah
Bruce R. Ramge	Nebraska		

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions to the *Life Insurance and Annuities Replacement Model Regulation* (#613) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 Spring National Meeting until adopting the revisions at the 2014 Fall National Meeting.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

There were concerns that using the term "CDAs" when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and using a drafting note to clarify that the terms are intended to include CDAs.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

PROJECT HISTORY - 2006

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION (#613)

1. Description of the project, issues addressed, etc.

This model regulation was amended to add an exemption from the model's replacement requirements for term life conversions between affiliated companies.

2. Name of group responsible for draft the model:

Inter-Affiliate Term Conversion Working Group of the Life Insurance and Annuities (A) Committee

States Participating:

Arkansas, Chair
Iowa
Kansas
New Mexico
North Dakota

3. Project authorized by what charge and date first given to the group:

The following charge was given in 2006:

Review the Life Insurance and Annuities Replacement Model Regulation in regard to term conversions between affiliated companies.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the working group. Numerous interested parties participated, including industry representatives, such as MetLife, the American Council of Life Insurers (ACLI), Prudential Financial, State Farm, and Ameriprise; and funded consumer representatives, such as the Center For Economic Justice, University of Georgia and The University of Texas at Austin.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There were two drafts of the proposed revisions. Each draft was circulated for comment to interested parties. In addition, all drafts were posted on the NAIC website. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the working group.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

One issue arose during the drafting process. That issue concerned the scope of the proposed revisions. Consumer representatives were concerned that the initial language for the proposed revisions was not sufficiently clear to ensure that the proposed revisions only applied in situations involving a term life policy. To address this concern, the working group agreed to revise the language in the first draft of the proposed revisions to clearly state that it applied to term conversions.

7. Any other important information (e.g., amending an accreditation standard).

None.

LIFE INSURANCE MULTIPLE POLICY MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to set forth guidelines for insurers to utilize to search for additional policies or insurance coverages on the life of an insured upon notification of death of the insured.

Section 2. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

Section 3. Exemptions

Companies selling group life insurance policies or credit life insurance policies for which the company does not maintain records of the certificate holders shall be exempt from the requirements of this regulation.

Section 4. Duties of Insurers

A. Upon submission of a death claim form pursuant to an insurance contract, insurers shall conduct a reasonable search for other policies on the decedent's life.

B. The company shall investigate additional policy files identified by the search, for which liability is not immediately verified, and complete a determination of liability no later than six (6) months following the claim filing date.

C. Where such other policies exist, the insurer shall notify the policy owner (if different than the insured) and the beneficiary and arrange for payment pursuant to the policies.

D. Insurers shall adopt a written claim processing standard and methodology that will allow the company to process a death or endowment or other claim being presented against a life insurance or accidental death or dismemberment policy;

E. The company, as a part of their claim processing standard and methodology, shall inquire for every claim filed with the company for death benefits about other names by which the insured may have been known, such as maiden name, hyphenated name, nickname, derivative form of first and middle name or an alias. If the filer of the claim form includes such additional name information on the claim form or if the company otherwise knows about other names by which the insured may have been known, the company shall include this information as a part of its search criterion to determine whether additional policies exist.

F. Claim records shall be maintained that demonstrate that the insurer has followed the written claim processing standard and methodology required by this section.

Section 5. Severability

If any section, term or provision of this regulation shall be judged invalid for any reason, that judgment shall not affect, impair or invalidate any other section, term or provision of this regulation, and the remaining sections, terms and provisions shall be and remain in full force and effect.

Section 6. Effective Date

This regulation shall become effective [insert date] and shall apply to claims for life insurance policies that may provide death, endowment, maturity or other benefits due to the death of the named insured, or endowment of an existing policy or any accidental death and dismemberment policies that would provide additional death benefits submitted on or after the effective date.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2003 Proc. 1st Quarter 113, 115-116, 136-137 (adopted).
2003 Proc. 2nd Quarter 12, 15 (adopted by Plenary).

LIFE INSURANCE MULTIPLE POLICY MODEL REGULATION

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LIFE INSURANCE MULTIPLE POLICY MODEL REGULATION

STATE PAGE KEY:

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-124-.04 (2003).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		

LIFE INSURANCE MULTIPLE POLICY MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Illinois			ILL. ADMIN. CODE tit. 50, § 919.50 (1974/2004).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NEV. ADMIN. CODE §§ 688A.250 to 688A.260 (2003); §§ 688B.050 to 688B.060 (2003.		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		

LIFE INSURANCE MULTIPLE POLICY MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2003

LIFE INSURANCE MULTIPLE POLICIES MODEL REGULATION (#615)

1. Project Description

The charge resulted from a issue that came to light during market conduct examinations conducted as part of the race-based premium problems. It appeared that many of the companies examined did not have adequate provisions in place to detect multiple policies on the same insured.

2. Group Responsible for Drafting Model and States Participating

The Small Face Amount Working Group was given a charge to study the issue. The current members of the working group are: Robert Wooley, Chair/Ron Musser (Louisiana); Mike Pickens, Vice Chair/John Hartnedy (Arkansas); Michael Bownes (Alabama); Sheldon Summers (California); Donna Lee Williams/Darryl Reese (Delaware); Philip Barlow (District of Columbia); Richard Robleto (Florida); Jane Simpson and Margeret Witten (Georgia); Ken Skiera (Illinois); Roger Strauss (Iowa); Brian Staples (Kentucky); John Sullivan (Michigan); Joe Hartley (Mississippi); Scott Lakin/Cindy Amann (Missouri); Greg Serio/Gail Keren (New York); Jim Long/Louis Belo (North Carolina); John Pouliot/Melissa Hull (Ohio); Carroll Fisher/Frank Stone (Oklahoma) Ernst Csiszar/Leslie Jones (South Carolina) Jose Montemayor/Mike Boerner/Bill Goodman (Texas); Merwin Stewart (Utah); and Jackie Cunningham (Virginia).

3. Charge Authorizing Project

The working group's charge reads: Complete a regulatory analysis of the small face amount (less than $15,000 face value) life insurance business, in all its various distribution forms, with an emphasis in this analysis on **the overriding goal of fair policyholder treatment, not only in terms of market conduct, such as appropriate disclosures and sales of multiple policies**, but also addressing the issue of fair value for the premiums paid and any other related issues. Consider for all policies the obligation of insurers to find multiple policies on one person when a claim has been filed.

4. General Description of Drafting Process

The issue was discussed extensively while Illinois was drafting its regulation and the working group heard a considerable number of comments on the issue. After the working group prepared its own draft, it was discussed during a conference call and at two national meetings and copies were available at the meetings and on the NAIC website. The working group received a number of comments.

5. Significant Issues Raised

The major point of contention was whether the working group should prescribe a "safe harbor" method of searching for multiple policies, similar to the method included in the newly adopted Illinois regulation, or whether it was sufficient to require the insurer to do a search. Since the accuracy of the company's searches would have to be reviewed by market conduct examiners to determine how effective its method was, the working group chose the approach of requiring a search without the specifics and forwarding the details on to the Market Conduct Examination Monitoring and Handbook Working Group of the Market Regulation (D) Task Force for its consideration and analysis.

ACCELERATED BENEFITS MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to regulate accelerated benefit provisions of individual and group life insurance policies and to provide required standards of disclosure. This regulation shall apply to all accelerated benefits provisions of individual and group life insurance policies except those subject to the Long-Term Care Insurance Model Act, issued or delivered in this state, on or after the effective date of this regulation.

Section 2. Definitions

A. "Accelerated benefits" covered under this regulation are benefits payable under a life insurance contract:

(1) To a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and

(2) That reduce the death benefit otherwise payable under the life insurance contract; and

(3) That are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

B. "Qualifying event" means one or more of the following:

(1) A medical condition that would result in a drastically limited life span as specified in the contract, for example, twenty-four (24) months or less;

(2) A medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die;

(3) A condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life;

(4) A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

(a) Coronary artery disease resulting in an acute infarction or requiring surgery;

(b) Permanent neurological deficit resulting from cerebral vascular accident;

(c) End stage renal failure;

(d) Acquired Immune Deficiency Syndrome; or

(e) Other medical conditions that the commissioner shall approve for any particular filing; or

(5) Other qualifying events that the commissioner shall approve for a particular filing.

Section 3. Type of Product

Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to [insert sections referencing life insurance provisions].

Section 4. Assignee/Beneficiary

Prior to the payment of the accelerated benefit, the insurer is required to obtain from an assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no acknowledgement is required.

Section 5. Criteria for Payment

A. Lump Sum Settlement Option Required. Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

B. Restrictions on Use of Proceeds. No restrictions are permitted on the use of the proceeds.

C. Accidental Death Benefit Provision. If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

Section 6. Disclosures

A. Descriptive Title. The terminology "accelerated benefit" shall be included in the descriptive title. Products regulated under this regulation shall not be described or marketed as long-term care insurance or as providing long-term care benefits.

B. Tax Consequences. A disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

C. Solicitations.

(1) A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to the company within the free look period.

Drafting Note: States may wish to consider a 30-day free look period for direct response solicitation.

(c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(2) If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.

(c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(3) Disclosure of Premium Charge.

(a) An insurer with financing options other than as described in Section 10A(2) and (3) of this regulation shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any additional premium or cost of insurance charge if the certificateholder is required to pay a charge.

(b) An insurer shall furnish an actuarial demonstration to the state insurance department when filing the product disclosing the method of arriving at its cost for the accelerated benefit.

(4) Disclosure of Administrative Expense Charge. The insurer shall disclose to the policyowner any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any administrative expense charge if the certificateholder is required to pay the charge.

D. Effect of the Benefit Payment. When a policyowner or certificateholder requests an acceleration, the insurer shall send a statement to the policyowner or certificateholder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policyowner or certificateholder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificateholder under a group policy to reflect any new, reduced in-force face amount of the contract.

Section 7. Effective Date of the Accelerated Benefits

The accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than thirty (30) days following the effective date of the policy or rider.

Section 8. Waiver of Premiums

The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

Section 9. Discrimination

An insurer shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. An insurer shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

Section 10. Actuarial Standards

A. Financing Options

(1) The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. This charge shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.

(2) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

(a) The current yield on ninety-day treasury bills; or

(b) The current maximum statutory adjustable policy loan interest rate.

(3) The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

(a) The current yield on ninety-day treasury bills; or

(b) The current maximum statutory adjustable policy loan interest rate.

The interest rate accrued on the portion of the lien that is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

B. Effect on Cash Value.

(1) Except as provided in Paragraph (2), when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

(2) Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans could also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

C. Effect of Any Outstanding Policy Loans on Accelerated Death Benefit Payment. When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

Section 11. Actuarial Disclosure and Reserves

A. Actuarial Memorandum. A qualified actuary should describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each state filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

B. Reserves

(1) When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a Member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the National Association of Insurance Commissioners (NAIC) may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:

(a) Policies upon which no claim has yet arisen; and

(b) Policies upon which an accelerated claim has arisen.

(2) For policies and certificates that provide actuarially equivalent benefits, no additional reserves need to be established.

(3) Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For a policy on which the policy lien exceeds the policy's statutory reserve liability, the excess shall be held as a non-admitted asset.

Section 12. Filing Requirement [Optional]

The filing [and prior approval] of forms containing an accelerated benefit is required.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1990 Proc. I 6, 27, 442, 444-446 (adopted as a guideline).
1991 Proc. I 9, 17, 539-540, 542-543, 544-548 (amended and reprinted as a regulation).

ACCELERATED BENEFITS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ACCELERATED BENEFITS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 113 (1997).		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1136 (1990).
Arkansas	CODE ARK. R. 054.00.60 (1994).		
California			CAL. INS. CODE §§ 10295 to 10295.19 (2013/2014).
Colorado			COLO. REV. STAT. § 10-7-113 (1989/1990).
Connecticut	CONN. GEN. STAT. § 38a-457 (1990/2011); CONN. AGENCIES REGS. §§ 38a-457 (1992/2013).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	BULLETIN 4-13-95 (1995) (adopted by reference).		
Florida	NO CURRENT ACTIVITY		

ACCELERATED BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/4 (1937/1989); ILL. ADMIN. CODE tit. 50, §§ 1407.20 to 1407.70 (1990/2000).
Indiana	760 IND. ADMIN. CODE 1-48 (1993/1995).		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. ADMIN. REGS. § 40-2-20 (1991/2015).		KAN. STAT. ANN. § 40-401 (1927/2013).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.1501 to XIII.1523 (Regulation 44) (1992).		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2555 (1989/1999).
Maryland	NO CURRENT ACTIVITY		
Massachusetts			211 MASS. CODE REGS. §§ 55.01 to 55.110 (1991/2005).
Michigan	MICH. COMP. LAWS § 500.603 (2003).		
Minnesota			MINN. STAT. § 61A.072 (1989/2003).
Mississippi	MISS. CODE ANN. §§ 83-7-101 to 83-7-119 (1991).		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		

ACCELERATED BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. ADMIN. CODE §§ 11:4-30.1 to 11:4-30.13 (1995/2003).
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAW § 3230 (1991/2014); § 3201 (1991/2014) (authority to adopt regulation); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 41.1 to 41.9 (Regulation 143) (1992/2006).
North Carolina	11 N.C. ADMIN. CODE 12.1201 to 12.1212 (1992).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3915.21 to 3915.24 (1991) (portions of model) (authority to adopt regulation); OHIO ADMIN. CODE 3901-6-06 (1997/2013).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-100 to 365:10-5-110 (1992/2007).		OKLA. STAT. tit. 36, § 702 (1957/1989).
Oregon	OR. REV. STAT. § 743.154 (1991/1993) (portions of model); OR. ADMIN. R. 836-051-0300 to 836-051-0380 (portions of model) (1992/1996).		

ACCELERATED BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 3.4301 to 3.4317 (1989/2008).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-70-10 to 5-70-150 (1992/2002).		
Washington	WASH. ADMIN. CODE 284-23-600 to 284-23-730 (1994/1998).		WASH. ADMIN. CODE 284-23-800 to 284-23-806 (2009).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

TITLE INSURERS MODEL ACT

Drafting Note: This model Act should be adopted concurrently with the Title Insurance Agent Model Act because the Acts contain many complementary provisions and both Acts are required to provide sufficient regulation of title insurance.

Table of Contents

Section 1. Title and Purpose

A. This Act shall be known and may be cited as the [insert state] Title Insurers Act.

B. The purpose of this Act is to provide for the effective regulation and supervision of title insurance and title insurers licensed to write title insurance this state.

Section 2. Application of Act and Construction with Other Laws

A. This Act shall apply to all persons engaged in the business of title insurance in this state.

B. Except as otherwise expressly provided in this Act, and except where the context otherwise requires, all provisions of the insurance code applying to insurance and insurance companies generally shall apply to title insurance and title insurers.

Section 3. Definitions

As used in this Act:

A. "Abstract of title" or "abstract" means a written history, synopsis or summary of the recorded instruments affecting the title to real property.

B. "Affiliate" means a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with the person specified.

C. "Bona fide employee" of the title insurer or title insurance agent means an individual who devotes substantially all of his or her time to performing services on behalf of a title insurer or title insurance agent and whose compensation for those services is in the form of salary or its equivalent paid by the title insurer or title insurance agent.

D. "Commissioner" means the insurance commissioner of [insert name of state], or the commissioner's representatives, or the commissioner, director or superintendent of insurance in any other state.

E. "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. "Direct operations" means that portion of a title insurer's operations which are attributable to business written by a bona fide employee.

G. "Escrow" means written instruments, money or other items deposited by one party with a depository, escrow agent or escrowee for delivery to another party upon the performance of a specified condition or the happening of a certain event.

H. "Escrow, settlement or closing fee" means the consideration for supervising or handling the actual execution, delivery or recording of transfer and lien documents and for disbursing funds.

I. "Foreign title insurer" means any title insurer incorporated or organized under the laws of any other state of the United States, the District of Columbia, or any other jurisdiction of the United States.

J. "Net retained liability" means the total liability retained by a title insurer for a single risk, after taking into account any ceded liability and collateral, acceptable to the commissioner, maintained by the insurer.

K. "Non-U.S. title insurer" means any title insurer incorporated or organized under the laws of any foreign nation or any province or territory.

L. "Person" means any natural person, partnership, association, cooperative, corporation, trust or other legal entity.

M. "Producer" means any person, including any officer, director or owner of five percent (5%) or more of the equity or capital of any person, engaged in this state in the trade, business, occupation or profession of:

(1) Buying or selling interests in real property;

(2) Making loans secured by interests in real property; or

(3) Acting as broker, agent, representative or attorney of a person who buys or sells any interest in real property or who lends or borrows money with the interest as security.

N. "Qualified financial institution" means an institution that is:

(1) Organized or (in the case of a U.S. branch or agency office of a foreign banking organization) licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers;

(2) Regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies;

(3) Insured by the appropriate federal entity; and

(4) Qualified under any additional rules established by the commissioner.

O. "Referral" means the directing or the exercising of any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

P. "Security" or "security deposit" means funds or other property received by the title insurer as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which the insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

Q. "Subsidiary" means an affiliate controlled by a person directly or indirectly through one or more intermediaries.

R. "Title insurance agent" or "agent" means an authorized person, other than a bona fide employee of the title insurer who, on behalf of the title insurer, performs the following acts, in conjunction with the issuance of a title insurance report or policy:

(1) Determines insurability and issues title insurance reports or policies, or both, based upon the performance or review of a search or abstract of title; and

(2) Performs one or more of the following functions:

(a) Collects or disburses premiums, escrow or security deposits or other funds;

(b) Handles escrows, settlements or closings;

(c) Solicits or negotiates title insurance business; or

(d) Records closing documents.

S. "Title insurance business" or "business of title insurance" means:

(1) Issuing as insurer or offering to issue as insurer a title insurance policy;

(2) Transacting or proposing to transact by a title insurer any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(a) Soliciting or negotiating the issuance of a title insurance policy;

(b) Guaranteeing, warranting or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units and proprietary leases and for all liens or charges affecting the same;

(c) Handling of escrows, settlements or closings;

(d) Executing title insurance policies;

(e) Effecting contracts of reinsurance; or

(f) Abstracting, searching or examining titles;

(3) Guaranteeing, warranting or insuring searches or examinations of title to real property or any interest in real property; or

(4) Guaranteeing or warranting the status of title as to ownership of or liens on real property and personal property by any person other than the principals to the transaction; or

(5) Doing or proposing to do any business substantially equivalent to any of the activities listed in this subsection in a manner designed to evade the provisions of this Act.

T. "Title insurance policy" or "policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or any interest in real property, against loss or damage arising from any or all of the following conditions existing on or before the policy date and not excepted or excluded:

(1) Defects in or liens or encumbrances on the insured title;

(2) Unmarketability of the insured title;

(3) Invalidity, lack of priority or unenforceability of liens or encumbrances on the stated property;

(4) Lack of legal right of access to the land; or

(5) Unenforceability of rights in title to the land.

U. "Title insurance report" or "report" means a preliminary report, commitment or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy.

V. "Title insurer" or "insurer" means a company organized under laws of this state for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in this state to transact the business of title insurance.

W. "Title plant" means a set of records consisting of documents, maps, surveys or entries affecting title to real property or any interest in or encumbrance on the property, which have been filed or recorded in the jurisdiction for which the title plant is established or maintained.

Section 4. Corporate Form Required

No person other than a domestic, foreign or non-U.S. title insurer organized on the stock plan and licensed under Section [insert section] of this code as a title insurer shall issue a title insurance policy or otherwise transact the business of title insurance in this state.

Section 5. Authorized Activities of Title Insurers

Subject to the exceptions and restrictions contained in this Act, a title insurer shall have the power to:

A. Do only title insurance business;

B. Reinsure title insurance policies; and

C. Perform ancillary activities, unless prohibited by the commissioner, including, examining titles to real property and any interest in real property and procuring and furnishing related information and information about relevant personal property, when not in contemplation of, or in conjunction with, the issuance of a title insurance policy.

Section 6. Limitations on Powers

A. No insurer that transacts any class, type or kind of business other than title insurance shall be eligible for the issuance or renewal of a license to transact the business of title insurance in this state nor shall title insurance be transacted, underwritten or issued by any insurer transacting or licensed to transact any other class, type or kind of business.

B. A title insurer shall not engage in the business of guaranteeing payment of the principal or the interest of bonds or mortgages.

Drafting Note: States that recognize "mortgage guarantee" as a separate class, type or kind of insurance may not need to include this subsection.

C. (1) Notwithstanding Subsection A of this section, and to the extent such coverage is lawful within this state, a title insurer is expressly authorized to issue closing or settlement protection to a proposed insured upon request if the title insurer issues a preliminary report, binder or title insurance policy. Such closing or settlement protection shall conform to the terms of coverage and form of instrument as required by the commissioner and may indemnify a proposed insured solely against loss of settlement funds only because of the following acts of a title insurer's named title insurance agent:

(a) Theft of settlement funds; and

(b) Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

(2) The Commissioner may promulgate or approve a required charge for providing the coverage.

(3) A title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement, or closing services.

Section 7. Minimum Capital and Surplus Requirements

Before being licensed to do an insurance business in this state, a title insurer shall establish and maintain a minimum paid-in capital of not less than $[insert amount] and, in addition, paid-in initial surplus of at least $[insert amount].

Drafting Note: Each state should insert appropriate amounts, keeping in mind that in most states title insurance is not covered by guaranty funds.

Section 8. Single Risk Limit

A. The net retained liability of a title insurer for a single risk in regard to property, whether assumed directly or as reinsurance, shall not exceed the aggregate of fifty percent (50%) of surplus as regards policyholders plus the statutory premium reserve less the company's investment in title plants, all as shown in the most recent annual statement of the insurer on file with the commissioner.

B. For purposes of this Act:

(1) A single risk shall be the insured amount of any title insurance policy, except that, where two or more title insurance policies are issued simultaneously covering different estates in the same real property, a single risk shall be the sum of the insured amounts of all the title insurance policies; and

(2) A policy under which a claim payment reduces the amount of insurance under one or more other title insurance policies shall be included in computing the single risk sum only to the extent that its amount exceeds the aggregate amount of the policy or policies whose amount of insurance is reduced.

Section 9. Admitted Asset Standards

In determining the financial condition of a title insurer doing business under this Act, the general investment provisions of [insert reference to applicable provision of the insurance code governing authorized investments] shall apply, except that an investment in a title plant or plants in an amount equal to the actual cost shall be allowed as an admitted asset for title insurers. The aggregate amount of the investment shall not exceed the lesser of twenty percent (20%) of admitted assets or forty percent (40%) of surplus to policyholders, as shown on the most recent annual statement of the title insurer on file with the commissioner.

Section 10. Reserves

In determining the financial condition of a title insurer doing business under this Act, the general provisions of the insurance code requiring the establishment of reserves sufficient to cover all known and unknown liabilities including allocated and unallocated loss adjustment expense, shall apply, except that a title insurer shall establish and maintain:

A. A known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches and guaranteed abstracts of title, and all unpaid losses, claims and allocated loss adjustment expenses for which the title insurer may be liable, and for which the insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow or security depositor.

B. A Statutory or Unearned Premium Reserve consisting of:

(1) The amount of statutory or unearned premium reserve required by the laws of the domiciliary state of the insurer if the insurer is a foreign or non-U.S. title insurer; or

(2) If the insurer is a domestic insurer of this state, a statutory or unearned premium reserve consisting of:

(a) The amount of the statutory or unearned premium or reinsurance reserve on the effective date of this Act, which balance shall be released in accordance with the law in effect at the time such sums were added to the reserve; and

(b) Out of total charges for policies of title insurance written or assumed commencing with the effective date of this Act, and until December 31, 1997, a title insurer shall add to and set aside in this reserve an amount equal to [insert amount] of the sum of the following items set forth in the title insurer's most recent annual statement on file with the commissioner:

(i) Direct premiums written;

(ii) Escrow and settlement service fees;

(iii) Other title fees and service charges including fees for closing protection letters; and

(iv) Premiums for reinsurance assumed less premiums for reinsurance ceded during year.

Drafting Note: Most states have a provision for a statutory or unearned premium reserve that was established many years ago. States should consider adopting a revised statutory or unearned premium reserve that more accurately reflects current conditions. When making revisions, please consider the following:

1. It is common for title defects to go undiscovered many years after the issuance of a title insurance policy. The purpose of the statutory or unearned premium reserve is to provide a fund for the payment of these late-reported claims. Additionally, the statutory or unearned premium reserve is intended to provide a reserve for "unallocated" loss adjustment expense on all claims. Unallocated loss adjustment expense consists of company overhead expenses needed to administer open and unreported claims.

2. When establishing statutory or unearned premium reserve requirements for title insurers domiciled in your state, keep in mind that there can be a wide difference among insurers as to the correct reserve requirement. For individual insurers, reserve requirements can change over time due to varying exposure to risk.

3. There is a built-in safety provision in case the statutory or unearned premium reserve is inadequate for a particular insurer. Insurers are required under the Title Insurers Model Act to provide a supplemental reserve, backed up by an actuarial opinion, that will make up for inadequacies. A statutory or unearned premium reserve that is too high may result in an unfair penalty for a domestic title insurer.

(c) Additions to the reserve after January 1, 1998 shall be made out of total charges for title insurance policies and guarantees written, equal to the sum of the following items, as set forth in the title insurer's most recent annual statement on file with the commissioner:

(i) For each title insurance policy on a single risk written or assumed after January 1, 1998, [insert amount] per $1,000 of net retained liability for policies under $500,000 and [insert amount] per $1,000 of net retained liability for policies of $500,000 or greater; and

(ii) [Insert amount] of escrow, settlement and closing fees collected in contemplation of the issuance of title insurance policies or guarantees.

(d) The aggregate of the amounts set aside in this reserve in any calendar year pursuant to Subsections B(2)(b) and B(2)(c) shall be released from the reserve and restored to net profits over a period of twenty (20) years pursuant to the following formula: thirty-five percent (35%) of the aggregate sum on July 1 of the year next succeeding the year of addition; fifteen percent (15%) of the aggregate sum on July 1 of each of the succeeding two (2) years; ten percent (10%) of the aggregate sum on July 1 of the next succeeding year; three percent (3%) of the aggregate sum on July 1 of each of the next three (3) succeeding years; two percent (2%) of the aggregate sum on July 1 of each of the next three (3) succeeding years; and one percent (1%) of the aggregate sum on July 1 of each of the next succeeding ten (10) years.

(e) The insurer shall calculate an adjusted statutory or unearned premium reserve as of the effective date of this Act. The adjusted reserve shall be calculated as if Subsections B(2)(b) through (B(2)(d) of this section had been in effect for all years beginning twenty (20) years prior to the effective date of this Act. For purposes of thiscalculation, the balance of the reserve as of that date shall be deemed to be zero. If the adjusted reserve so calculated exceeds the aggregate amount set aside for statutory or unearned premiums in the insurer's annual statement on file with the commissioner on the effective date of this Act, the insurer shall, out of total charges for policies of title insurance, increase its statutory or unearned premium reserve by an amount equal to one-sixth of that excess in each of the succeeding six years, commencing with the calendar year that includes the effective date of this Act, until the entire excess has been added.

(f) The aggregate of the amounts set aside in this reserve in any calendar year as adjustments to the insurer's statutory or unearned premium reserve pursuant to Subsection B(2)(e) shall be released from the reserve and restored to net profits, or equity if the additions required by Subsection B(2)(e) of this section reduced equity directly, over a period not exceeding ten (10) years pursuant to the following table:

Year of Addition	Release
Year 1*	Equally over 10 years
Year 2	Equally over 9 years
Year 3	Equally over 8 years
Year 4	Equally over 7 years
Year 5	Equally over 6 years
Year 6	Equally over 5 years

* (The calendar year following the effective date of this Act).

C. A supplemental reserve shall be established consisting of any other reserves necessary, when taken in combination with the reserves required by Subsections A and B of this section, to cover the company's liabilities with respect to all losses, claims and loss adjusted expenses.

D. Each title insurer subject to the provisions of this Act shall file with its annual statement required under [insert section] a certification by a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer must conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

E. [Temporary Provision] The supplemental reserve required under Subsection C of this section shall be phased in as follows: twenty-five percent (25%) of the otherwise applicable supplemental reserve will be required until December 31, 1997; fifty percent (50%) of the otherwise applicable supplemental reserve will be required until December 31, 1998; and, seventy-five percent (75%) of the otherwise applicable supplemental reserve will be required until December 31, 1999.

Section 11. Liquidation, Dissolution or Insolvency

A. Section [cite insurance rehabilitation and liquidation law] shall apply to all title insurers subject to the Title Insurance Act, except as otherwise provided in this section. In applying the provisions of [cite state's insurance rehabilitation and liquidation law], the court shall consider the unique aspects of title insurance and shall have broad authority to fashion relief that provides for the maximum protection of the title insurance policyholders.

B. Security and escrow funds held by or on behalf of the title insurer shall not become general assets and shall be administered as secured creditor claims as defined in Section [cite insurance rehabilitation and liquidation law].

C. Title insurance policies that are in force at the time an order of liquidation is entered shall not be canceled except upon a showing to the court of good cause by the liquidator. The determination of good cause shall be within the discretion of the court. In making this determination, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

D. The court may set appropriate dates that potential claimants must file their claims with the liquidator. The court may set different dates for claims based upon the title insurance policy than for all other claims. In setting dates, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

E. As of the date of the order of insolvency or liquidation, all premiums paid, due or to become due under policies of the title insurers, shall be fully earned. It shall be the obligation of agents, insureds or representatives of the title insurer to pay fully earned premium to the liquidator or rehabilitator.

Section 12. Restrictions on Dividends

A title insurer shall only declare or distribute a dividends to shareholders without the prior written approval of the commissioner, as would be permitted under [insert section of insurance code governing extraordinary dividends] for insurers other than life insurers.

Section 13. Diversification Requirement

A. Without the prior written approval of the commissioner, a domestic title insurer shall not accept:

(1) Additional business from a title insurance agent that is not an affiliated company with the insurer if, when added to other business written through the title insurance agent during the same calendar year, that agent's aggregate premiums written on behalf of the title insurer will exceed twenty percent (20%) of the title insurer's gross premiums written during the prior calendar year, as shown on the title insurer's most recent annual statement on file with the commissioner; or

(2) Additional direct operations business from a single source if, when added to other direct operations business from the single source during the same calendar year, the aggregate premiums written on the direct operations business of the single source will exceed twenty percent (20%) of the title insurer's gross premiums written during the prior calendar year as shown on the title insurers most recent annual statement on file with the commissioner. For purposes of this section a "single source" means a person that refers business to the title insurer and any other person that controls, is controlled by, or is under common control with, that person.

B. In determining whether prior approval may be given, the commissioner shall consider:

(1) The potential that the acceptance of more business from the title agent or source may adversely affect the financial solidity of the title insurer;

(2) The availability of competing title agents or additional sources in the territories in which the title insurer accepts risks;

(3) The number of years the title insurer has been in business;

(4) Reinsurance arrangements mitigating the concentration of business from the agent or source;

(5) The comparative profitability of the agent's or source's book of business;

(6) The degree of oversight of the agent's operations exercised by the title insurer; and

(7) Any other circumstances deemed by the commissioner to be appropriate.

Section 14. Direct Operations—Policyholder Treatment

A. When a title insurance report includes an offer to issue an owner's policy covering the resale of owner-occupied residential property, the report shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the report cannot be delivered prior to the day of closing, the title insurer shall document the reasons for the delay. The report furnished to the purchaser-mortgagor shall incorporate the following statement on the first page in bold type:

"Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land."

B. A title insurer issuing a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan, where no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the commissioner, to the purchaser-mortgagor at the time the commitment is prepared. The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage-lender, and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased. The notice shall explain what a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's policy. The notice shall also explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known. A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least five (5) years after the effective date of the policy.

Section 15. Duties of Title Insurers Utilizing the Services of Title Insurance Agents

A. The title insurer shall not accept business from a title insurance agent unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, specifies the division of responsibilities.

Drafting Note: States adopting the companion Title Insurance Agent Model Act may wish to cross reference Section 8 of the agent model which specifies minimum provisions for contracts between title insurers and title insurance agents.

B. For each title insurance agent under contract with the insurer, the title insurer shall have on file a statement of financial condition, of each title insurance agent as of the end of the previous calendar year setting forth an income statement of business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31st certified by the agent as being a true and accurate representation of the agent's financial condition. Attorneys actively engaged in the practice of law, other than that related to title insurance business, are exempt from the requirements of this paragraph.

C. The title insurer shall, at least annually, conduct an on-site review of the underwriting, claims and escrow practices of the agent which shall include a review of the agent's policy blank inventory and processing operations. If the title agent does not maintain separate bank or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title agent.

D. Within thirty (30) days of executing or terminating a contract with a title insurance agent, the title insurer shall provide written notification of the appointment or termination and the reason for termination to the commissioner. Notices of appointment of a title insurance agent shall be made on a form promulgated by the commissioner.

E. A title insurer shall not appoint to its board of directors an officer, director, employee or controlling shareholder of any title insurance agent who wrote one percent (1%) or more of the title insurer's direct premiums written during the previous calendar year as shown on the title insurer's most recent annual statement on file with the commissioner. This subsection shall not apply to relationships governed by [cite state's insurance holding company act.]

F. The title insurer shall maintain an inventory of all policy forms or policy numbers allocated to each title insurance agent.

G. The title insurer shall have on file proof that the title insurance agent is licensed by this state.

H. The title insurer shall establish the underwriting guidelines and, where applicable, limitations on title claims settlement authority to be incorporated into contracts with its title insurance agents.

Drafting Note: States may wish to establish *de minimis* standards for this section.

Section 16. Conditions for Maintaining Escrow and Security Deposit Accounts

A title insurer may operate as an escrow, security, settlement or closing agent, provided that:

A. All funds deposited with the title insurer in connection with any escrow, settlement, closing or security deposit shall be submitted for collection to or deposited in a separate fiduciary trust account or accounts in a qualified financial institution no later than the close of the next business day, in accordance with the following requirements:

(1) The funds shall be the property of the person or persons entitled to them under the provisions of the escrow, settlement, security deposit or closing agreement and shall be segregated for each depository by escrow, settlement, security deposit or closing in the records of the title insurer in a manner that permits the funds to be identified on an individual basis; and

(2) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

B. Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom such funds may be disbursed.

C. Funds held in a security deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions the commissioner may require.

D. Any interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid, net of administrative costs, to the depositing party, unless the instructions for the funds or a governing statute provides otherwise.

E. Disbursements may be made out of an escrow, settlement or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurer or the insurer's depository;

(3) Checks, drafts, negotiable orders of withdrawal, money orders and any other item that has been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Federal Expedited Funds Availability Act, 12 U.S.C. § 4001, et seq.; or

(5) Credit transfers through the Automated Clearing House (ACH) which have been deemed available by the depository institution receiving the credits. The credits must conform to the operating rules set forth by the National Automated Clearing House Association (NACHA).

Drafting Note: States with an existing "good funds" statute should review it to determine if it is sufficient for application to title insurance business. If sufficient, Subsection E should be deleted and a cross-reference to the state good funds statute should be inserted. If the state good funds statute is insufficient, Subsection E should be retained and would be controlling for title insurance transactions.

F. Nothing in this Act shall be deemed to prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction, provided all parties consent to the transaction in writing.

G. Nothing in this Act is intended to amend, alter or supersede other sections of this Act, or the laws of this state or the United States, regarding an escrow holder's duties and obligations.

H. The commissioner may prescribe a standard agreement for escrow, settlement, closing or security deposit funds.

Section 17. Prohibition of Rebate and Fee Splitting

A. A title insurer or other person shall not give or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other service provided by a title insurer.

[Optional Subsection B]

[B. Any title insurer doing business in the same county as a title insurer or title insurance agent who may be in violation of the prohibitions or limitations of this section shall have a cause of action against the violating title insurer or title insurance agent or recipient and, upon establishing the existence of a violation, shall be entitled to injunctive relief as the court may deem necessary or desirable to prevent violations of this section in the future. In any action under this subsection, the court may award to the successful party the court costs of the action together with reasonable attorney fees.**]**

Drafting Note: "County" in the preceding subsection refers to counties, boroughs or parishes defined by the state.

Section 18. Favored Agent of Title Insurer

A title insurer shall not participate in any transaction in which it knows that a producer or other person requires, directly or indirectly, or through any trustee, director, officer, agent, employee or affiliate, as a condition, agreement or understanding to selling or furnishing any other person a loan, or loan extension, credit, sale, property, contract, lease or service, that the other person shall place a title insurance policy of any kind with the title insurer or through a particular title insurance agent.

Section 19. Premium Rate Filings and Standards

A. No title insurer may charge any rates regulated by the state after the effective date of this Act, except in accordance with the premium rate schedule and manual filed with and approved by the commissioner in accordance with applicable statutes and regulations governing rate filings. The commissioner may provide by regulation for interim use of premium rate schedules in effect prior to the effective date of this Act.

B. The commissioner may establish rules, including rules providing statistical plans, for use by all title insurers and title insurance agents in the recording and reporting of revenue, loss and expense experience in such form and detail as is necessary to aid him or her in the establishment of rates and fees.

C. The commissioner may require that the information provided under this section be verified by oath of the insurer's or agent's president or vice president or secretary or actuary, as applicable. The commissioner may further require that the information required under this section be subject to an audit conducted by an independent certified public accountant. The commissioner shall have the authority to establish a minimum threshold level at which an audit would be required.

D. Information filed with the commissioner relating to the experience of a particular agent shall be kept confidential unless the commissioner finds it in the public interest to disclose the information required of title insurers or title insurance agents under this section.

Section 20. Form Filing

A. A title insurer or authorized rate service organization shall not deliver or issue for delivery or permit any of its authorized title insurance agents to deliver in this state, any form, in connection with title insurance written, unless it has been filed with the commissioner and approved by the commissioner or thirty (30) days have elapsed and it has not been disapproved as misleading or violative of public policy.

B. Forms covered by this section shall include:

(1) Title insurance policies, including standard form endorsements; and

(2) Title insurance reports issued prior to the issuance of a title insurance policy.

C. After notice and opportunity to be heard are given to the insurer or rate service organization which submitted a form for approval, the commissioner may withdraw approval of the form on finding that the use of the form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of withdrawal of approval shall not be less than ninety (90) days after notice of withdrawal is given.

D. An approved policy form or endorsement providing coverage for which no identifiable premium is assessed shall be incorporated into every applicable title insurance policy. The insurer shall disclose any additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard of conditions relating to the approved policy forms or endorsements.

E. Any term or condition related to an insurance coverage provided by an approved title insurance policy or any exception to the coverage, except those ascertained from a search and examination of records relating to a title or inspection or survey of a property to be insured, may only be included in the policy after the term, condition or exception has been filed with the commissioner and approved.

Section 21. Filing by Rating Bureaus

A. A title insurer or title insurance agent may satisfy its obligation to file premium rates, rating manuals and forms as required by this Act by becoming a member of, or a subscriber to, a rate service organization, organized and licensed under the provisions of this code, where the organization makes the filings, and by authorizing the commissioner in writing to accept the filings on the insurer's behalf.

B. Nothing in this Act shall be construed as requiring any title insurer or title insurance agent to become a member of, or a subscriber to, any rate service organization. Nothing in this Act shall be construed as prohibiting the filing of deviations from rate service organization filings by any member or subscriber.

Section 22. Record Retention Requirements

Evidence of the examination of title and determination of insurability for business written by a title insurer and records relating to escrow and security deposits shall be preserved and retained by the insurer for as long as appropriate to the circumstances but, in no event, less than [insert amount] years after the title insurance policy has been issued or [insert amount] years after the escrow or security deposit account has been closed. This section shall not apply to a title insurer acting as coinsurer if one of the other coinsurers has complied with this section.

Section 23. Rules and Regulations

The commissioner may issue rules, regulations and orders necessary to carry out the provisions of this Act.

Drafting Note: States may want to consider developing rules and regulations with standards for title plant security and quality of data maintained by title plants.

Section 24. Penalties and Liabilities

A. If the commissioner determines that the title insurer or any other person has violated this Act, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the commissioner may order:

(1) A penalty not exceeding $[insert amount] for each violation; and

(2) Revocation or suspension of the title insurer's license.

B. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance code.

Drafting Note: Each state should consider whether references to regulations or specific statutory chapters should replace "code" in this subsection.

C. Nothing contained in this Act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and creditors.

Section 25. Violations of the Real Estate Settlement Procedures Act (RESPA)

The commissioner or attorney general may bring an action in a court of competent jurisdiction to enjoin violations of RESPA, 12 U.S.C. Section 2607, as amended.

Section 26. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 27. Effective Date

This Act shall be effective on [insert date] and applies to all transactions entered into after the effective date, except that:

A. If the capital and surplus required prior to the effective date of this Act was less than that required by Section 7, a title insurer shall have two (2) years after the effective date of this Act to comply with Section 7; and

B. Section 10 provides for a multi-year compliance period during which requisite reserves must be established.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 4th Quarter 11, 33, 997, 1000-1011 (adopted)

TITLE INSURERS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

TITLE INSURERS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-25-1.1 to 27-25-10 (2001/2012).
Alaska			ALASKA STAT. §§ 21.66.010 to 21.66.480 (1966/2011); ALASKA ADMIN. CODE tit. 3, §§ 27.301 to 27.399 (2000).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1561 to 20-1592 (1967/2004).
Arkansas			ARK. CODE ANN. § 23-62-108 (1959); §§ 23-103-401 to 23-103-417 (2007/2011).
California			CAL. INS. CODE §§ 12340 to 12418.4 (1935/2013); CAL. CODE REGS. tit. 10, §§ 2355.1 to 2355.2 (2007/2012).
Colorado			COLO. REV. STAT. §§ 10-11-101 to 10-11-202 (1963/2013); 3 COLO. CODE REGS. §§ 702-8:8-1-1 to 702-8:8-1-5 (1989/2010); BULLETIN 4-28-2010 (2010); BULLETIN B-5.31 (#2) (2016).

TITLE INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut	CONN. GEN. STAT. §§ 38a-400 to 38a-425 (1990/2013).		TITLE BULLETIN T-4-07 (2007).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	D.C. CODE ANN. §§ 31-5031.01 to 31-5031.24 (2010) (portions of model).		D.C. CODE ANN. §§ 26-1301 to 26-1336 (1901/2004); BULLETIN 12-001-IB (2012).
Florida			FLA. STAT. §§ 627.7711 to 627.798 (1982/2013); § 631.400 (2011); FLA. ADMIN. CODE ANN. r. 69O-186.002 to 69O-186.015 (1974/2016).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:20-101 to 431:20-125 (1988/2006).		
Idaho			IDAHO CODE ANN. §§ 41-2701 to 41-2714 (1961/2010); IDAHO ADMIN. CODE r. 18.05.01.001 to 18.05.01.032 (2009).
Illinois			215 ILL. COMP. STAT. §§ 155/1 to 155/26 (1986/2014); ILL. ADMIN. CODE tit. 50, 8100.100 to 8100.1600 (2009/2011).
Indiana			IND. CODE §§ 27-7-3-1 to 27-7-3-22 (1937/2013).
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. § 40-2404 (1955/2005).
Kentucky			KY. REV. STAT. ANN. §§ 304.22-010 to 304.22-040 (1972).
Louisiana	LA. STAT. ANN. §§ 22:511 to 22:537 (2008).		BULLETIN 3-3-2009 (2009).

TITLE INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine			ME. REV. STAT. ANN. tit. 24-A, § 3201 (1969).
Maryland			MD. CODE ANN., INS. §§ 22-101 to 22-105 (1967/1997); MD. CODE REGS. 31.16.03 (2009).
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 114 to 116A (1884/1939).
Michigan			MICH. COMP. LAWS §§ 500.7300 to 500.7318 (1966).
Minnesota			MINN. STAT. §§ 68A.01 to 68A.04 (1967/2004).
Mississippi			MISS. CODE ANN. §§ 83-15-1 to 83-15-11 (1958/1977).
Missouri			MO. CODE REGS. ANN. tit. 20, §§ 500-7.020 to 500-7.200 (2009).
Montana	MONT. CODE ANN. §§ 33-25-104 to 33-25-403 (1985).		MEMORANDUM 2-27-2014 (2014).
Nebraska	NEB. REV. STAT. §§ 44-1978 to 44-19,105 (1997/2009).		NEB. ADMIN. R. & REGS. tit. 210, ch. 34 (1994/2004); BULLETIN CB-131 (2013).
Nevada			NEV. REV. STAT. §§ 692A.011 to 692A.270 (1977/2007).
New Hampshire			N.H. REV. STAT. ANN. §§ 416-A:1 to 416-A:22 (1971/2009).
New Jersey			N.J. REV. STAT. §§ 17:46B-1 to 17:46B-62 (1975/2004).

TITLE INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico			N.M. STAT. ANN. §§ 59A-30-1 to 59A-30-14 (1985/1989); N.M. CODE R. §§ 13.14.1.1 to 13.14.10.19 (1996/2014); §§ 13.14.16.1 to 13.14.16.19 (1996/2010); §§ 13.14.17.1 to 13.14.19 (1997/2014).
New York			N.Y. INS. LAW §§ 6401 to 6411 (1984).
North Carolina			N.C. GEN. STAT. §§ 58-26-1 to 58-26-45 (1899/2003).
North Dakota			N.D. CENT. CODE §§ 26.1-20-01 to 26.1-20-06 (1984/2015).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3953.01 to 3953.35 (1967/2014).
Oklahoma			OKLA. STAT. tit. 36, §§ 5001 to 5007 (1957/2014); OKLA. ADMIN. CODE §§ 365:20-3-1 to 365:20-3-5 (1987/2014).
Oregon			OR. REV. STAT. §§ 731.438 to 731.439 (1983/2003); OR. ADMIN. R. §§ 836-080-0305 to 836-080-0370 (1980/1996); § 836-031-0410 (2005).
Pennsylvania			40 PA. STAT. ANN. §§ 910-1 to 901-55 (1992).
Puerto Rico			P.R. LAWS ANN. tit.26, §§ 2401 to 2404 (1976).
Rhode Island	27 R.I. GEN. LAWS ANN. §§ 27-2.6-1 to 27-2.6-21 (2010).		NOTICE 5-24-2006 (#1) (2006); BULLETIN 2010-6 (2010).
South Carolina			S.C. CODE ANN. §§ 38-75-905 to 38-75-1010 (1988).

TITLE INSURERS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota			S.D. CODIFIED LAWS §§ 58-25-1 to 58-25-27 (1966/2002).
Tennessee			TENN. CODE ANN. §§ 56-35-101 to 56-35-205 (1955/1985).
Texas			TEX. INS. CODE ANN. §§ 2501.001 to 2751.104 (2007).
Utah			UTAH CODE ANN. § 31A-19a-209 (1985/2013); § 31A-2-404 (2013) (authority to adopt regulations); UTAH ADMIN. CODE r. 592-1-1to 592-11-8 (2009); BULLETIN 2012-1 (2012).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 1151 to 1161 (1968).
Virginia			VA. CODE ANN. §§ 38.2-4600 to 38.2-4616 (1986/2005).
Washington			WASH. REV. CODE ANN. §§ 48.29.005 to 48.29.901 (1947/2005); WASH. ADMIN. CODE 284-29A-100 to 284-29A-180 (2009/2013).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			BULLETIN 6-24-2014 (2014); BULLETIN 4-30-2012 (2012).
Wyoming	WYO. STAT. ANN. §§ 26-23-301 to 26-23-336 (1983/2004).		

MORTGAGE GUARANTY INSURANCE MODEL ACT

Table of Contents

Section 1. Title

This Act may be cited as the Mortgage Guaranty Insurance Act.

Section 2. Definitions

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

A. "Authorized Real Estate Security" means:

(1) An amortized note, bond or other instrument of indebtedness, except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan, not exceeding one hundred three percent (103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:

(a) The real estate loan secured in this manner is one of a type that a creditor, which is supervised and regulated by a department of any state or territory of the U.S or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

(b) The loan is to finance the acquisition, initial construction or refinancing of real estate that is a:

(i) Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or

(ii) Mixed-use building with only one non-residential use and one one-family dwelling unit; or

(iii) Building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes.

(c) The lien on the real estate may be subject to and subordinate to other liens, leases, rights, restrictions, easements, covenants, conditions or regulations of use that do not impair the use of the real estate for its intended purpose.

(2) Notwithstanding the foregoing, a loan referenced in Section 2A(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the mortgage guaranty insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.

(3) An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a), unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.

B. "Bulk Mortgage Guaranty Insurance" means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.

C. "Certificate of Insurance" means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular authorized real estate security under a master policy, identifying the terms, conditions and representations, in addition to those contained in the master policy and endorsements, applicable to such coverage.

D. "Commissioner." The term "commissioner" shall mean the insurance commissioner, the commissioner's deputies, or the Insurance Department, as appropriate.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.

E. "Contingency Reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.

F. "Domiciliary Commissioner" means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled.

G. "Effective Guaranty" refers to the assumed backing of existing or future holders of securities by virtue of their issuer's conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.

H. "Loss" refers to losses and loss adjustment expenses.

I. "Master Policy" means a document issued by a mortgage guaranty insurance company that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.

J. "Mortgage Guaranty Insurance" is insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any authorized real estate security.

K. "Mortgage Guaranty Quality Assurance Program" means an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.

L. "NAIC" means the National Association of Insurance Commissioners.

M. "Pool Mortgage Guaranty Insurance" means mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.

N. "Right of Rescission" represents a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the mortgage guaranty insurance company in connection with the insurance application, resulting in an insured loan that did not meet the mortgage guaranty insurance company's eligibility requirements in effect on the date of submission of the insurance application.

O. "Risk in Force" means the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.

Section 3. Insurer's Authority to Transact Business

A company may not transact the business of mortgage guaranty insurance until it has obtained a certificate of authority from the commissioner.

Section 4. Mortgage Guaranty Insurance as Monoline

A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

Section 5. Risk Concentration

A mortgage guaranty insurance company shall not expose itself to any loss on any one authorized real estate security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

Section 6. Capital and Surplus

A. **Initial and Minimum Capital and Surplus Requirements.** A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance unless, if a stock insurance company, it has paid-in capital of at least $10,000,000 and paid-in surplus of at least $15,000,000, or if a mutual insurance company, a minimum initial surplus of $25,000,000. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders' surplus of at least $20,000,000.

B. **Minimum Capital Requirements Applicability.** A mortgage guaranty insurance company formed prior to the passage of this Act may maintain the amount of capital and surplus or minimum policyholders' surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.

C. **Minimum Capital Requirements Adjustments.** The domiciliary commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders' surplus required under Section 6A under the following circumstances:

(1) For an affiliated reinsurer that is a mortgage guaranty insurance company and that is or will be engaged solely in the assumption of risks from affiliated mortgage guaranty insurance companies, provided that the affiliated reinsurer is in run-off and, in the domiciliary commissioner's opinion,

the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.

(2) For mortgage guaranty insurance companies that are in run-off and not writing new business that is justified in a business plan, in the domiciliary commissioner's opinion.

Section 7. Geographic Concentration

A. A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and contingency reserve.

B. No mortgage guaranty insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the U.S Department of Commerce.

C. The provisions of this section shall not apply to a mortgage guaranty insurance company until it has possessed a certificate of authority in this state for three (3) years.

Section 8. Advertising

No mortgage guaranty insurance company or an agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any advertising media or communication to the effect that the real estate investments of any financial institution are "insured investments," unless the advertising media or communication clearly states that the loans are insured by mortgage guaranty insurance companies possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government.

Section 9. Investment Limitation

Investments in notes or other evidence of indebtedness secured by a mortgage or other liens upon residential real property shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contract of sale are acquired in the course of good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired. This section shall not apply to investments backed by the full faith and credit of the U.S. Government or investments with the effective guaranty of the U.S. Government. This section shall not apply to investments held by a mortgage guaranty insurance company prior to the passage of this Act.

Section 10. Reserve Requirements

A. **Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves.** Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the NAIC.

B. **Contingency Reserve.** Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:

(1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.

(2) Except as provided within this Act, a mortgage guaranty insurance company's contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:

(a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or

(b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the requirements of Section 15 as required in [insert section of the mortgage guaranty Insurance model law requiring minimum policyholder's position] as filed with the most recently filed annual statement.

(i) The mortgage guaranty insurance company's domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

A. **Prohibition of Captive Reinsurance.** A mortgage guaranty insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.

B. **Reinsurance Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the contingency reserve requirement of Section 10. The unearned premium reserve and the loss reserves required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. The cession shall be accounted for as provided in the accounting practices and procedures prescribed or permitted by the applicable Accounting Practices and Procedures Manual of the NAIC.

Section 12. Sound Underwriting Practices

A. **Underwriting Review and Approval Required.** All certificates of mortgage guaranty insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the mortgage guaranty insurance company's underwriting standards.

B. **Quality Control Reviews.** Quality control reviews for bulk mortgage guaranty insurance and pool mortgage guaranty insurance shall be based on a reasonable method of sampling of post-closing loan documentation for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the mortgage guaranty insurance company's underwriting standards.

C. **Minimum Underwriting Standards.** Mortgage guaranty insurance companies shall establish formal underwriting standards which set forth the basis for concluding that prudent underwriting standards have been met.

D. **Underwriting Review and Approval.** A mortgage guaranty insurance company's underwriting standards shall be:

(1) Reviewed and approved by executive management, including, but not limited to the highest-ranking executive officer and financial officer; and

(2) Communicated across the organization to promote consistent business practices with respect to underwriting.

E. **Notification of Changes in Underwriting Standards.** On or before March 1 of each year, a mortgage guaranty insurance company shall file with the domiciliary commissioner changes to its underwriting standards and an analysis of the changes implemented during the course of the immediately preceding year. The annual summary of material underwriting standards changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.

F. **Nondiscrimination.** In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurance company may not discriminate on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.

Drafting Note: States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12F.

Section 13. Quality Assurance

A. **Quality Assurance Program.** A mortgage guaranty insurance company shall establish a formal internal mortgage guaranty quality assurance program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This mortgage guaranty quality assurance program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting inadequacies or non-compliance. This shall include, but not limited to:

(1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit.

(2) **Senior Management Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to an enterprise risk management committee or other equivalent senior management level oversight body.

(3) **Board of Director Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.

(4) **Policy and Procedures Documentation.** Mortgage guaranty quality assurance program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.

(5) **Underwriting Risk Review.** Quality assurance review shall include an examination of underwriting risks including classification of risk and compliance with risk tolerance levels.

(6) **Lender Performance Reviews.** Quality assurance monitoring provisions shall include an assessment of lender performance.

(7) **Underwriting Performance Reviews.** Quality assurance monitoring provisions shall assess compliance with underwriting standard.

(8) **Problem Loan Trend Reviews.** Quality assurance monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.

(9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.

(10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.

(11) **Internal Audit Validation.** Periodic internal audits shall be conducted to validate compliance with the mortgage guaranty quality assurance program.

B. **Regulator Access and Review of Quality Assurance Program.** The commissioner shall be provided access to an insurer's mortgage guaranty quality assurance program for review at any reasonable time upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

Section 14. Policy Forms and Premium Rates Filed

A. **Policy Forms.** Policy forms, endorsements, and modifications (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings or a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default, the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

B. **Premium Rates.** Each mortgage guaranty insurance company (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall file with the commissioner the rate to be charged including all modifications.

C. **Premium Charges.** Every mortgage guaranty insurance company shall make available to insureds the premium charges for mortgage guaranty insurance policies via a company website or an integration with a third-party system. The premium rate provided shall show the entire amount of premium charge for the type of mortgage guaranty insurance policy to be issued by the insurance company.

Drafting Note: Open rating states may delete a portion or all of Section 14 and insert their own rating law.

Section 15. Risk in Force and Waivers

A. **Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five (25) times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total risk in force exceeding twenty-five (25) times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total risk in force no longer exceeds twenty-five (25) times its capital, surplus and contingency reserve. Total risk in force shall be calculated on an individual entity basis.

B. **Waiver.** The commissioner may waive the requirement found in Section 15A at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of Section 15A and shall, at a minimum, address the factors specified in Section 15C.

C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:

(1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.

(4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.

(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.

(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

(7) The adequacy of the mortgage guaranty insurer's reserves.

(8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.

(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.

(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.

(11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist in the review of the mortgage guaranty insurer's request submitted pursuant to Section 15B. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. **Specified Duration.** Any waiver shall be:

(1) For a specified period of time not to exceed two years; and

(2) Subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by Section 15A.

Section 16. Conflict of Interest

A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage

lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the domiciliary commissioner's discretion, based on the domiciliary commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

Section 17. Compensating Balances Prohibited

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences

A. **Inducements.** A mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the authorized real estate security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, lessor, lessee or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

B. **Compensation for Placement.** In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for the value of the insurance itself or claim payments thereon as provided by contract or settlement.

C. **Rebates.** A mortgage guaranty insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section 14C. No mortgage guaranty insurance company shall quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.

D. **Undue Contractual Preferences.**

(1) Any contract, letter agreement, or other arrangement used to clarify any terms, conditions, or interpretations of a master policy or certificate shall be documented in writing.

(2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the mortgage guaranty insurance model act, including mortgage insurer discretion, rights and responsibilities related to:

(a) Underwriting standards.

(b) Quality assurance.

(c) Rescission.

E. **Sanctions.** The commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company, or in his or her discretion, issue a cease and desist order to a mortgage guaranty insurance company that pays a commission, rebate, or makes any unlawful conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a cease and desist order, the commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company that does not comply with the terms thereof.

F. **Educational Efforts and Promotional Materials Permitted.** A mortgage guaranty insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

Section 19. Rescission

All mortgage guaranty insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

Section 20. Records Retention

A. **Record Files.** A licensed mortgage guaranty insurance company shall maintain its records in a manner which allows the commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.

B. **Retention Period.** Policy and claim records shall be retained for the period during which the certificate or claim is active plus five (5) years, unless otherwise specified by the insurance commissioner. Recordkeeping requirements shall relate to:

(1) Records to clearly document the application, underwriting, and issuance of each master policy and certificate of insurance; and

(2) Claim records to clearly document the inception, handling, and disposition.

C. **Record Format.** Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.

D. **Record Maintenance.** Record maintenance under this Act shall comply with the following requirements:

(1) Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.

(2) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.

Section 21. Regulations

The commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).
1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).
2023 Summer National Meeting (amended).

MORTGAGE GUARANTY INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MORTGAGE GUARANTY INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-043-.01 to 482-1-043-.10 (2008).
Alaska			ALASKA STAT. § 21.12.110 (1976) (mortgage guaranty insurance defined).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1541 to 20-1560 (1977/2010).	
Arkansas			ARK. CODE ANN. § 23-62-110 (2005) (mortgage guaranty insurance defined).
California		CAL. INS. CODE §§ 12640.01 to 12640.18 (1961/2016).	
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. 635.011 to 635.091 (1983/2010); FLA. ADMIN. CODE ANN. r. 69O-185.001 to 69O-185.004 (1974/2013).

MORTGAGE GUARANTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho		IDAHO CODE ANN. §§ 41-2650 to 41-2656 (1972/2015) (portions of model).	
Illinois		ILL. ADMIN. CODE tit. 50, §§ 202.10 to 202.60 (1982/2000).	
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE §§ 515C.1 to 515C.11 (1963/2010).
Kansas		KAN. STAT. ANN. §§ 40-3501 to 40-3521 (1977/2012).	
Kentucky			KY. REV. STAT. ANN. §§ 304.23-010 to 304.23-040 (1970).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		

MORTGAGE GUARANTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey		N.J. STAT. ANN. §§ 17:46A-1 to 17:46A-10 (1968/2015).	
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAW §§ 6501 to 6508 (1984/2003).
North Carolina			N.C. GEN. STAT. §§ 58-10-120 to 58-10-145 (2001/2009).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE 3901-1-13 (1978/2007).	
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV.STAT. §§ 743.282 to 743.286 (1969/1973).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 2301 to 2307 (1976).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 3502.001 to 3502.204 (2005).
Utah	NO CURRENT ACTIVITY		

MORTGAGE GUARANTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. ADMIN. CODE INS. § 3.09 (1957/2000).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2023

MORTGAGE GUARANTY INSURANCE MODEL ACT (#630)

1. Description of the Project, Issues Addressed, etc.

The current NAIC *Mortgage Guaranty Insurance Model Act* (#630) was first adopted in 1976 and amended in 1979. Model #630 was created to provide effective regulation and supervision of mortgage guaranty insurers. Model #630 defines mortgage guaranty insurance as insurance against financial loss by reason of nonpayment of principal, interest, or other sums agreed to be paid on any note secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate. Mortgage guaranty insurance may also cover against financial loss by reason of nonpayment of rent under the terms of a written lease. As of April 2012, eight states had adopted the most recent version of the model in a substantially similar manner. An additional 12 states have adopted an older version of the model, legislation, or regulation derived from other sources such as bulletins and administrative rulings.

The Mortgage Guaranty Insurance (E) Working Group was formed in November 2012. By early 2013, the Working Group developed a list of potential regulatory changes to Model #630 to address changes in mortgage lending and mortgage finance since the model's original approval in the 1970s and to respond to the lessons learned during the 2008 national recession and housing market downturn. As a result, a Request for NAIC Model Law Development was made and approved by the Executive (EX) Committee at the 2013 Summer National Meeting.

Development of the modernized model has a long history dating back to the fall of 2012. At that time, development of a capital model to accompany Model #630 was the key focus of attention. During 2013, mortgage guaranty insurers engaged Oliver Wyman to begin working on a Mortgage Guaranty Capital Model. Over the next several years, the Mortgage Guaranty Capital Model was developed. It was determined in December 2016 that a secondary contractor would need to be hired to further assess the reliability of the Mortgage Guaranty Capital Model. In September 2017, Milliman began its work to review and validate the Mortgage Guaranty Capital Model.

In March 2018, Milliman provided its assessment of the capital model to the Working Group. It indicated that inconsistencies and errors were found in the data preparation steps used to: 1) estimate the capital model coefficients and the application of the same capital model coefficients; and 2) forecast future loan performance. Milliman stated that these inconsistencies and errors were material to the capital model and would need to be addressed before the Mortgage Guaranty Capital Model could be implemented.

As a result, Milliman continued its work on the Mortgage Guaranty Capital Model, and in December 2019, it was exposed for public comment. The comments regarding the exposure were expected to be discussed during the 2020 Spring National Meeting. However, due to the COVID-19 pandemic, this meeting was cancelled. The Working Group also began working on an annual statement exhibit to begin collecting data for the capital model. In April 2021, the Mortgage Guaranty Insurance (E) Working Group referred the exhibit proposal to the Blanks (E) Working Group. The exhibit was finalized and implemented into the blank effective year-end 2021. In May 2022, the Mortgage Guaranty Insurance (E) Working Group decided to pause the development of the capital model and continue collecting data for further analysis in the future. As a result, the Working Group focused on finalizing the model.

2. Name of Group Responsible for Drafting the Model and States Participating

The Mortgage Guaranty Insurance (E) Working Group comprised the drafting Group and consisted of the following states during 2023: North Carolina (chair); Arizona; California; Florida, Missouri, New York, Pennsylvania; Texas; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Executive (EX) Committee approved the Request for NAIC Model Law Development during the 2013 Summer National Meeting. Throughout the course of model development, the Financial Condition (E) Committee chair approved extensions due to extenuating circumstances.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Working Group formed a drafting group, which consisted of: Jackie Obusek (NC–Chair); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner (PA); Amy Garcia (TX); and

Amy Malm (WI). Following the lengthy hiatus from the development of the model, due to work being completed on the Mortgage Guaranty Capital Model, the drafting group began finalization of model in May 2022 without consideration of the capital model. During its May meeting, the drafting group discussed the overall approach to finalizing the model and a rather aggressive timeline for completion.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group met in open session on Oct. 6 and Dec. 13, 2022, and March 22, 2023. During these sessions, interested regulators and parties submitted comment letters to the Working Group. The drafting group held nine regulator-only discussion and planning calls between May 2022 and March 2023. The Working Group exposed the model for public comment on Oct. 7, 2022, and again on Feb. 27, 2023, and May 11, 2023. Comments were received from: the California Department of Insurance (DOI); the Center for Economic Justice (CEJ); and the Mortgage Guaranty Consortium (Arch Mortgage Insurance Company, Enact Mortgage Insurance Corporation, Essent Guaranty Inc., Mortgage Guaranty Insurance Corporation, National Mortgage Insurance Corporation, and Radian Guaranty Inc).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Section 10, Reserve Requirements – Contingency Reserve
The most significant issue raised during development was related to the recording of the contingency reserves when reinsurance is used. The specific provision is: "The Mortgage Guaranty Insurance company shall make an annual contribution to the Contingency Reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve." The mortgage insurers indicated that many reinsurers do not complete a statutory financial statement and would not have the ability to record the contingency reserve. The drafting group members discussed the topic and agreed to leave the provision as stated.

Section 21, No Private Right of Action Provision
The mortgage guaranty insurers proposed the following provision for inclusion in the model: "No Private Right of Action. Nothing in this Act is intended to, or does, create a private right of action based upon compliance or noncompliance with any of the Act's provisions. Authority to enforce compliance with this Act is vested exclusively in the Commissioner." Following discussion by the drafting group, the provision was added to the model and included in the Feb. 27, 2023, exposure. The drafting group received several comments on the provision. Following discussion, Section 21 was removed from the model.

7. List the Key Provisions of the Model (sections considered most essential to state adoption)

Section 10. Reserve Requirements

A. **Unearned Premium Reserves, Loss Reserves, and Premium Deficiency Reserves.** Financial reporting will be prepared in accordance with the *Accounting Practices and Procedures Manual* (AP&P Manual) and Annual Financial Statement Instructions of the NAIC.

B. **Contingency Reserve.** Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:

(1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve, which, in the aggregate, shall be equal to 50% of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.

(2) Except as provided within this act, a mortgage guaranty insurance company's contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:

(a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or

(b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts that are in excess of the requirements of Section 15 as required in (insert section of the mortgage guaranty insurance model law requiring minimum policyholder's position) as filed with the most recently filed annual statement.

(i.) The mortgage guaranty insurance company's domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this act may be computed and maintained as required previously.

Section 15. Risk in Force and Waivers

A. **Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding 25 times its capital, surplus, and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total risk in force exceeding 25 times its capital, surplus, and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total risk in force no longer exceeds 25 times its capital, surplus, and contingency reserve. Total risk in force shall be calculated on an individual entity basis.

B. **Waiver.** The commissioner may waive the requirement found in subsection (a) of this section at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of subsection (a) of this section and shall, at a minimum, address the factors specified in subsection (j) of this section.

C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:

(1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.

(4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.

(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.

(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

(7) The adequacy of the mortgage guaranty insurer's reserves.

(8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.

(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.

(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.

(11) The capital contributions that have been infused or are available for future infusion into the mortgage guaranty insurer.

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including the quality and type of the risks included in the aggregate insured risk.

D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist the commissioner in the review of the mortgage guaranty insurer's request submitted pursuant to subsection (i) of this section. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. **Specified Duration.** Any waiver shall be (i) for a specified period of time not to exceed two years and (ii) subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section.

8. Any Other Important Information (e.g., amending an accreditation standard)

None. It is not an accreditation standard, and the Working Group is not making a recommendation that it be considered as an accreditation standard.

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this Act is to:

A. Promote the public welfare by regulating lender-placed insurance on real property.

B. Create a legal framework within which lender-placed insurance on real property may be written in this state.

C. Help maintain the separation between lenders/servicers and insurers/insurance producers.

D. Minimize the possibilities of unfair competitive practices in the sale, placement, solicitation and negotiation of lender-placed insurance.

Section 2. Scope

A. This Act applies to insurers and insurance producers engaged in any transaction involving lender-placed insurance as defined in this Act.

B. All lender-placed insurance written in connection with mortgaged real property, including manufactured and mobile homes, is subject to the provisions of this Act, except:

(1) Transactions involving extensions of credit primarily for business, commercial or agricultural purposes.

(2) Insurance offered by the lender or servicer and elected by the mortgagor at the mortgagor's option.

(3) Insurance purchased by a lender or servicer on real estate owned property.

(4) Insurance for which no specific charge is made to the mortgagor or the mortgagor's account.

Drafting Note: Nothing in this Act shall be construed to create or imply a private cause of action for violation of this Act, and the commissioner shall have authority to enforce this Act subject to the laws of this state. Furthermore, nothing in this Act shall be construed to extinguish any mortgagor rights available under common law or other state statutes.

Section 3. Definitions

As used in this Act:

A. "Affiliate" shall mean a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

B. "Individual lender-placed insurance" means coverage for individual real property evidenced by a certificate of coverage under a master lender-placed insurance policy or a lender-placed insurance policy for individual real property.

C. "Insurance Producer" means a person or entity (or its Affiliates) required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

D. "Insurer" means an insurance company, association or exchange authorized to issue lender-placed insurance in [insert applicable state] (or its Affiliates).

E. "Investor" means a person or entity (and its Affiliates) holding a beneficial interest in loans secured by real property.

F. "Lapse" means the moment in time in which a mortgagor has failed to secure or maintain valid and/or sufficient insurance upon mortgaged real property as required by a mortgage agreement.

G. "Lender" means a person or entity (and its Affiliates) making loans secured by an interest in real property.

H. "Lender-placed insurance" means insurance obtained by a lender or servicer when a mortgagor does not maintain valid and/or sufficient insurance upon mortgaged real property as required by the terms of the mortgage agreement. It may be purchased unilaterally by the lender or servicer, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized property as a result of fire, theft, collision or other risks of loss that would either impair a lender, servicer or investor's interest or adversely affect the value of collateral covered by limited dual interest insurance. It is purchased according to the terms of the mortgage agreement as a result of the mortgagor's failure to provide evidence of required insurance.

I. "Loss ratio" means the ratio of incurred losses to earned premium.

J. "Master lender-placed insurance policy" means a group policy issued to a lender or servicer providing coverage for all loans in the lender or servicer's loan portfolio as needed.

K. "Mortgage agreement" means the written document that sets forth an obligation or a liability of any kind secured by a lien on real property and due from, owing or incurred by a mortgagor to a lender on account of a mortgage loan, including the security agreement, Deed of Trust and any other document of similar effect, and any other documents incorporated by reference.

L. "Mortgage loan" means a loan, advance, guarantee or other extension of credit from a lender to a mortgagor.

M. "Mortgage transaction" means a transaction by the terms of which the repayment of money loaned or payment of real property sold is to be made at a future date or dates.

N. "Mortgagee" means the person who holds mortgaged real property as security for repayment of a mortgage agreement.

O. "Mortgagor" means the person who is obligated on a mortgage loan pursuant to a mortgage agreement.

P. "Person" means an individual or entity.

Q. "Real Estate Owned Property" means property owned or held by a lender or servicer following foreclosure under the related Mortgage agreement or the acceptance of a deed in lieu of foreclosure.

R. "Replacement Cost Value (RCV)" is the estimated cost to replace covered property at the time of loss or damage without deduction for depreciation. RCV is not market value, but it is instead the cost to replace covered property to its pre-loss condition.

S. "Servicer" means a person or entity (and its Affiliates) contractually obligated to service one or more mortgage loans for a Lender or Investor. The term "Servicer" includes entities involved in subservicing arrangements.

Section 4. Term of Insurance Policy

A. Lender-placed insurance shall become effective no earlier than the date of lapse of insurance upon mortgaged real property subject to the terms of a mortgage agreement and/or any other state or federal law requiring the same.

B. Individual lender-placed insurance shall terminate on the earliest of the following dates:

(1) The date insurance that is acceptable under the mortgage agreement becomes effective, subject to the mortgagor providing sufficient evidence of such acceptable insurance.

(2) The date the applicable real property no longer serves as collateral for a mortgage loan pursuant to a mortgage agreement.

(3) Such other date as specified by the individual policy or certificate of insurance.

(4) Such other date as specified by the lender or servicer.

(5) The termination date of the policy.

C. An insurance charge shall not be made to a mortgagor for lender-placed insurance for a term longer than the scheduled term of the lender-placed insurance, nor may an insurance charge be made to the mortgagor for lender-placed insurance before the effective date of the lender-placed insurance.

Section 5. Calculation of Coverage and Payment of Premiums

A. Any lender-placed insurance coverage, and subsequent calculation of premium, should be based upon the replacement cost value of the property as best determined as follows:

(1) The dwelling coverage amount set forth in the most recent evidence of insurance coverage provided by the mortgagee ("last known coverage amount" or "LKCA"), if known to the lender or servicer.

(2) The insurer shall inquire of the insured, at least once, as to the LKCA; and if it is not able to obtain the LKCA from the insured or in another manner, the insurer may proceed as set forth below.

(3) If the LKCA is unknown, the replacement cost of the property serving as collateral as calculated by the insurer, unless the use of replacement cost for this purpose is prohibited by other state or federal law.

(4) If the LKCA is unknown and the replacement cost is not available or its use is prohibited, the unpaid principal balance of the mortgage loan.

B. In the event of a covered loss, any replacement cost coverage provided by an insurer in excess of the unpaid principal balance of the mortgage loan shall be paid to the mortgagor.

C. An insurer shall not write lender-placed insurance for which the premium rate differs from that determined by the schedules of the insurer on file with the commissioner as of the effective date of any such policy.

Section 6. Prohibited Practices

A. An insurer or insurance producer shall not issue lender-placed insurance on mortgaged property that the insurer or insurance producer or an Affiliate of the insurer or insurance producer owns, performs the servicing for, or owns the servicing right to the mortgaged property.

B. An insurer or insurance producer shall not compensate a lender, insurer, investor or servicer (including through the payment of commissions) on lender-placed property insurance policies issued by the insurer.

C. An insurer or insurance producer shall not share lender-placed insurance premium or risk with the lender, investor or servicer that obtained the lender-placed insurance.

D. An insurer or insurance producer shall not offer contingent commissions, profit sharing, or other payments dependent on profitability or loss ratios to any person affiliated with a servicer or the insurer in connection with lender-placed insurance.

E. An insurer shall not provide free or below-cost outsourced services to lenders, investors or servicers, and an insurer will not outsource its own functions to lenders, insurance producers, investors or servicers on an above-cost basis.

F. An insurer or insurance producer shall not make any payments, including but not limited to the payment of expenses to a lender, insurer, investor or servicer for the purpose of securing lender-placed insurance business or related outsourced services.

Section 7. Non-Circumvention

Nothing in this Act shall be construed to allow an insurance producer or an insurer solely underwriting lender-placed insurance to circumvent the requirements set forth within this Act. Any such part of any requirements, limitations or exclusions provided herein apply in any part to any insurer or insurance producer involved in lender-placed insurance.

Section 8. Evidence of Coverage

Lender-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance, or other evidence of insurance coverage shall be mailed, first class mailed, or delivered in person to the last known address of the mortgagor or delivered in accordance with [inset reference to Electronic Transaction Act]. Notwithstanding any other statutory or regulatory required information, the individual policy or certificate of insurance coverage shall include the following information:

A. The address and identification of the insured property.

B. The coverage amount or amounts if multiple coverages are provided.

C. The effective date of the coverage.

D. The term of coverage.

E. The premium charge for the coverage.

F. Contact information for filing a claim.

G. A complete description of the coverage provided.

Section 9. Filing, Approval and Withdrawal of Forms and Rates

A. All policy forms and certificates of insurance to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Commissioner.

B The Commissioner shall review the rates to determine whether the rates are excessive, inadequate or unfairly discriminatory. This analysis shall include a determination as to whether expenses included by the insurer in the rate are appropriate.

C. All insurers shall re-file lender-placed property insurance rates at least once every four (4) years.

D. All insurers writing lender-placed insurance shall have separate rates for lender-placed insurance and voluntary insurance obtained by a mortgage servicer on real estate owned property.

E. Upon the introduction of a new lender-placed insurance program, the insurer shall reference its experience in existing programs in the associated filings. Nothing in this Act shall limit an insurer's discretion, as actuarially appropriate, to distinguish different terms, conditions, exclusions, eligibility criteria or other unique or different characteristics. Moreover, an insurer may, where actuarially acceptable, rely upon models or, in the case of flood filings where applicable experience is not credible, on Federal Emergency Management Agency (FEMA) National Flood Insurance Program (NFIP) data.

F. No later than April 1 of each year, each insurer with at least $100,000 in direct written premium for lender-placed insurance in this state during the prior calendar year shall report to the Commissioner the following information for the prior calendar year:

(1) Actual loss ratio.

(2) Earned premium.

(3) Any aggregate schedule rating debit/credit to earned premium.

(4) Itemized expenses.

(5) Paid losses.

(6) Loss reserves, including case reserves and reserves for incurred but not reported losses.

This report shall be separately produced for each lender-placed program and presented on both an individual-jurisdiction and countrywide basis.

G. Except in the case of lender-placed flood insurance, to which this paragraph does not apply, if an insurer experiences an annual loss ratio of less than 35% in any lender-placed program for two consecutive years, it shall submit a rate filing (either adjusting its rates or supporting their continuance) to the Commissioner no more than 90 days after the submission of the data required in Section 9F above.

Drafting Note: The 35% trigger for re-filing rates is not intended to be, nor should be interpreted as, a loss ratio standard for determining whether rates are excessive or inadequate. The loss ratio standard in this section is solely directed to prompt a re-filing of rates by the insurer.

H. Except as specifically set forth in this Section, rate and form filing requirements shall be subject to the insurance laws of this state.

Section 10. Enforcement

The Commissioner shall have all rights and powers to enforce the provisions of this Act as provided by section(s) [insert section(s) number] of the Insurance Code of this state.

Section 11. Regulatory Authority

The commissioner may, after notice and hearing, promulgate reasonable regulations and orders to carry out and effectuate the provisions of this Act.

Section 12. Judicial Review

A. A person subject to an order or final determination of the commissioner under Section 8 or Section 13 may obtain a review of the order or final determination by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order or final determination of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding; and the questions determined shall determine whether the filing of the petition shall operate as a stay of the order or final determination of the commissioner, and they shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order or final determination of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

B. To the extent that the order or final determination of the commissioner is affirmed, the court shall issue its own order commanding obedience to the terms of the order or final determination of the commissioner. If either party applies to the court for leave to adduce additional evidence and shows to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and be adduced upon the hearing in the manner and upon the terms and conditions the court may deem proper. The commissioner may modify the findings of fact or make new findings by reason of the additional evidence so taken and shall file such modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order or final determination, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgment, order or final determination or decree would not be subject to review by an appellate court, provision should therefore be inserted here.

C. An order issued by the commissioner under Section 13 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no petition has been duly filed within that time except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 13.

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review be dismissed.

D. No order of the commissioner under this Act or order of a court to enforce the same shall relieve or absolve any person affected by the order from liability under any other laws of this state.

Drafting Note: States may delete this section if the substance of it already exists in state law.

Section 13. Penalties

An insurer that violates an order of the commissioner while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to either or both of the following:

A. Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation, but not to exceed an aggregate penalty of $250,000.

B. Suspension or revocation of the insurer's license.

Drafting Note: States may delete or modify this section if the substance of it already exists in state law.

Section 14. Severability Provisions

If any provision of this Act, or the application of the provision to any person or circumstance, is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 15. Effective Date

This Act shall take effect [insert effective date].

Chronological Summary of Action (all references are to the Proceeding of the NAIC)

2021 Spring National Meeting (adopted).

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
RHODE ISLAND	27 R.I. GEN. LAWS ANN. § 27-6.1-1 TO 27-6.1-12 (2022).		
Puerto Rico	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2021

REAL PROPERTY LENDER-PLACED INSURANCE MODEL ACT (#631)

1. Description of the Project, Issues Addressed, etc.

The Creditor-Placed Insurance Model Act Review (C) Working Group was appointed in May 2015 with a charge to review information from a 2012 public hearing on lender-placed insurance (LPI) and determine if changes were needed to the *Creditor-Placed Insurance Model Act* (#375) having to do with creditor-placed automobile insurance. The Working Group met throughout 2015, 2016 and 2017 to review a New York regulation and Florida orders concerning LPI. In 2017, the Working Group began discussing the need to split the topics of personal property and real property into two different sections or two different models. In July 2017, the Working Group decided it would need to split the personal property from real property into two different models, and the Property and Casualty Insurance (C) Committee adopted a Request for NAIC Model Law Development on July 18, 2017.

In 2018, the Property and Casualty Insurance (C) Committee appointed the Lender-Placed Insurance Model Act (C) Working Group to only focus on drafting a new model related to lender-placed homeowners' insurance.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2020 members of the Lender-Placed Insurance Model Act (C) Working Group were: Florida (Chair), Rhode Island (Vice Chair), Alaska, California, Connecticut, District of Columbia, Louisiana, Mississippi, North Dakota, Oklahoma, Texas, Virginia and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

On July 18, 2017, the Property and Casualty Insurance (C) Committee adopted a Request for NAIC Model Law Development. In 2018, the Property and Casualty Insurance (C) Committee appointed the Lender-Placed Insurance Model Act (C) Working Group to only focus on drafting a new model related to lender-placed homeowners' insurance.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Lender-Placed Insurance Model Act (C) Working Group reviewed sections of the Real Property Lender-Place Insurance Model Act (Model) on various conference calls and asked for comments on an ongoing basis throughout 2017 and 2018. A draft of the Model was exposed in March 2018, and it was discussed on Sept. 18, 2018. The final draft of the Model was exposed on Oct. 19, 2020, through Nov. 3, 2020.

Numerous written comments were submitted to the Working Group, including from the Center for Economic Justice (CEJ); the National Consumer Law Center (NCLC), a joint industry group made up of the American Bankers Association (ABA), the Consumer Credit Industry Association (CCIA), the Council of Insurance Agents & Brokers, the National Association of Mutual Insurance Companies (NAMIC), and the American Property Casualty Insurance Association (APCIA); as well as numerous states.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Once the focus of the Model was limited to real property in 2018, the Lender-Placed Insurance Model Act (C) Working Group exposed the draft of a new model law for real property LPI in March 2018 for a 45-day public comment period ending April 30, 2018. On Sept. 18, 2018, the Working Group reviewed comments received, as well as a new draft of the Model reflecting those comments. The Working Group exposed the new draft through Oct. 31, 2018.

The Working Group met Oct. 19, 2020, to hear from commenters on the most recent version of the proposed Model and to expose the Model for a 15-day public comment period ending Nov. 3, 2020.

On Nov. 13, 2020, the Working Group met to hear from commenters and review new edits to the Model made by Rhode Island. The Working Group agreed to several changes to the Model and unanimously adopted the Model during this conference call.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Scope of the Model: Early on, consideration was given to revising Model #375 so that it would include both personal property and real property. The Lender-Placed Insurance Model Act (C) Working Group decided to create a new model focused on real property, and a model law request was adopted by the Property and Casualty Insurance (C) Committee on July 18, 2017. In its 2018 charges, the Working Group was charged with only creating a new model focused on real property.

Tracking Expenses and Review of Rates: Some commenters wanted a prohibition of tracking expenses because they said servicers are paid for tracking, and the practice of allowing insurers to provide free tracking and recoup the cost from LPI premiums is unfair. Working Group members argued that states retain the authority to review expenses in rate filings and judge whether expenses are appropriate to pass to consumers. The Working Group agreed to revise Section 9B to read: "The Commissioner shall review the rates to determine whether the rates are excessive, inadequate or unfairly discriminatory. This analysis shall include a determination as to whether expenses included by the insurer in the rate are appropriate."

Loss Ratios: Some commenters argued for a lower loss ratio threshold. The Working Group agreed to a drafting note following Section 9G that reads: "The 35% trigger for re-filing rates is not intended to be nor should be interpreted as a loss ratio standard for determining whether rates are excessive or inadequate. The loss ratio standard in this section is solely directed to prompt a re-filing of rates by the insurer."

Single and Dual-Interest: Some commenters argued that only dual-interest LPI be permitted because the borrower is named as an additional insured with dual-interest and has some rights to file a claim under the policy. The Working Group found most policies to be dual-interest, and it decided not to include a prohibition of single-interest LPI within the Model.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

TRAVEL INSURANCE MODEL ACT

Table of Contents

Drafting Note: This Travel Insurance Model Act is intended to be enacted as a standalone chapter of the insurance code with appropriate cross references to seamlessly incorporate provisions such as licensing and premium tax into the adopting state's existing statutory structure. Alternatively, sections such as the licensing and premium tax provisions that may fit into other sections of an adopting state's statutory structure could be pulled from the Model and incorporated into the sections of the adopting state's insurance code that address those topics.

Section 1. Short Title

This Act shall be known as the "Travel Insurance Model Act."

Section 2. Scope and Purposes

A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Travel Insurance may be sold in this state.

B. The requirements of this Act shall apply to Travel Insurance that covers any resident of this state, and is sold, solicited, negotiated, or offered in this state, and policies and certificates are delivered or issued for delivery in this state. It shall not apply to Cancellation Fee Waivers or Travel Assistance Services, except as expressly provided herein.

C. All other applicable provisions of this state's insurance laws shall continue to apply to Travel Insurance except that the specific provisions of this Act shall supersede any general provisions of law that would otherwise be applicable to Travel Insurance.

Section 3. Definitions

As used in this Act:

A. "Aggregator Site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

B. "Blanket Travel Insurance" means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to individual members of the Eligible Group.

C. "Cancellation Fee Waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the non-refundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A Cancellation Fee Waiver is not insurance.

D. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: Insert the title of the state's chief insurance regulatory official wherever the term "Commissioner" appears.

E. Solely for the purposes of Travel Insurance, "Eligible Group" means two (2) or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including but not limited to any of the following:

(1) Any entity engaged in the business of providing travel or travel services, including but not limited to: tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operator, owner, or lessor of a means of transportation of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel;

(2) Any college, school, or other institution of learning, covering students, teachers, employees, or volunteers;

(3) Any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(4) Any sports team, camp, or sponsor thereof, covering participants, members, campers, employees, officials, supervisors, or volunteers;

(5) Any religious, charitable, recreational, educational, or civic organization, or branch thereof, covering any group of members, participants, or volunteers;

(6) Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors, or purchasers;

(7) Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members;

(8) Any trust or the trustees of a fund established, created or maintained for the benefit of and covering members, employees or customers, subject to the Commissioner's permitting the use of a trust and the state's premium tax provisions in [refer to Section 5 herein or, if not used, the state's existing premium tax provisions] of one or more associations meeting the above requirements of Paragraph (7) above;

(9) Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(10) Any volunteer fire department, ambulance, rescue, police, court, or any first aid, civil defense, or other such volunteer group;

(11) Preschools, daycare institutions for children or adults, and senior citizen clubs;

(12) Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner or lessor of a means of transportation, or the automobile or truck rental or leasing company, is the policyholder under a policy to which this section applies; or

(13) Any other group where the Commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

F. "Fulfillment Materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

G. "Group Travel Insurance" means Travel Insurance issued to any Eligible Group.

H. "Limited Lines Travel Insurance Producer" means a

(1) Licensed managing general agent or third-party administrator,

(2) Licensed insurance producer, including a limited lines producer, or

(3) Travel Administrator.

I. "Offer and Disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums.

J. "Primary Certificate Holder", specific to Section 5, Premium Tax, means an individual person who elects and purchases Travel Insurance under a Group Policy.

K. "Primary Policyholder", specific to Section 5, Premium Tax, means an individual person who elects and purchases individual Travel Insurance.

L. "Travel Administrator" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with Travel Insurance, except that a person shall not be considered a Travel Administrator if that person's only actions that would otherwise cause it to be considered a Travel Administrator are among the following:

(1) A person working for a Travel Administrator to the extent that the person's activities are subject to the supervision and control of the Travel Administrator;

(2) An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license;

(3) A Travel Retailer offering and disseminating Travel Insurance and registered under the license of a Limited Lines Travel Insurance Producer in accordance with this Act;

(4) An individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with insurance coverage; or

(5) A business entity that is affiliated with a licensed insurer while acting as a Travel Administrator for the direct and assumed insurance business of an affiliated insurer.

M. "Travel Assistance Services" means non-insurance services for which the consumer is not indemnified based on a fortuitous event, and where providing the service does not result in transfer or shifting of risk that would constitute the business of insurance. Travel Assistance Services include, but are not limited to: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel. Travel Assistance Services are not insurance and not related to insurance.

N. "Travel Insurance" means insurance coverage for personal risks incident to planned travel, including:

(1) Interruption or cancellation of trip or event;

(2) Loss of baggage or personal effects;

(3) Damages to accommodations or rental vehicles;

(4) Sickness, accident, disability or death occurring during travel;

(5) Emergency evacuation;

(6) Repatriation of remains; or

(7) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Travel Insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

Drafting Note: States may wish to consider making a clear distinction between Travel Insurance and other similar, yet distinct coverages. For example, in 43 states, insurers file collision damage insurance (CDI) for vehicles rented during insured travel as Travel Insurance, while in 6 states, insurers file CDI as Travel Insurance **only** if it is ancillary to other Travel Insurance coverages, such as for travel cancellation or interruption. One state requires CDI to be filed under Private Passenger Auto Physical Damage [line 21.1].

Drafting Note: Policies with travel components that provide major medical coverage providing comprehensive medical protection for trips with durations of six months or longer are not prohibited by this definition but are outside the scope of this model law and may be regulated under other applicable provisions of the state's insurance code, rather than under this model law. Some states may also believe that standalone major medical coverage that only provides comprehensive medical protection for trips with durations of less than six months should be filed as an individual health or group health travel product. If an adopting state believes that additional clarity is necessary, the state may choose to insert the following: [For policies that provide major medical coverage providing comprehensive health protection for trips with durations of six months or longer, see section X of the state insurance code.] [For policies that provide standalone major medical coverage that only provide comprehensive medical protection for trips with durations of less than six months, see section X of the state insurance code.]

O. "Travel Protection Plans" means plans that provide one or more of the following: Travel Insurance, Travel Assistance Services, and Cancellation Fee Waivers.

P. "Travel Retailer" means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

Drafting Note: States that have recently adopted Travel Insurance producer licensing and registration laws or regulations may refer to the applicable definitions adopted therein rather than restating them in this section.

Section 4. Licensing and Registration

A. The Commissioner may issue a Limited Lines Travel Insurance Producer License to an individual or business entity that has filed with the Commissioner an application for a Limited Lines Travel Insurance Producer License in a form and manner prescribed by the Commissioner. Such Limited Lines Travel Insurance Producer shall be licensed to sell, solicit or negotiate Travel Insurance through a licensed insurer. No person may act as a Limited Lines Travel Insurance Producer or Travel Insurance Retailer unless properly licensed or registered, respectively.

B. A Travel Retailer may offer and disseminate Travel Insurance under a Limited Lines Travel Insurance Producer business entity license only if the following conditions are met:

(1) The Limited Lines Travel Insurance Producer or Travel Retailer provides to purchasers of Travel Insurance:

(a) A description of the material terms or the actual material terms of the insurance coverage;

(b) A description of the process for filing a claim;

(c) A description of the review or cancellation process for the Travel Insurance policy; and

(d) The identity and contact information of the insurer and Limited Lines Travel Insurance Producer.

(2) At the time of licensure, the Limited Lines Travel Insurance Producer shall establish and maintain a register, on a form prescribed by the Commissioner, of each Travel Retailer that offers Travel Insurance on the Limited Lines Travel Insurance Producer's behalf. The register shall be maintained and updated by the Limited Lines Travel Insurance Producer and shall include the name, address, and contact information of the Travel Retailer and an officer or person who directs or controls the Travel Retailer's operations, and the Travel Retailer's Federal Tax Identification Number. The Limited Lines Travel Insurance Producer shall submit such register to the state insurance department upon reasonable request. The Limited Lines Travel Insurance Producer shall also certify that the Travel Retailer registered complies with 18 USC §1033. The grounds for the suspension, revocation and the penalties applicable to resident insurance producers under [insert applicable reference to insurance code], shall be applicable to the Limited Lines Travel Insurance Producers and Travel Retailers.

(3) The Limited Lines Travel Insurance Producer has designated one of its employees who is a licensed individual producer as the person (a "Designated Responsible Producer" or "DRP") responsible for the compliance with the Travel Insurance laws and regulations applicable to the Limited Lines Travel Insurance Producer and its registrants.

(4) The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the Limited Lines Travel Insurance Producer's insurance operations complies with the fingerprinting requirements applicable to insurance producers in the resident state of the Limited Lines Travel Insurance Producer.

(5) The Limited Lines Travel Insurance Producer has paid all applicable licensing fees as set forth in applicable state law.

(6) The Limited Lines Travel Insurance Producer requires each employee and authorized representative of the Travel Retailer whose duties include offering and disseminating Travel Insurance to receive a program of instruction or training, which is subject, at the discretion of the Commissioner, to review and approval. The training material shall, at a minimum, contain adequate instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

C. Any Travel Retailer offering or disseminating Travel Insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the travel insurer. Such materials shall include information which, at a minimum:

(1) Provides the identity and contact information of the insurer and the Limited Lines Travel Insurance Producer;

(2) Explains that the purchase of Travel Insurance is not required in order to purchase any other product or service from the Travel Retailer; and

(3) Explains that an unlicensed Travel Retailer is permitted to provide only general information about the insurance offered by the Travel Retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the Travel Retailer or to evaluate the adequacy of the customer's existing insurance coverage.

D. A Travel Retailer employee or authorized representative, who is not licensed as an insurance producer may not:

(1) Evaluate or interpret the technical terms, benefits, and conditions of the offered Travel Insurance coverage;

(2) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(3) Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

E. Notwithstanding any other provision in law, a Travel Retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating Travel Insurance on behalf of and under the direction of a Limited Lines Travel Insurance Producer meeting the conditions stated in this Act, is authorized to receive related compensation, upon registration by the Limited Lines Travel Insurance Producer as described in Subsection B(2) above.

F. Responsibility: As the insurer's designee, the Limited Lines Travel Insurance Producer is responsible for the acts of the Travel Retailer and shall use reasonable means to ensure compliance by the Travel Retailer with this Act.

G. Any person licensed in a major line of authority as an insurance producer is authorized to sell, solicit and negotiate travel insurance. A property and casualty insurance producer is not required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

Drafting Note: States that have already implemented a licensing and registration law or regulation consistent with the NCOIL Limited Lines Travel Insurance Model Act and NAIC Uniform Licensing Standard 34 (Limited Lines Travel Insurance Standard) may choose to cross-reference that law or regulation instead of using the language set forth in this Section. States that have not yet implemented such a law or regulation with respect to Travel Insurance may choose to incorporate this Section under their existing producer licensing laws.

Section 5. Premium Tax

A. A travel insurer shall pay premium tax, as provided in [insert reference to the state's existing premium tax provision] on Travel Insurance premiums paid by any of the following:

(1) An individual primary policyholder who is a resident of this state;

(2) A primary certificate-holder who is a resident of this state who elects coverage under a Group Travel Insurance policy; or

(3) A Blanket Travel Insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased Blanket Travel Insurance in this state for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permit the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

B. A travel insurer shall:

(1) Document the state of residence or principal place of business of the policyholder or certificate-holder, as required in Section 5A; and,

(2) Report as premium only the amount allocable to Travel Insurance and not any amounts received for Travel Assistance Services or Cancellation Fee Waivers.

Section 6. Travel Protection Plans

A. Travel Protection Plans may be offered for one price for the combined features that the Travel Protection Plan offers in this state if:

B. The Travel Protection Plan clearly discloses to the consumer, at or prior to the time of purchase, that it includes Travel Insurance, Travel Assistance Services, and Cancellation Fee Waivers as applicable, and provides information and an opportunity, at or prior to the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each; and

C. The Fulfillment Materials:

(1) Describe and delineate the Travel Insurance, Travel Assistance Services, and Cancellation Fee Waivers in the Travel Protection Plan, and

(2) Include the Travel Insurance disclosures and the contact information for persons providing Travel Assistance Services, and Cancellation Fee Waivers, as applicable.

Section 7. Sales Practices

A. All persons offering Travel Insurance to residents of this state are subject to the Unfair Trade Practices Act at [insert reference to NAIC model *Unfair Trade Practices Act* (#880)], except as otherwise provided in this Section. In the event of a conflict between this Act and other provisions of the [insurance code] regarding the sale and marketing of Travel Insurance and Travel Protection Plans, the provisions of this Act shall control.

B. Illusory Travel Insurance. Offering or selling a Travel Insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under [insert reference to NAIC model *Unfair Trade Practices Act* (#880)].

C. Marketing

(1) All documents provided to consumers prior to the purchase of Travel Insurance, including but not limited to sales materials, advertising materials, and marketing materials, shall be consistent with the Travel Insurance policy itself, including but not limited to, forms, endorsements, policies, rate filings, and certificates of insurance.

(2) For Travel Insurance policies or certificates that contain pre-existing condition exclusions, information and an opportunity to learn more about the pre-existing condition exclusions shall be provided any time prior to the time of purchase, and in the coverage's Fulfillment Materials.

(3) The Fulfillment Materials and the information described in Section 4B(1)(a)-(d) shall be provided to a policyholder or certificate holder as soon as practicable, following the purchase of a Travel Protection Plan. Unless the insured has either started a covered trip or filed a claim under the Travel Insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the Travel Protection Plan price from the date of purchase of a Travel Protection Plan until at least:

(a) Fifteen (15) days following the date of delivery of the Travel Protection Plan's Fulfillment Materials by postal mail; or

(b) Ten (10) days following the date of delivery of the Travel Protection Plan's Fulfillment Materials by means other than postal mail.

For the purposes of this section, delivery means handing Fulfillment Materials to the policyholder or certificate holder or sending Fulfillment Materials by postal mail or electronic means to the policyholder or certificate holder.

(4) The company shall disclose in the policy documentation and Fulfillment Materials whether the Travel Insurance is primary or secondary to other applicable coverage.

(5) Where Travel Insurance is marketed directly to a consumer through an insurer's website or by others through an Aggregator Site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

D. Opt out. No person offering, soliciting, or negotiating Travel Insurance or Travel Protection Plans on an individual or group basis may do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

E. It shall be an unfair trade practice to market Blanket Travel Insurance coverage as free.

F. Where a consumer's destination jurisdiction requires insurance coverage, it shall not be an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(1) Purchasing the coverage required by the destination jurisdiction through the Travel Retailer or Limited Lines Travel Insurance Producer supplying the trip or travel package; or

(2) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

Section 8. Travel Administrators

A. Notwithstanding any other provisions of the [insurance code], no person shall act or represent itself as a Travel Administrator for Travel Insurance in this state unless that person:

(1) Is a licensed property and casualty insurance producer in this state for activities permitted under that producer license; or

(2) Holds a valid managing general agent (MGA) license in this state; or

(3) Holds a valid third-party administrator (TPA) license in this state.

B. A Travel Administrator and its employees are exempt from the licensing requirements of [reference to adjuster licensing act] for Travel Insurance it administers.

C. An insurer is responsible for the acts of a Travel Administrator administering Travel Insurance underwritten by the insurer, and is responsible for ensuring that the Travel Administrator maintains all books and records relevant to the insurer to be made available by the Travel Administrator to the Commissioner upon request.

Drafting Note: It is recommended that states review their licensing requirements for each type of entity to determine whether modifications are needed to conform with the statutory and administrative requirements of the state.

Section 9. Policy

A. Notwithstanding any other provision of the [insurance code], Travel Insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance, provided, however, that travel insurance that provides coverage for sickness, accident, disability or death occurring during travel, either exclusively, or in conjunction with related coverages of emergency evacuation or repatriation of remains, may be filed under either an accident and health line of insurance or an inland marine line of insurance.

Drafting Note: For consistency, states may wish to update their statutory definition of inland marine to include Travel Insurance as defined in this Act. This provision contemplates that Travel Insurance will be subject to the same state laws and regulations as any other inland marine insurance.

B. Travel Insurance may be in the form of an individual, group, or blanket policy.

C. Eligibility and underwriting standards for Travel Insurance may be developed and provided based on Travel Protection Plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for inland marine.

Section 10. Regulations

The Commissioner may promulgate regulations to implement the provisions of this Act.

Section 11. Effective Date

This Act shall take effect 90 days after enactment.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

4th Quarter 2018 (adopted new model).

TRAVEL INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

TRAVEL INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	H.B. 235 (2022).		
Alaska			ALASKA STAT. §§ 21.27.150 to 21.27.152 (2017); BULLETIN 2013-7 (2013).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-3553 (2014/2020); BULLETIN 2014-9 (2014).
Arkansas	ARK. CODE ANN. § 23-64-234 (2019).		
California			CAL. INS. CODE §§ 1752 to 1757 (1959/2018).
Colorado			COLO. REV. STAT. § 10-2-414.5 (2014).
Connecticut			CONN. GEN. STAT. § 38A-398 (2017/2018).
Delaware			DEL. CODE ANN. tit. 18, §§ 1770 to 1776 (2014).
District of Columbia	NO CURRENT ACTIVITY		

TRAVEL INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 626.321 (2003/2019).
Georgia	GA. CODE ANN. § 33-23-12 (2021).		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:9A-103 (2001); § 431:9A-107.5 (2001/2019).
Idaho			IDAHO CODE §§ 41-1090 to 41-1097 (2017).
Illinois	215 ILL. COMP. STAT. ANN. §§ 5/1620 to 5/1660 (2021).		215 ILL. COMP. STAT. § 5/500-10 (2002/2015).
Indiana	S.B. 277 (2022).		IND. CODE § 27-1-15.6-2 (2001/2018).
Iowa	H.F. 2540 (2022).		
Kansas			KAN. STAT. ANN. § 40-4903 (2001/2018).
Kentucky	KY. REV. STAT. ANN. §§ 304.52-010 to 304.52-090 (2021).		KY. REV. STAT. ANN. § 304.9-020 (2010/2016).
Louisiana			LA. REV. STAT. ANN. §§ 22:1351 to 22:1358 (2017); §§ 22:1782.1 to 22:1782.3 (2014).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 7051 to 7056 (2021); § 1420-F (2021) (portions of model).		
Maryland	MD. CODE ANN., INS., § 10-101 (2018); § 10-122 (1957/2018); §§ 19-1001 to 19-1005 (2018) (portions of model).		

TRAVEL INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ch. 175, § 162Z (2016).
Michigan			MICH. COMP. LAWS § 500.1202 (1956/2016).
Minnesota			MINN. STAT. § 60K.383 (2012).
Mississippi	H.B. 160 (2022).		MISS. CODE ANN. §§ 83-83-1 to 83-83-13 (2015).
Missouri	H.B. 2168 (2022).		MO. REV. STAT. § 375.159 (2013).
Montana			MONT. CODE ANN. §§ 33-17-1401 to 33-17-1404 (2013).
Nebraska	L.B. 863 (2022).		NEB. REV. STAT. § 44-4068 (2015/2018).
Nevada			NEV. REV. STAT. §§ 683A.368 to 683A.370 (2015).
New Hampshire			N.H. REV. STAT. ANN. §§ 402-L:1 to 402-L:5 (2015).
New Jersey			N.J. ADMIN. CODE § 11:17-1.2 (1993/2015); § 11:17-2.4 (2015).
New Mexico			N.M. STAT. ANN. § 59A-12-18.1 (2013/2016).
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. § 58-33-19 (2013).
North Dakota			N.D. CENT. CODE § 26.1-26-54 (2015).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	S.B. 256 (2022).		OHIO REV. CODE ANN. § 3905.064 (2018).

TRAVEL INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. STAT. tit. 36, §§ 6710 to 6719 (2018).		
Oregon			OR. REV. STAT. §§ 744.101 to 744.104 (2015).
Pennsylvania			40 PA. STAT. ANN. §§ 4601 to 4609 (2018).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-79.1-1 to 27-79.1-13 (2013/2019).		
South Carolina	S.C. CODE ANN. §§ 38-43-710 to 38-43-820 (2021).		
South Dakota	H.B. 1130 (2022).		S.D. CODIFIED LAWS §§ 58-30-209 to 58-30-218 (2014).
Tennessee	H.B. 1925/S.B. 1868 (2022).		TENN. CODE ANN. §§ 56-6-1401 to 56-6-1407 (2015).
Texas	TEX. INS. CODE ANN. §§ 4055.151 to 4055.158 (2003/2019); §§ 3504.0001 to 3504.0007 (2019).		
Utah	H.B. 338 (2022).		UTAH CODE ANN. §§ 31A-23A-902 to 31A-23A-907 (2014).
Vermont	H. 515 (2022).		4 VT. CODE R. §§ 3-58.1 to 58.8 (RULE 58) (2017).
Virgin Islands			V.I. CODE ANN. tit. 22, § 759 (2017).
Virginia	VA. CODE ANN. §§ 38.2-1887 to 38.2-1890 (2013/2019).		
Washington			WASH. ADMIN. CODE R. §§ 284-17-001 to 284-17-011 (2009/2013).

TRAVEL INSURANCE MODEL ACT

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West Virginia			W. VA. CODE § 33-12-32b (2015).
Wisconsin	WIS. STAT. § 632.977 (2021).		
Wyoming			WYO. STAT. ANN. § 26-9-202 (2001/2017); § 26-9-234 (2013).

PROJECT HISTORY - 2018

TRAVEL INSURANCE MODEL ACT (#632)

1. Description of the Project, Issues Addressed, etc.

The Travel Insurance (C) Working Group was formed in late 2015. The charge to the Working Group was to consider the development of a model law or guideline to establish appropriate regulatory standards for the travel and tourism insurance industry. The Working Group began addressing this charge in the Spring 2016 by presenting three potential items to address as a starting point. They were:

1: Refunds to consumers under free look periods. Consider whether free look periods should be mandatory for travel insurance products and draft a model law or guideline that will promote a consistent interpretation and treatment of that requirement.

2: Unlicensed producer activity. While the Working Group determined that current licensing laws across the country appear to be relatively clear, given the variance in state laws regarding limited lines travel insurance licensing for producers and variance in compliance with these laws, it was deemed appropriate to review the NAIC uniform producer licensing standard for limited lines travel insurance and the travel insurance limited line laws enacted in the states.

3: Self-funding certain benefits without holding a license as an insurer. The Working Group determined that it would be appropriate and necessary to provide clarity regarding whether certain products are insurance and should be written through licensed insurers only or; if other benefits are being offered, such as "cancel for any reason" coverage which may not constitute insurance, whether a license to sell and payment of premium taxes should be required. Further, the Working Group would address packaging non-insurance products and services with other benefits that do not require a license to sell. Finally, it was expected that the determination could result in clarity regarding the required payment of premium taxes.

Industry representatives indicated that a need to develop a model law based on travel insurance products not fitting into standard interpretations of current insurance laws and rules indicated that the development of a model law should proceed in order to gain more regulatory clarity in the travel insurance space. Other issues identified by the industry included: 1) the enhancement of provisions that govern the sale and marketing of travel insurance including such things as restrictions on opt-out sales, enhanced disclosures for pre-existing condition exclusions, minimum "free look" provisions, and policy disclosures; 2) cancellation fee waiver or refund programs being provided together; 3) rate and form review provisions; 4) clear definitions including proper documentation and payment of premium taxes; 5) travel administrator licensing and audit requirements; and 6) clear and targeted enforcement and penalty provisions.

In addition to the issues identified in the beginning, the Working Group sought to add to, delete, revise or confirm the language adopted by the National Council of Insurance Legislators (NCOIL) regarding amendments to its Limited Lines Travel Insurance Model Act which was later renamed the NCOIL Travel Insurance Model Act. Issues to address included:

- Defining "travel insurance."
- Defining "bundled non-insurance products and services" as well as determining whether "bundling" should be allowed.
- Determining the issue of "competitive market" as defined in the NCOIL model.
- Determining the appropriateness of the travel line of authority being "inland marine."
- Exploring the appropriateness of excluding terrorism coverage in travel insurance products.
- Coordinating benefits provisions needed.
- Other consumer disclosures needed.
- Related licensing issues.
- Identifying and clarifying issues related to premium tax.
- Determining the appropriateness of regulation related to opt-out.
- Identifying and clarifying issues related to authority to enforce.

2. Name of Group Responsible for Drafting the Model and States Participating

The NAIC Travel Insurance Model Act (Model Act) was drafted by the Travel Insurance (C) Working Group. The members of the Working Group were: Maryland, Chair; Virginia, Vice Chair; California; Connecticut; District of Columbia; Florida; Hawaii; Illinois; Louisiana; Missouri; New Mexico; North Carolina; Oklahoma; Pennsylvania; Rohde Island; Utah; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

The charge to the Working Group was to consider the development of a model law or guideline to establish appropriate regulatory standards for the travel and tourism insurance industry. Once the determination as made that it would be appropriate to draft a model law, the Working Group drafted and sent to its parent, the Property and Casualty Insurance (C) Committee, a model law request (MLR) in June 2017. It was approved by the Executive (EX) Committee later that month. The Working Group was given the charge to develop a travel insurance model law for 2017. That work continued into 2018.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

Prior to the 2016 Fall National Meeting, the Working Group became aware of the work being done by the NCOIL to draft amendments to its Limited Lines Travel Insurance Model Act that would expand beyond just the licensing issues and provide broader coverage for travel insurance in general. That work was shared with the Working Group. The Working Group members felt it could serve as a potential framework or basis for its work going forward. The Working Group then began going through the NCOIL model section by section, including detailed discussions regarding the definitions. Comments were submitted by all stakeholders and all were considered throughout the process.

Parties who regularly participated in the process outside of the members include: the Center for Economic Justice (CEJ), the U.S. Travel Insurance Association (UStiA), the Independent Insurance Agents and Brokers of America (IIABA), the Tourism & Travel Industry Consumer Coalition (TTICC), the United States Fire Insurance Company (US Fire), the American Insurance Association (AIA) and UnitedHealth Group.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Once the MLR was approved by the Executive (EX) Committee, the Working Group began the process of going through the NCOIL model section by section, including detailed discussions regarding the definitions. The Working Group held 14 conference calls and meetings in 2017 and nine in 2018, ending with the adoption of the proposed Model Act during its June 13 call. It was presented to the Property and Casualty Insurance (C) Committee with one amendment at the Summer National Meeting in Boston, MA and was adopted unanimously.

During this process, all meetings were held in an open session and posted prior, including materials that summarized all submitted comments and letters for both model definitions and the non-definition sections. As the Working Group moved through discussions of each section, the associated definitions as well as the section content was discussed including submitted comments. Each new version of the Model Act, with the revisions approved during the previous conference call or meeting, was published to the Travel Insurance (C) Working Group' webpage. As comments were submitted, they were added to the spreadsheet which contained comments by section or by definition, and these comments were posted for public access as well.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was a broad range of perspectives presented on many of the issues, definitions and language throughout the process of reviewing the Model Act. All were considered and debated, and ultimately a decision was made regarding the will of the Working Group. There was considerable debate over the definitions including "travel insurance," "limited lines travel insurance producer," "eligible groups," "blanket travel insurance" (which references "eligible groups") and "cancellation fee waiver." The appropriateness of allowing for the bundling of non-insurance and insurance products into the travel protection plan was thoroughly discussed. Issues related to licensing and permissible activities of travel retailers, administrators and producers were also discussed along with the related regulatory issues around "authority to enforce." A great deal of time was spent on the Sales Practices section as well. Consideration was also given to the wording around "free look" periods related to the provision of fulfillment materials. Specifically, consideration was given to whether it be delivered via postal mail or other means such as electronically.

The appropriateness of classifying the travel insurance product as "inland marine" also received attention. During the Working Group's deliberations, there were differing opinions presented; however, a majority of the Working Group members agreed with that classification. After adoption of the Model Act by the Property and Casualty Insurance (C) Committee, Washington and Utah submitted letters proposing that the determination be referred to the Health Insurance Managed Care (B) Committee for review, based on concerns related to whether the inclusion of accident and health coverages fits within the NAIC model *Nationwide Inland Marine Definition* (#701).

7. Any Other Important Information (e.g., amending an accreditation standard)

The following amendment to the Model Act adopted by the Working Group was proposed during the Property and Casualty Insurance (C) Committee's meeting:

Section 9. Policy

A. Notwithstanding any other provision of the [insurance code], Travel Insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance, provided however, that Travel Insurance that provides coverage for SICKNESS, ACCIDENT, DISABILITY OR DEATH OCCURRING DURING TRAVEL, either exclusively, or in conjunction with related coverages of emergency evacuation or repatriation of remains may be filed under either an accident and health line of insurance or an inland marine line of insurance.

Drafting Note: For consistency, states may wish to update their statutory definition of inland marine to include Travel Insurance as defined in this Act. This provision contemplates that Travel Insurance will be subject to the same state laws and regulations as any other inland marine insurance.

The proposed Model Act was adopted as amended.

PET INSURANCE MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known as the "Pet Insurance Act."

Section 2. Scope and Purpose

A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Pet Insurance may be sold in this state.

B. The requirements of this Act shall apply to Pet Insurance policies that are issued to any resident of this state, and are sold, solicited, negotiated, or offered in this state, and policies or certificates that are delivered or issued for delivery in this state.

C. All other applicable provisions of this state's insurance laws shall continue to apply to Pet Insurance except that the specific provisions of this Act shall supersede any general provisions of law that would otherwise be applicable to Pet Insurance.

Section 3. Definitions

If a pet insurer uses any of the terms in this Act in a policy of pet insurance, the pet insurer shall use the definition of each of those terms as set forth herein and include the definition of the term(s) in the policy. The pet insurer shall also make the definition available through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

Nothing in this Act shall in any way prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.

As used in this Act:

A. "Chronic condition" means a condition that can be treated or managed, but not cured.

B. "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

C. "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

D. "Orthopedic" refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, and joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.

E. "Pet insurance" means a property insurance policy that provides coverage for accidents and illnesses of pets.

F. "Preexisting condition" means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

(1) A veterinarian provided medical advice;

(2) The pet received previous treatment; or

(3) Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

G. "Renewal" means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

H. "Veterinarian" means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

I. "Veterinary expenses" means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.

J. "Waiting period" means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

K. "Wellness program" means a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. If any wellness program [insert language from state statute or regulation that defines the trigger for insurance contracts, which might include language such as: [undertakes to indemnify another], or [pays a specified amount upon determinable contingencies] or [provides coverage for a fortuitous event]], it is transacting in the business of insurance and is subject to the insurance code. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being "the business of insurance," unless other indications of insurance also exist.

Section 4. Disclosures

A. A pet insurer transacting pet insurance shall disclose the following to consumers:

(1) If the policy excludes coverage due to any of the following:

(a) A preexisting condition;

(b) A hereditary disorder;

(c) A congenital anomaly or disorder; or

(d) A chronic condition.

(2) If the policy includes any other exclusions, the following statement: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

(3) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit.

(4) Whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet or a change in the geographic location of the insured.

(5) If the underwriting company differs from the brand name used to market and sell the product.

B. Right to Examine and Return the Policy.

(1) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants shall have the right to examine and return the policy, certificate or rider to the company or an agent/insurance producer of the company within fifteen (15) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason,

(2) Pet insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. The following free look statement or language substantially similar shall be included:

"You have 15 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or you may return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return it within 15 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."

C. A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines claim payments under a pet insurance policy within the policy, prior to policy issuance and through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

D. A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do both of the following:

(1) Clearly disclose the applicable benefit schedule in the policy.

(2) Disclose all benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

E. A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

(1) Include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer's basis for determining usual and customary fees and how that basis is applied in calculating claim payments.

(2) Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

F. If any medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

G. Waiting periods and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

H. The pet insurer shall include a summary of all policy provisions required in Subsections (A) through (G), inclusive, in a separate document titled "Insurer Disclosure of Important Policy Provisions."

I. The pet insurer shall post the "Insurer Disclosure of Important Policy Provisions" document required in Subsection (H) through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

J. In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the "Insurer Disclosure of Important Policy Provisions" document required pursuant to Subsection (H) in at least 12-point type when it delivers the policy.

K. At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with the following information, printed in 12-point boldface type:

(1) The [insert state insurance department]'s mailing address, toll-free telephone number and website address.

(2) The address and customer service telephone number of the pet insurer or the agent or broker of record.

(3) If the policy was issued or delivered by an agent or broker, a statement advising the policyholder to contact the broker or agent for assistance.

L. The disclosures required in this section shall be in addition to any other disclosure requirements required by law or regulation.

Section 5. Policy Conditions

A. A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

B. A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.

(1) A pet insurer utilizing a waiting period permitted in Subsection 5B shall include a provision in its contract that allows the waiting periods to be waived upon completion of a medical examination. Pet insurers may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.

(a) A medical examination under Subsection 5B(1) shall be paid for by the policyholder, unless the policy specifies that the pet insurer will pay for the examination.

(b) A pet insurer can specify elements to be included as part of the examination and require documentation thereof, provided the specifications do not unreasonably restrict a consumer's ability to waive the waiting periods in Subsection 5B.

(2) Waiting periods, and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

C. A pet insurer must not require a veterinary examination of the covered pet for the insured to have their policy renewed.

D. If a pet insurer includes any prescriptive, wellness, or non-insurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in the insurance code.

E. An insured's eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.

Section 6. Sales Practices for Wellness Programs

A. A pet insurer and/or producer shall not do the following:

(1) Market a wellness program as pet insurance;

(2) Market a wellness program during the sale, solicitation, or negotiation of pet insurance.

B. If a wellness program is sold by a pet insurer and/or producer:

(1) The purchase of the wellness program shall not be a requirement to the purchase of pet insurance.

(2) The costs of the wellness program shall be separate and identifiable from any pet insurance policy sold by a pet insurer and/or producer.

(3) The terms and conditions for the wellness program shall be separate from any pet insurance policy sold by a pet insurer and/or producer.

(4) The products or coverages available through the wellness program shall not duplicate products or coverages available through the pet insurance policy; and

(5) The advertising of the wellness program shall not be misleading and shall be in accordance with Subsection 6B of this Model.

(6) A pet insurer and/or producer shall clearly disclose the following to consumers, printed in 12-point boldface type:

(a) That wellness programs are not insurance.

(b) The address and customer service telephone number of the pet insurer or producer or broker of record.

(c) The [insert state insurance department]'s mailing address, toll-free telephone number, and website address.

C. Coverages included in the pet insurance policy contract described as "wellness" benefits are insurance.

Section 7. Insurance Producer Training

A. An insurance producer shall not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in Subsection C of this Section.

B. Insurers shall ensure that its producers are trained under Subsection C of this Section and that its producers have been appropriately trained on the coverages and conditions of its pet insurance products.

C. The training required under this subsection shall include information on the following topics:

(1) Preexisting conditions and waiting periods;

(2) The differences between pet insurance and noninsurance wellness programs;

(3) Hereditary disorders, congenital anomalies or disorders and chronic conditions and how pet insurance policies interact with those conditions or disorders; and

(4) Rating, underwriting, renewal and other related administrative topics.

D. The satisfaction of the training requirements of another state that are substantially similar to the provisions of Subsection C shall be deemed to satisfy the training requirements in this state.

Section 8. Regulations

The commissioner may promulgate rules and regulations to administer this Act.

Section 9. Violations

Violations of this Act shall be subject to penalties pursuant to [insert state administrative code].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

Summer 2022 (adopted).

PET INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PET INSURANCE MODEL LAW

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Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	DEL. CODE ANN. tit. 18, §§ 8801 to 8809 (2023).		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

PET INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. STAT. ANN. §§ 22:1371 to 22:1375 (2023).		
Maine	ME. REV. STAT. tit. 24-A, §§ 3151 to 3161 (2022).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	MISS. CODE ANN. §§ 83-87-1 to 83-87-9 (2023).		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. REV. STAT. §§ 44-6501 to 44-6510 (2023).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. §§ 402-P:1 to 402-P:6 (2023).		
New Jersey	NO CURRENT ACTIVITY		

PET INSURANCE MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. REV. CODE §§ 48.205.010 to 48.205.080 (2023).		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2022

PET INSURANCE MODEL ACT (#633)

1. Description of the Project, Issues Addressed, etc.

Development of the Pet Insurance Act. This model addresses required disclosures, definitions, policy conditions, sales practices for wellness programs, and producer training requirements.

2. Name of Group Responsible for Drafting the Model and States Participating

Pet Insurance (C) Working Group
Participating states: Virginia, Chair; California, Co-Chair; Alaska; Arkansas; Connecticut; District of Columbia; Louisiana; Maryland; Massachusetts; Missouri; Pennsylvania; Rhode Island; Utah; Vermont; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

Authorized by a charge from the Property and Casualty Insurance (C) Committee on March 28, 2019. The Working Group adopted the Request for NAIC Model Law Development on June 27, 2019, and the Property and Casualty Insurance (C) Committee adopted it on July 18, 2019. The Executive (EX) Committee and Plenary adopted the Request for NAIC Model Law Development on Aug. 6, 2019.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Drafted by the full membership of the Pet Insurance (C) Working Group. Also participating in the drafting process were: the American Property Casualty Insurance Association (APCIA); the American Veterinarian Medical Association (AVMA); the Center for Economic Justice (CEJ); the Center for Insurance Research (CIR); the Chubb Group, Companion Protect;, Mars Veterinary Health; Nationwide Insurance Group; North American Pet Health Insurance Association (NAPHIA); Trupanion; and Unum Life Insurance Company.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

A draft model law was presented to the Working Group on Oct. 1, 2019. The Working Group exposed Sections 1–4 for a public comment period on Oct. 1, 2019. It met to discuss Sections 1–4 on Nov. 7, 2019; Dec. 19, 2019; Feb. 19, 2020; March 5, 2020; and July 16, 2020.

The Working Group exposed Sections 5–6 for a public comment period on July 16, 2020. It met to discuss Sections 5–6 on Sept. 30, 2020, and Oct. 21, 2020.

The Working Group exposed Sections 7–9 for a public comment period on Sept. 30, 2020. It met to discuss Sections 7–9 on Nov. 6, 2020; Nov. 24, 2020; and Feb. 18, 2021.

The Working Group met to discuss open issues in the model on March 4, 2021; March 26, 2021; April 29, 2021; May 19, 2021; June 10, 2021; June 24, 2021; July 8, 2021; July 22, 2021; and July 29, 2021. It adopted a draft model on Aug. 4, 2021. The Working Group held additional meetings to discuss issues in the model on Sept. 8, 2021, and Oct. 7, 2021. The Working Group adopted the revised draft model on Oct. 21, 2021. The Property and Casualty Insurance (C) Committee adopted the draft model on Nov. 10, 2021. Before its consideration at the Joint Meeting of Executive (C) Committee and Plenary during the Fall National Meeting, there were concerns about the producer training section. The model was sent back to the Working Group for review. The Working Group met June 7, 2022 and July 21, 2022 to revise the language in Section 7. The model was adopted by the Working Group on July 21, 2022. The model was adopted by the Property and Casualty Insurance (C) Committee on August 1, 2022.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Free Look Period – There was discussion that a free look period would offer a better understanding for consumers with a newer product like pet insurance. Many state insurance regulators commented that the free look period was not necessary or actuarial sound. The inclusion of this free look period in the California pet insurance law was requested by industry and supported by many interested parties. State insurance regulators adopted language that insurers can implement a maximum 15-day free look period in which consumers can examine and return the policy for a full refund if no claim has been made on the policy.

Renewals – State insurance regulators wanted clear language added to the model that would not allow a condition that was covered under a policy to be considered a preexisting condition—and, therefore, excluded from coverage—on subsequent policy renewals. While industry did indicate that it would like the ability to issue one-year policies that do not offer a renewal and could then use a preexisting exclusion for a previously covered condition, state insurance regulators stated that these policies would not be considered a renewal and, therefore, the added language would not affect industry's ability to sell these types of policies.

Waiting Period – Some state insurance regulators took issue with the allowance of a waiting period for certain conditions as proposed by the industry. State insurance regulators adopted the allowance of a 30-day waiting period for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.

Wellness Plans – There was discussion about whether wellness plans should be considered insurance or if those plans should be allowed to cover services that could be covered in insurance plans. State insurance regulators adopted a new section of the model to outline sales practices for wellness plans that are sold by licensed insurance entities. Wellness plans that are not sold by licensed entities and do not provide insurance coverage are not regulated by insurance departments and are not addressed in this model.

Licensing – Several state insurance regulators questioned the inclusion of licensing requirements in the model. After discussion with the Producer Licensing (D) Task Force, the licensing section was removed from the model. The Working Group adopted guidelines for producer training requirements.

Producer Training – Regulators in several states wanted to ensure that the language around producer training did not infringe on the work of the Producer Licensing (D) Task Force. They also wanted to make sure the model appropriately addressed reciprocity in states that had different but substantially similar training requirements.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

LONG-TERM CARE INSURANCE MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Drafting Note: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Drafting Note: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Drafting Note: See Section 6J.

Drafting Note: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.

B. "Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after the filing the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

G. (1) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in [insert reference to state law equivalent to Section 4G(1)(e) of the Long-Term Care Insurance Model Act];

(e) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(2) "Qualified long-term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Drafting Note: The definition of "qualified long-term care insurance contract" has been added to assist states in regulating long-term care insurance policies that are federally tax-qualified. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code, as amended, provide a definition of this term and clarify federal income tax treatment of premiums and benefits. Treasury Regulations 1.7702B-1 and 1.7702B-2, and Notice 97-31 issued by the Internal Revenue Service, further address these issues.

Section 5. Extraterritorial Jurisdiction—Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

A. The commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Drafting Note: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

(1) Be cancelled, non-renewed or otherwise terminated on the grounds of the age, gender or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. Preexisting condition.

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization.

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) A long-term care insurance policy or rider shall not condition eligibility for non-institutional benefits on the prior or continuing receipt of skilled care services.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

Drafting Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. (1) Long-term care insurance applicants shall have the right to return the policy, certificate or rider to the company or an agent/insurance producer of the company within thirty (30) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason.

(2) Long-term care insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. This requirement shall not apply to certificates issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act. The following free look statement or language substantially similar shall be included:

"You have 30 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the agent/insurance producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (h) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A description of the eligibility triggers for benefits and how those triggers are met;

(c) A statement of the principal exclusions, reductions and limitations contained in the policy;

(d) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(e) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(f) A description of the terms under which the policy or certificate may be returned and premium refunded;

(g) A brief description of the relationship of cost of care and benefits; and

(h) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

H. A certificate issued pursuant to a group long-term care insurance policy that policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

Drafting Note: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

J. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance or annuity policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care benefits;

(4) A statement that any long-term care inflation protection option required by [cite to state's inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy. If inflation protection was not required to be offered, or if inflation protection was required to be offered but was rejected, a statement that inflation protection is not available under the policy that provides long-term care benefits, and an explanation of other options available under the policy, if any, to increase the funds available to pay for the long-term care benefits;

(5) If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees, fees or other costs related to long-term care costs of insurance charges in the base policy and any riders; and

(c) Current and projected periodic and maximum lifetime benefits; and

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state's basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite to state's life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].

K. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) Any costs or changes that apply or will apply to the policy or any riders;

(3) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(4) The amount of long-term care benefits existing or remaining.

L. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

M. Any policy, certificate or rider advertised, marketed or offered as long-term care or nursing home insurance, as defined in Section 4A of the NAIC Long-Term Care Insurance Model Act, shall comply with the provisions of this Act.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is *both* material to the acceptance for coverage *and* which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D. (1) A long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [cite to state's life insurance incontestability clause]. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. Nonforfeiture Benefits

A. Except as provided in Subsection B, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

B. When a group long-term care insurance policy is issued, the offer required in Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

C. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Producer Training Requirements

A. (1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.

(2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course as set forth in Subsection B, within one year from [insert effective date of this legislation].

(3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in Subsection B.

(4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].

B. (1) The one-time training required by this Section shall be no less than eight (8) hours and the ongoing training required by this Section shall be no less than four (4) hours every 24 months.

(2) The training required under Paragraph (1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs, including, but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(b) Available long-term services and providers;

(c) Changes or improvements in long-term care services or providers;

(d) Alternatives to the purchase of private long-term care insurance;

(e) The effect of inflation on benefits and the importance of inflation protection; and

(f) Consumer suitability standards and guidelines.

(3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. (1) Insurers subject to this Act shall obtain verification that a producer receives training required by Subsection A before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the commissioner upon request.

(2) Insurers subject to this Act shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.

D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

Drafting Note: Guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, provided by the Centers for Medicare & Medicaid Services in the July 27, 2006 State Medicaid Director Letter (SMDL #06-019) states that "[t]he State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage of [long term care]." There is no guidance as to how the State insurance department is to accomplish this requirement. This drafting note provides information to the State insurance departments with respect to achieving the aforementioned requirements.

Section 9C of the NAIC Long-Term Care Insurance Model Act requires insurers to obtain and maintain records verifying that producers who sell, solicit or negotiate long-term care insurance products on their behalf have received the training required in this Section and to make such records available to the State insurance department. In addition, Section 9C(2) requires insurers to obtain and maintain records concerning the training of their agents for Partnership policies. Insurers are to maintain records that verify its producers have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

State insurance departments, in order to meet the standards contained in the DRA concerning producer training should consider developing a process to communicate with the State Medicaid agency on how the DRA requirements will be met. They should develop a process to verify insurance company compliance with these requirements including, as an audit step, the verification of compliance with the above requirements as part of a market conduct examination. In addition, State insurance departments should consider performing annual, random verifications of insurance company compliance. Finally, consideration may be given to deeming thos training programs, specifically approved by the State for Partnership policy training that qualify for Continuing Education, as meeting the requirements contained in Section 9C(2).

Section 10. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 11. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 12. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

Section 14. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. I 9, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. I 8, 136, 819, 844, 845(amended).
1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 823-824 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 701-704 (amended).
1998 Proc. 1st Quarter 16, 17, 769, 801-804, 894 (amended).
1999 Proc. 4th Quarter 18, 929, 969, 972-978 (amended).
2006 Proc. 4th Quarter 44, 48-60 (amended, reprinted).
2007 Proc. 3rd Quarter 42-44 (amended).
2009 Proc. 3rd Quarter Vol. I 95-102, 114-119, 205-210, 312-315 (amended).
2016 Proc. 3rd Quarter (amended).

LONG-TERM CARE INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LONG-TERM CARE INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-19-100 to 27-19-110 (2003).	
Alaska		ALASKA STAT. §§ 21.53.010 to 21.53.200 (1990/2011).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1691 to 20-1691.12 (1987/2008).	
Arkansas		ARK. CODE ANN. §§ 23-97-301 to 23-97-321 (2005).	
California			CAL. INS. CODE §§ 10231 to 10237.6 (1989/2018).
Colorado		COLO. REV. STAT. §§ 10-19-101 to 10-19-115 (1990/2018).	3 COLO. CODE REGS. § 702-4:4-4-1 (1997/2011); 702-4:4-4-4 (2010/2013) (partnerships); BULLETIN B-1-20 (2007); BULLETIN B-4.30 (2012).
Connecticut			CONN. GEN. STAT. § 38a-501 (1991/2017) (commissioner shall develop regulations).
Delaware		DEL. CODE ANN. tit. 18, §§ 7101 to 7109 (1989/2010).	DOMESTIC FOREIGN INSURERS BULLETIN 23 (2006).

LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia		D.C. CODE §§ 31-3601 to 31-3612 (2000/2005).	
Florida			FLA. STAT. §§ 627.9401 to 627.9408 (1988/2015); FLA. ADMIN. CODE ANN. r. 69O-157.001 to 69O-157.023 (1989/2008); MEMORANDUM 2003-002 (2003); MEMORANDUM 2006-16 (2006); MEMORANDUM 2007-011 (2007); MEMORANDUM 2008-002 (2008).
Georgia		GA. CODE ANN. §§ 33-42-1 to 33-42-6 (1988/2019).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. 431:10H-101 to 431:10H-117 (1999/2017).	
Idaho		IDAHO CODE §§ 41-4601 to 41-4611 (1988/1999).	BULLETIN 2007-8 (2007); BULLETIN 2016-2 (2016).
Illinois		215 ILL. COMP. STATS. 5/351A-1 to 5/351A-11 (1989/2001).	
Indiana			IND. CODE §§ 27-8-12-1 to 27-8-12-19 (1987/2003).
Iowa		IOWA CODE §§ 514G.101 to 514G.113 (2008/2015).	BULLETIN 2008-17 (2008); BULLETIN 2009-7 (2009); BULLETIN 2009-7 (REVISED) (2009); BULLETIN 2014-1 (2014).
Kansas		KAN. STAT. ANN. §§ 40-2225 to 40-2228 (1987/2002).	KAN. STAT. ANN. § 40-2136 (2008/2012).

LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kentucky		KY. REV. STAT. §§ 304.14-600 to 304.14-625 (1992/2010).	KY. REV. STAT. § 304.14-630 (2010); KY. REV. STAT. § 304.14-560 (1990/2010) (Consumer's Guide); BULLETIN 91-1 (1991); BULLETIN 92-2 (1992); BULLETIN 93-1 (1993); BULLETIN 94-1 (1994); BULLETIN 96-4 (1996); BULLETIN 8-4 (2004).
Louisiana		LA. REV. STAT. ANN. §§ 22:1181 to 22:1191 (1989/2012).	BULLETIN 9-5-2006 #1 and #2 (2006); BULLETIN 12-28-2009 (2009).
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 5071 to 5084 (2000/2019).	ME. REV. STAT. ANN. tit. 36, § 2525 (1989) (tax credit); BULLETIN 347 (2007); BULLETIN 362 (2009); BULLETIN 363 (2009); BULLETIN 417 2017); BULLETIN 418 (2017); BULLETIN 419 (2017).
Maryland			MD. CODE ANN. INS. §§ 18-101 to 18-120 (2008/2014); MD. CODE ANN. INS. § 16-214 (1996) (life insurance riders); BULLETIN 13-2009 (2009); BULLETIN 2010-33 (2010).
Massachusetts		MASS. GEN. LAWS ch. 176U, §§ 1 to 9 (2013/2019); 211 MASS. CODE REGS. §§ 65:01 to 65:102 (1989/2005).	BULLETIN 2013-11 (2013).
Michigan		MICH. COMP. LAWS §§ 500.3901 to 500.3955 (1992/2006).	MEMORANDUM 1-27-2016 (2016); BULLETIN 2016-01-INS (2016).

LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. §§ 62S.01 to 62S.34 (1997/2019) (qualified policies); MINN. STAT. §§ 62A.46 to 62A.56 (1986/2003) (non-qualified policies); BULLETIN 2007-4 (2007); BULLETIN 2007-4 (ADDENDUM) (2007); BULLETIN 2007-5 (2007); BULLETIN 2007-10 (2007); MINN. R. §§ 2745.0010 to 2745.0050 (1992) (non-qualified plans).
Mississippi			MISS. CODE ANN. §§ 43-13-601 to 43-13-607 (2014) (partnership program).
Missouri		MO. REV. STAT. §§ 376.1100 to 376.1130 (1990/2002).	BULLETIN 2008-04 (2008); BULLETIN 2008-09 (2008).
Montana		MONT. CODE ANN. §§ 33-20-127 to 33-20-128 (1991/2007); MONT. CODE ANN. §§ 33-22-1101 to 33-22-1129 (1989/2007).	MEMORANDUM 9-7-2007 (2007); MEMORANDUM 2-23-2010 (2010).
Nebraska		NEB. REV. STAT. §§ 44-4501 to 44-4521 (1987/2018).	BULLETIN CB-113 (2007); BULLETIN CB-114 (2007); BULLETIN CB-133 (#2) (2015).
Nevada			NEV. ADMIN. CODE §§ 687B.005 to 687B.140 (1988/2016).
New Hampshire		N.H. REV. STAT. ANN. §§ 415-D:1 to 415-D:13 (1990/2003).	BULLETIN 2010-020-AB (2010).
New Jersey		N.J. REV. STAT. §§ 17B:27E-1 to 17B:27E-12 (2004); N.J. ADMIN. CODE §§ 11:4-34.1 to 11:4-34.32 (1989/2010).	
New Mexico		N.M. STAT. ANN. §§ 59A-23A-1 to 59A-23A-13 (1989/2013).	
New York			N.Y. INS. LAW § 1117 (1986/2016).

LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina		N.C. GEN. STAT. §§ 58-55-1 to 58-55-50 (1987/2019).	N.C. GEN. STAT. § 108A-70.4 (2010) (partnerships); BULLETIN 2011-B-6 (2011).
North Dakota		N.D. CENT. CODE §§ 26.1-45-01 to 26.1-45-14 (1987/2019).	BULLETIN 2007-4 (2007); BULLETIN 2007-3 (2007); BULLETIN 2012-2 (2012); BULLETIN 2013-1 (2013); BULLETIN 2014-1 (2014).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. ANN. §§ 3923.41 to 3923.50 (1988/2013); BULLETIN 2008-2 (2008).
Oklahoma			OKLA. STAT. tit. 36, §§ 4421 to 4430 (1987/2018); BULLETIN 6-23-2008 #1 and #2 (2008).
Oregon		OR. REV. STAT. §§ 743.650 to 743.665 (1989/2016).	BULLETIN 2014-3 (2014).
Pennsylvania		40 PA. CONS. STAT. §§ 991.1101 to 991.1115 (1921/2010); 31 PA. CODE §§ 89a.101 to 89a.129 (2002).	NOTICE 7-30-2016 (2016).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 10251 to 10261 (2011).	
Rhode Island			R.I. GEN. LAW §§ 27-34.2-1 to 27-34.2-22 (1988/2013); BULLETIN 2011-2 (2011); BULLETIN 2018-16 (2018).
South Carolina			S.C. CODE ANN. §§ 38-72-10 to 38-72-100 (1988/2019); BULLETIN 4-2009 (2009).
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-17B-1 to 58-17B-16 (1989/2007).	BULLETIN 89-3 (1989); BULLETIN 95-2 (1995); BULLETIN 2007-4 (2007); BULLETIN 2007-7 (2007).
Tennessee		TENN. CODE ANN. §§ 56-42-101 to 56-42-111 (1988/2016).	BULLETIN 9-22-2008 (2008) (partnership); MEMORANDUM 9-29-2015 (2015) (partnerships).

LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas		TEX. CODE ANN. § 1201.105 (2005); TEX. CODE ANN. §§ 1651.001 to 1651.107 (2005/2017); 28 TEX. ADMIN. CODE §§ 3.3801 to 3.3874 (1990/2009).	BULLETIN B-0018-15 (2015); BULLETIN B-0010-18 (2018).
Utah		UTAH CODE ANN. §§ 31A-22-1401 to 31A-22-1414 (1991/2019).	BULLETIN 2014-7 (2014).
Vermont		VT. STAT. ANN. tit. 8, §§ 8081 to 8099 (2005/2011).	BULLETIN HCA-130 (2010).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			V.A. CODE §§ 38.2-5200 to 38.2-5210 (1987/2002); ADMIN. LETTER 1990-23 (1990) (NAIC Shopper's Guide); ADMIN. LETTER 2007-3 (2007).
Washington			WASH. REV. CODE ANN. §§ 48.84.010 to 48.84.910 (1986/2008); WASH. REV. CODE ANN. §§ 48.85.010 to 48.85.900 (1993/2012) (partnership).
West Virginia		W.VA. CODE ANN. §§ 33-15A-1 to 33-15A-11 (1989/2004).	W. VA. CODE ANN. § 33-12-8a (2009) (producer training); INFORMATIONAL LETTER 182 (2012).
Wisconsin		WIS. ADMIN. CODE § INS. 3.46 (1991/2014).	WIS. STAT. ANN. § 146.91 (1987/2007); § 632.84 (1987/1989); § 600.03 (1977/2013); § 625.16 (1981/1990); § 3.455 (1991/2008); BULLETIN 7-23-2001 (2001); BULLETIN 11-19-2008 (2008); BULLETIN 11-21-2008 (2008).
Wyoming			WYO. STAT. ANN. §§ 26-38-101 to 26-38-111 (1988/1999); MEMORANDUM 01-2009 (2009) (partnerships).

PROJECT HISTORY - 2016

LONG-TERM CARE INSURANCE MODEL ACT (#640)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Long-Term Care Insurance Model Act* (#640) were made pursuant to the charge of the Long-Term Care Consumer Disclosure (B) Subgroup to: 1) review the existing requirements for consumer disclosures contained in Model #640, the *Long-Term Care Insurance Model Regulation* (#641) and the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* (Guidance Manual), and make recommendations for needed improvements to the Task Force; and 2) continue to consider all consumer disclosure requirements for long-term care insurance (LTCI), including those provided at the time of issue as well as those provided at the time of rate increase.

2. Name of Group Responsible for Drafting the Model and States Participating.

Long-Term Care Consumer Disclosure (B) Subgroup of the Senior Issues (B) Task Force.

California, Chair	Louisiana	South Carolina
Florida, Vice Chair	Maine	Texas
Indiana	North Carolina	Utah
Iowa	Oregon	Washington
Kentucky	Rhode Island	

3. Project Authorized by What Charge and Date First Given to the Group.

The Senior Issues (B) Task Force appointed the Long-Term Care Consumer Disclosure (B) Subgroup at the 2014 Summer National Meeting to update LTCI consumer disclosures, as they had not been reviewed in some time and may have needed important changes.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Long-Term Care Consumer Disclosure (B) Subgroup began with Section 6 of Model #640 and made changes to various parts of said section. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP), American Council of Life Insurers (ACLI), Brenda J. Cude of the University of Georgia, and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

The Long-Term Care Consumer Disclosure (B) Subgroup met 16 times via open conference call (April 26, 2016; March 24, 2016; Feb. 25, 2016; Jan. 21, 2016, Dec. 3, 2015; Oct. 29, 2015; Sept. 10, 2015; Aug. 4, 2015; July 16, 2015; June 29, 2015; May 11, 2015; April 9, 2015; March 5, 2015; Jan. 29, 2015, Dec. 18, 2014; and Oct. 28, 2014). The Subgroup adopted its changes on April 26, 2016. The Senior Issues (B) Task Force exposed the model revisions for public comment from May 16, 2016, to May 31, 2016. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Senior Issues (B) Task Force adopted the model revisions on June 9, 2016. The Health Insurance and Managed Care (B) Committee adopted the model revisions on Oct. 25, 2016.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2006

LONG TERM CARE INSURANCE MODEL ACT (#640)

1. Description of the Project, Issues Addressed, etc.

A new Section 9 establishing producer training requirements was added to the model act. These amendments require an initial 8 hours of training and 4 hours on ongoing training for producers who sell, solicit or negotiate long-term care insurance. The model act enumerates the topics that the training must cover and places the responsibility on insurers to ensure that producers are properly trained.

The revisions to Section 9 also address the requirement placed on state insurance departments under the federal Deficit Reduction Act (DRA) of 2005 and guidance provided by Centers for Medicare & Medicaid Services (CMS) with respect to producer training about the long-term care Partnership program. The DRA and CMS guidance requires that "[t]he state insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage of long-term care."

The revisions to the model act require that the insurers obtain verification that a producer has obtained the required training before permitting the producer to sell solicit or negotiate long-term care insurance products. The insurer must also maintain records available to commissioners upon request sufficient for the state insurance department to provide assurance to the state Medicaid agency that appropriate training has been received.

The amendments to the model act also address what is meant by the term "field issued" and the circumstances under which it is allowed.

2. Name of Group Responsible for Drafting the Model and States Participating

Long Term Care (B) Working Group (previously Senior Issues (B) Task Force)

Kansas - Chair, Florida – Vice Chair, Wisconsin – Vice Chair, Alabama, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Michigan, Minnesota, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The Health Insurance and Managed Care (B) Committee has a standing charge to "Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace." This charge was delegated to the Senior Issues Task Force until Spring 2006, when the charge was delegated to the newly formed Long-Term Care (B) Working Group.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The task force has been working since 2003 to identify issues and draft language to revise the model regulation.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Long-Term Care Insurance Model Act was last updated in August 2000. At that time, rating practices and enhanced consumer disclosures were added to the model. After adopting the revisions to the model act, the task force decided to give states a few years to revise their laws before undertaking to revise the model act again. Because of the rapidly evolving nature of long-term care, the task force recognized the need to begin review of the model regulation. In 2003, the task force solicited input from the states about areas where states had "gone further" than the model act to protect consumers. The results were compiled into a list of issues for the task force to consider. Some issues were referred to the Life and Health Actuarial Task Force, while other issues remained with the Senior Issues Task Force to debate and consider. These revisions represent areas where consensus has been reached.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

These revisions represent those areas where the regulators, industry groups and consumer groups were able to reach consensus. More controversial issues are still the subject of debate and discussion by the Long Term Care Working Group.

7. Any Other Important Information (e.g., amending an accreditation standard).

LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act], to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of law enacting the NAIC Long-Term Care Insurance Model Act and establishing the commissioner's authority to issue regulations].

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

Drafting Note: This regulation, like the NAIC Long-Term Care Insurance Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

Drafting Note: The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a new category of long-term care insurance called Qualified Long-Term Care Insurance. This regulation is intended to provide requirements for all long-term care insurance contracts, including qualified long-term care insurance contracts, as defined in the NAIC Long-Term Care Insurance Model Act and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The amendments to this regulation made in recognition of Section 7702B do not require nor prohibit the continued sale of long-term care insurance policies and certificates that are not considered qualified long-term care insurance contracts.

Section 4. Definitions

For the purpose of this regulation, the terms "long-term care insurance," "qualified long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in Section 4 of the NAIC Long-Term Care Insurance Model Act. In addition, the following definitions apply.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

A. "Benefit trigger", for the purposes of independent review, means a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Drafting Note: This definition is not intended to be a required definitional element of a long-term care insurance policy, but rather intended to clarify the scope and intent of Section 31. The requirement for a description of the benefit trigger in the policy or certificate is currently found in Section 8.

B. (1) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Sections 20 and 20.1, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

C. "Incidental," as used in Sections 20J and 20.1J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Drafting Note: The phrase "value of the benefits" is used in defining "incidental" to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

D. "Independent review organization" means an organization that conducts independent reviews of long-term care benefit trigger decisions.

E. "Licensed health care professional" means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

Drafting Note: For purposes of Section 31, it may be appropriate for certain licensed health care professionals, such as physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists, to review a benefit trigger determination. However, some of these health care professionals may not meet the definition of a licensed health care practitioner under Section 7702B(c)(4) of the Internal Revenue Code. For tax-qualified long-term care insurance contracts, only a licensed health care professional who meets the definition of a licensed health care practitioner may certify that an individual is a chronically ill individual.

F. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

G. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Section 5. Policy Definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Drafting Note: This section is intended to specify required definitional elements of several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Drafting Note: The U. S. Treasury Department may, at some time in the future, develop additional or different policy definitions intended to satisfy the requirements of Section 7702B of the Internal Revenue Code of 1986, as amended, for qualified long-term insurance contracts. States should consider developing a mechanism to allow definitions that may be developed by the federal agency to be used in qualified long-term care insurance contracts.

Section 6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 8 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable. "

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(8) (a) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(b) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

Drafting Note: Paragraph (8) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates. However, the issuer of long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of issue irrespective of any licensing, registration or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved.

(9) This subsection is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to or contain incentives to use certain

providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. (1) The premium charged to an insured shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 26, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 26, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

(1) In the case of a group defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by [insert reference to state law comparable to Section 2W of the NAIC Insurance Information and Privacy Protection Model Act], is maintained.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Section 7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice. " The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing

B. Reinstatement. In addition to the requirement in Subsection A, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Drafting Note: The language in Subsection B addressing the provision of proof of cognitive impairment or less of functional capacity has been amended to more precisely clarify the original intent in adopting the reinstatement provision.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

(2) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations. "

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits. "

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits. " Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 33E3 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 33E3 that the policy is not intended to be a qualified long-term care insurance contract.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e. g. , next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.

Drafting Note: It is intended that the disclosures in Section 9B be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of and review situations where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of Subsections B and C of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least [forty-five (45) days] prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 10. Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) A copy of the disclosure documents required in Section 9; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in (i) or the specification of and justification for a lower margin as required by (ii).

(i) A composite margin shall not be less than 10% of lifetime claims.

(ii) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.

(iii) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

Drafting Note: For the justification required in (iii) above, examples of such considerations, if applicable to the product and company, might be found in Society of Actuaries research studies entitled "Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance" (2012) and "Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance Programs" (2014).

(iv) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

Drafting Note: Actual margins may be included in several actuarial assumptions (e. g. mortality, lapse, underwriting selection wear-off, etc.) in addition to some of the margin in the morbidity assumption. The composite margin is the total of such margins over best-estimate assumptions.

(e) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: In the event a series of increases is being applied to another policy form, intermediate premium levels are not to be used in this comparison.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

(f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

(3) An actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

(a) An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c),

(b) A complete description of pricing assumptions; and

(c) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in Paragraph (2)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(d) A demonstration that the gross premiums include the minimum composite margin specified in Paragraph (2)(d).

C. In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may accept a review done for another state or states if such review is for the same policy form or where any differences in benefits and premiums are not material and such review was completed within eighteen months of the date of the actuarial certification in Subsection B(2) above.

Section 11. Prohibition Against Post-Claims Underwriting

A. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. (1) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) A report of a physical examination;

(b) An assessment of functional capacity;

(c) An attending physician's statement; or

(d) Copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

Section 12. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 365 benefit days and less than a $25 daily maximum benefit constitute illusory home health care benefits.

Section 13. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Long-Term Care Insurance Model Act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. (1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by [insert reference to Section 4(E)(1) of the Long-Term Care Insurance Model Act], the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of [cite to state's life insurance replacement regulation similar to the NAIC Life Insurance and Annuities Replacement Model Regulation]. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]
The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)

F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

G. For purposes of this section:

(1) "Policy" means only long-term care insurance;

(2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) "Report" means on a statewide basis.

H. Reports required under this section shall be filed with the commissioner.

I. Annual rate certification requirements.

(1) This subsection applies to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

(2) The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this section.

(a) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(i) A statement of the sufficiency of the current premium rate schedule including:

(I) For the rate schedules currently marketed,

a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

b. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify its approval of the form for future sales pursuant to [*Reference State form approval authority and administrative procedures rules*].

Drafting Note: In accordance with the 2014 amendments to Section 10, in situations where the premium rates have been approved with less than the normal minimum margin for moderately adverse experience, any adverse experience should be reviewed to determine if the lower margins can be continued for new business.

(II) For the rate schedules that are no longer marketed,

a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

b. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

(ii) A description of the review performed that led to the statement.

(b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (2)(a).

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

Drafting Note: ASOP No. 18, the NAIC *Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* and the Academy of Actuaries Practice Note "Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability" all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

(iii) A description of the credibility of the experience data.

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

(c) The actuarial certification required pursuant to Paragraph (2)(a) must be based on calendar year data and submitted annually no later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to Paragraph (2)(b) must be submitted at least once every three (3) years with the certification.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not certify to the maintenance of margins.

Section 16. Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC Producer Licensing Model Act].

Section 17. Discretionary Powers of Commissioner

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Drafting Note: This provision is intended to provide the commissioner with limited discretion and flexibility to accommodate specific and innovative long-term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

Section 18. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events;

(2) Covered long-term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;

(13) Maximum benefit;

(14) Availability of eligible facilities;

(15) Margins in claim costs;

(16) Optional nature of benefit;

(17) Delay in eligibility for benefit;

(18) Inflation protection provisions; and

(19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [insert reference to state law equivalent to the Health Insurance Reserves Model Regulation].

Drafting Note: HIPAA applies the reserve method to qualified long-term care contracts that is applied to all insurance contracts except life insurance contracts, annuity contracts, or noncancellable accident and health contracts.

Section 19. Loss Ratio

A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, 20 and 20.1.

B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification; and

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;

(4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 19 above which removes the word "individual": (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 20. Premium Rate Schedule Increases

Drafting Note: Section 20 applies to policies issued for effective dates prior to the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC in 2014). Policies issued on or after that date should adhere to the requirements of Section 20.1 instead of Section 20. Section 20 and Section 20.1 are identical with the exceptions of Subsections A, C and G.

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval. " States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10. B(2)(e) or Section 20. B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Insurance Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms "adequately match the projected experience" include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

(c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20.1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC in 2014. Policies issued prior to the date that is six (6) months after adoption of the amended regulation should adhere to the requirements of Section 20 instead of Section 20.1. Section 20 and Section 20.1 are identical with the exception of Subsections A, C and G.

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval. " States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10B(2)(e) or Section 20B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims, without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;

(3) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

(4) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Insurance Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms "adequately match the projected experience" include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section.

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

(c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 21. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to [cite state law equivalent to Section 5 of the Long-Term Care Insurance Model Act], it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Section 22. Filing Requirements for Advertising

A. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Section 23. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(b) Excessive insurance is not sold or issued.

(2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations. "

(3) Provide copies of the disclosure forms required in Section 9C (Appendices B and F) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6 A(3) of this regulation.

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 28D(3) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 28D(4).

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC Long-Term Care Insurance Model Act], when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any long-term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(d) Subparagraphs (a) through (c) shall not apply to qualified long-term care insurance contracts.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of state unfair trade practices act].

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to long-term care insurance policies and certificates.

Section 24. Suitability

A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) Train its agents in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

C. (1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet. " The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Section 25. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 26. Availability of New Services or Providers

A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date of the new policy series is made available for sale in this state.

Drafting Note: New long-term care services or providers that are material in nature shall not include changes to policy structure; or benefits or provisions that are minor in nature. Examples of when notification need not be provided include: changes in elimination periods, benefit periods and benefit amounts.

B. Notwithstanding Subsection A above, notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

C. The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

Drafting Note: An example of an acceptable alternative program is underwriting concessions.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this Subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 14 and 24, and the reporting requirements of Section 15A to E of this regulation.

F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the offering entity. However, if the policy is issued to a group defined in Section 4E(4) of the Long-Term Care Insurance Model Act, the notification shall be made to each certificateholder.

G. Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

H. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

I. This section shall become effective on or after [insert the effective date of the amended regulation].

Section 27. Right to Reduce Coverage and Lower Premiums

A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly or monthly benefit amount.

(2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

(3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

(1) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(2) Be consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this regulation.

F. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

G. The requirements of Subsections A through F shall apply to any long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].

H. A premium increase notice required by Section 9E of this regulation shall include:

(1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) A disclosure stating that all options available to the policyholder may not be of equal value; and

(3) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

I. The requirements of Subsection H shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].

Drafting Note: Compliance with this Section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

Section 28. Nonforfeiture Benefit Requirement

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection D(4) shall still apply.

D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

Triggers for a Substantial Premium Increase

	Percent Increase Over

Issue Age	Initial Premium
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

(5) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 27 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Paragraph (6)(c) applies.

(6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 27 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.

(7) For any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

(a) In the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table; and

(b) Values above 100% in the table in Paragraph (3) above shall be reduced to 100%.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection D(3) but not Subsection D(4), are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.

(4) (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2) and (3) below, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

(3) The last sentence in Subsection C and Subsections D(4) and D(6) shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] one year after adoption.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19, Section 20 or Section 20.1, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection D(3) or D(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

(a) Reduced paid-up insurance;

(b) Extended term insurance;

(c) Shortened benefit period; or

(d) Other similar offerings approved by the commissioner.

Section 29. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring;

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in this section shall be effective [insert date 12 months after adoption of this provision] and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the Long-Term Care Insurance Model Act] that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

Section 30. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. For purposes of this section the following definitions apply:

(1) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) (a) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or

(ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Drafting Note: With respect to the activities of daily living (ADL) benefit trigger, HIPAA provides that tax-qualified contracts must take into account at least five of the six ADLs specified in Section 29B. This model regulation requires that eligibility for payment of benefits be no more restrictive than requiring a deficiency in the ability to perform not more than three ADLs, of the six listed. Thus, in this regard, a contract that complies with this regulation will also be tax-qualified. States do not need to alter their regulations from this model regulation with respect to the ADL trigger for tax-qualified contracts.

(b) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(3) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(4) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

Drafting Note: Terms used in the definition of a "chronically ill individual," such as substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment, are not defined by the Internal Revenue Code of 1986, as amended, although the meaning of the terms has been addressed by Treasury Department and Internal Revenue Service guidance. The requirement that an insured be certified as a chronically ill individual at least once every 12 months by a licensed health care practitioner does not preclude an insurer from requiring more frequent assessments of an insured's condition in order to determine whether benefits are payable under a contract. However, states are also free to limit an insurer's ability to perform more frequent assessments without affecting the tax-qualified status of the contract.

Qualified long-term care insurance contracts that pay benefits upon a loss of functional capacity must include a provision for triggering benefits that is different from that found in Section 29 of this model regulation. The Internal Revenue Service has stated that the 90-day requirement under this benefit trigger does not establish a waiting period before which benefits may be paid or before which services may constitute qualified long-term care services.

Under Section 7702B of the Internal Revenue Code, as amended, only "licensed health care practitioners" can certify that an insured is a chronically ill individual. This term includes only physicians (within the meaning of Section 1861(r)(1) of the Social Security Act), registered professional nurses and licensed social workers.

Section 7702B does not preclude a contract from specifying a subset of "licensed health care practitioners" who can perform certifications, e. g., only physicians within the meaning of Section 1861(r)(1) of the Social Security Act that are approved by the insurance company. The Secretary of the Treasury may in regulations expand the types of individuals who are considered "licensed health care practitioners. "

Section 7702B(c)(2) states that an individual will be considered chronically ill if he or she is certified by a licensed health care practitioner as having a level of disability similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of disability described in Section 7702B(c)(2)(A)(i) (Section 30C of this regulation). At present, the Secretary of the Treasury has prescribed no such standard. Federal tax law does not require a qualified long-term care insurance contract to include this benefit trigger in the contract. In addition, this model regulation does not mandate inclusion of this undefined benefit trigger in policies at the present time. If the Treasury Department prescribes an additional benefit trigger in the future, consideration will be given at that time to making appropriate amendments to this regulation.

B. A qualified long term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Drafting Note: The federal tax requirements for the term "qualified long-term care services" has been added to assist states in regulating qualified long-term care insurance contracts, which are defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The Internal Revenue Code of 1986 is subject to amendment by Congress and to interpretation by the Treasury Department, the Internal Revenue Service and the courts.

Since a qualified long-term care insurance contract can provide insurance coverage "only" for qualified long-term care services, and such services are ones required by a "chronically ill individual," benefits from such a contract can only be provided to an individual who is chronically ill. Federal tax law does not, however, prohibit the provision of coverage of some, but not all, qualified long-term care services. Thus, a contract may cover only nursing home services or limit benefits to those performed by eligible providers consistent with the requirements of federal tax law. Likewise, the federal tax law does not preclude a contract from specifying the need for hands-on assistance for purposes of determining whether the insured can perform an activity of daily living. Under this regulation, however, benefit triggers requiring greater degrees of impairment than the minimum standard established by federal tax law are permitted only to the extent otherwise consistent with this regulation and the model act.

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

Drafting Note: Section 7702B of the Internal Revenue Code of 1986, as amended, includes a provision for triggering benefits that is different from that found in Section 29 of this model regulation. The definitions used in the triggering of benefits in Section 7702B (substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment) have been defined in guidance promulgated by the Department of the Treasury.

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

E. Certifications required pursuant to Subsection C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

F. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Section 31. Appealing An Insurer's Determination That The Benefit Trigger Is Not Met.

Drafting Note: Consistent with the NAIC model law procedures revised and adopted by the NAIC in September 2008, these revisions to the Long-Term Care Insurance Model Regulation provide minimum regulatory standards for independent review of benefit trigger determinations. The regulatory provisions and procedures set forth in this section are the minimum national standard for benefit trigger independent review. Nothing in this regulation would, nor is it the intent of these revisions to, prohibit a state that supported these model revisions from enacting regulations that go beyond this minimum standard to provide for a larger role and greater involvement for insurance departments in the independent review process. In determining the use of these minimum standards for any federal legislation or regulations pertaining to long-term care insurance, policymakers should view these as minimum standards and not prohibit states from enacting standards that go beyond these minimums.

A. For purposes of this section, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164. 502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

B. If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

(1) The reason that the insurer determined that the insured's benefit trigger has not been met;

(2) The insured's right to internal appeal in accordance with subsection C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

(3) The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with Subsection D.

C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in Subsection D to the insured and the insured's authorized representative, if applicable.

(3) As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your

request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it. "

Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions should modify the language in paragraph (3) accordingly.

(4) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its determination of independent review ineligibility.

(5) The appeal process described in Subsection C is not deemed to be a 'new service or provider' as referenced in Section 26, Availability of New Services or Providers, and therefore does not trigger the notice requirements of that section.

D. Independent Review of Benefit Trigger Determination.

(1) Request. The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in Subsection C has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

(2) Cost. The cost of the independent review shall be borne by the insurer.

(3) Independent Review Process.

(a) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the state. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

(b) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(i) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section;

(ii) The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

(iii) Such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(c) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in Subsection C.

(i) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(ii) The insurer shall complete its review of the information and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the insurer's receipt of such new or additional information.

(iii) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in Subparagraph (i) below. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(d) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that the request for independent review has been received, accepted and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.

(e) Within five (5) business days of receipt of the request for independent review, the independent review organization assigned pursuant to this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer and the commissioner that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization should consider when conducting its review.

(f) The independent review organization shall review all of the information and documents received pursuant to Subparagraph (e) that has been provided to the independent review organization. The independent review organization shall provide copies of any documentation or information provided by the insured or the insured's authorized representative to the insurer for its review, if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information in accordance with Subparagraph (h).

(g) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider such information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

(h) If the insurer overturns its benefit trigger determination:

(i) The insurer shall provide notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision; and

(ii) The independent review process shall immediately cease.

(i) The independent review organization shall provide the insured and the insured's authorized representative, if applicable, the insurer and the commissioner written notice of its decision, within 30 calendar days from receipt of the referral referenced in Paragraph (3)(b). If the independent review organization overturns the insurer's decision, it shall:

(i) Establish the precise date within the specific period of time under review that the benefit trigger was deemed to have been met;

(ii) Specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and

(iii) For tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.

(j) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.

(k) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.

(l) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

(m) The insurance department shall utilize the criteria set forth in Appendix H, Guidelines for Long-Term Care Independent Review Entities, in certifying or approving entities to review long-term care insurance benefit trigger decisions.

Drafting Note: States that do not maintain a list of qualified independent review organizations to review long-term care benefit trigger decisions or have another mechanism for certifying or approving independent review organizations, should replace the language in Subparagraph (m) with the following:

The insurance department shall accept another state's certification of an independent review organization, provided such state requires the independent review organization to meet substantially similar qualifications as those contained in Appendix H.

(n) The commissioner shall maintain and periodically update a list of approved independent review organizations.

E. Certification of Long-Term Care Insurance Independent Review Organizations. The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

(1) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e. g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.

(2) Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with an entity that previously provided medical care to the insured.

(3) Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

(4) Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.

(5) Be state approved or certified to conduct such reviews if the state requires such approvals or certifications.

(6) Provide a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

(7) Provide the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(8) Have on staff or contract with a licensed health care practitioner, as defined by Section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

F. Maintenance of Records and Reporting Obligations by Independent Review Organizations. Each certified independent review organization shall comply with the following:

(1) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date such resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting such review in an easily accessible and retrievable format for the year in which it received the information, plus two (2) calendar years.

(2) Be able to document measures taken to appropriately safeguard the confidentiality of such records and prevent unauthorized use and disclosures in accordance with applicable federal and state law.

(3) Report annually to the commissioner, by June 1, in the aggregate and for each long-term care insurer all of the following:

(a) The total number of requests received for independent review of long-term care benefit trigger decisions;

(b) The total number of reviews conducted and the resolution of such reviews (i. e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);

(c) The number of reviews withdrawn prior to review;

(d) The percentage of reviews conducted within the prescribed timeframe set forth in Subsection C(3)(i); and

(e) Such other information the commissioner may require.

(4) Report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

Drafting Note: States may wish to consider the mechanism to be used for oversight of independent review entities' activities as they relate to the review of long-term care insurance benefit trigger decisions. Specifically, states will need to consider whether the oversight mechanism should be statutory, regulatory or contractually based (i. e. , in the state's contract with the independent review organization) to specify such details as the term of any state approval or certification of an independent review organization, privacy protections afforded protected health information, commitment to review benefit trigger decisions within the prescribed regulatory timeframe, notice requirements to the state should the independent review entity cease to meet the qualifications required of an independent review organization for long-term care insurance benefit trigger decisions, and to establish a reporting mechanism by which independent review organization report to the commissioner on the number of requests received for independent review of long-term care benefit trigger decisions in the aggregate and from each long-term care insurer, and the resolution of such review (e. g., uphold insurer benefit trigger denial, overturn insurer benefit trigger denial).

G. Additional Rights. Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:

(1) An insured's misrepresentation;

(2) Changes in the insured's benefit eligibility; and

(3) Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

H. Applicability. The requirements of this Regulation apply to a benefit trigger request made on or after [insert number of months after adoption of the regulation] under a long-term care insurance policy.

I. Conflict with Other Laws. The provisions of this section supersede any other external review requirements found in [insert reference to state external review law].

Section 32. Prompt Payment of Clean Claims

A. For purposes of this section:

(1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

B. Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(1) The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or

(2) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

C. Within thirty (30) business days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

D. If an insurer fails to comply with Subsection B or C, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to Subsection B or all requested additional information with respect to Subsection C. The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

E. The provisions of Section 32 shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

F. Any violation of this regulation by an insurer if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of the [insert reference to state law equivalent to the NAIC Unfair Trade Practices Model Act.]

G. The provisions of Section 32 supersedes any other claim payment requirement found in [insert reference to state prompt payment law].

Section 33. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6G of the Long-Term Care Insurance Model Act] [cite provision of law requiring the commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e. g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Section 34. Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under [cite for Section 6 of Long-Term Care Insurance Model Act].

Section 35. Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

Section [ ]. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Drafting Note: The NAIC recognizes that long-term care insurance is in an evolutionary stage. The product market needs to be able to develop in order to be responsive to the needs of consumers. In addition, since long-term care insurance and long-term care insurance regulations are continually changing, a state should consider the fact that not all replacements are improper.

The NAIC also recognizes that currently, long-term care insurance products are being primarily sold to the senior citizen market, a market that has been identified as being susceptible to abusive marketing practices. In response, the NAIC has adopted consumer protection amendments in its model regulation for Medicare supplement insurance. The Medicare supplement insurance model regulation limits agents' compensation in order to address the potential for marketing abuses resulting from the large difference between first year and renewal commissions.

If a state believes that there is evidence that the long-term care insurance market is experiencing similar abuses, it may wish to consider adopting the optional agent compensation provision above.

In considering these agent compensation limitations, states should recognize the emerging nature of the long-term care insurance market. Long-term care insurance is evolving along both health insurance indemnity and life insurance lines. A state may want to consider that, since life insurance products usually contain nonforfeiture and cash value accumulation features and are normally targeted to a younger age group than long-term care indemnity products, such life insurance products could be exempted from these compensation limitation requirements.

The compensation provision such as provided above should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

APPENDIX A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF _____
FOR THE REPORTING YEAR 19[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX B

Long-Term Care Insurance
Personal Worksheet

Drafting Note: Companies shall at a minimum provide all of the information shown below and in the same order. The company may include additional information related to this long-term care insurance coverage in relevant and readable language. Bracketed statements indicate the companies should choose the applicable statement, are allowed flexibility in inserting numerical ranges, etc.

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

The premium for the coverage you are considering will be [$_____ per [insert payment interval] **or a total of** [$_____ per year] [a one-time single premium of $_____].

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.

Drafting Note: Companies will insert payment interval – monthly, quarterly, etc. and the appropriate dollar amount.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable - The company **cannot** increase your premiums on this [policy] [certificate] [rider]].

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider]].

Drafting Note: Companies will insert the appropriate policy type and the associated bracketed statement. Premium guarantees shall not be shown on this form.

Premium Increase History

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]

Drafting Note: If the summary of premium increases is extensive, the company may disclose the required premium increase history via an addendum attached to this worksheet. The company may substitute the language below for the last sentence in the paragraph above and include the full summary as an attachment to this worksheet.

"Over the past 3 years, the company has increased premiums by ___%." "A summary of premium increases in the last 10 years is attached to this worksheet."

Companies that have increased premiums by 30% or more in the last ten years must include the following statement: "There was a 30% or greater premium increase in _____[insert year]." "A summary of premium increases in the last 10 years is attached to this worksheet."

Questions About Your Income

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?
□Current income from employment □Current income from investments □Other current income □Savings □ Sell investments □Sell other assets □Money from my family □Other _____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.

Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?
□ Yes □ No □Had not thought about it □Do not know □Does not apply

[What would you do if the premiums went up, for example, by 50%?
□Pay the higher premium □Call the company/agent □Reduce benefits □Drop the **[policy] [certificate] [rider]** □Do not know]

Drafting Note: The company is not required to use the bracketed question above if the coverage is fully paid up or is noncancellable.

What is your household annual income from all sources? (check one)
□[Less than $10,000] □$[10,000-19,999] □$[20,000-29,999] □$[30,000-50,000] □ [More than $50,000]

Drafting Note: The companies may choose the income ranges to put in the brackets to fit its suitability standards.

Do you expect your income to change over the next 10 years? (check one)
□No □Yes, expect increase □Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?
□ Yes □ No □Do not know

Will you buy inflation protection? (check one)
□ Yes □ No

Inflation may increase the cost of long-term care in the future.
If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?
□From my income □From savings □ From investments □Sell other assets □Money from my family □Other

The national average annual cost of long-term care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. This figure should also be used when calculating the cost of long-term care in the "approximate cost $____ for that period of care" question found below. In the above statement, the second figure will equal 163% of the first figure.

What [elimination period][waiting period][cash deductible] are you considering?

[Number of days _____ in [elimination period][waiting period]

Approximate cost of care for this period: $_____
($xxx per day times number of days in [elimination period] [waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible $_____]

How do you plan to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)
□From my income □From my savings/investments □My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
□[Less than $20,000] □ [$20,000-$29,999] □ [$30,000-$49,999] □ [More than $50,000]

Drafting Note: Companies may choose the asset ranges to put in the brackets to fit its suitability standards.

Do you expect the value of your assets to change over the next ten years? (check one)
□No □Yes, expect to increase □Yes, expect to decrease

If you're buying this [policy] [certificate] [rider] to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

□ The answers to the questions above describe my financial situation.
Or
□ I choose not to complete this information.
(Check one.)

□ I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Drafting Note: For direct mail situations, the lead in sentence should be changed to "I agree that I have reviewed this worksheet including the premium…."

Signed:_____ _____
(Applicant) (Date)

[□ I explained to the applicant the importance of answering these questions.

Signed:_____ _____
(Agent) (Date)

Agent's Printed Name:_____]

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]

[My agent has advised me that this long-term care insurance [policy] [certificate] [rider] does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [certificate] [rider] for you.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy
Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance. " Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance. " Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of _____
For the Reporting Year of _____

Company Name:_____ Due: June 30 annually
Company Address:_____
_____
Company NAIC Number:_____
Contact Person: _____Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

☐ Per Claimant – counts each individual who makes one or a series of claim requests.

☐ Per Transaction – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	Nationwide Data[1]
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

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APPENDIX F

Instructions: *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.*

As used in this Appendix:

"Policy" shall mean policy, certificate, or rider, as applicable.
"Premium" shall include premium schedules, as applicable.
Companies may substitute whichever term is appropriate to reflect the long-term care insurance for which the applicant is applying.

Long-Term Care Insurance
Potential Premium Increase Disclosure Form

Important Notice: Your long-term care insurance company **may** increase the premium for your policy **every year**. You have certain rights and it's important that you understand them before you buy a long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable*. Companies can increase the premiums for guaranteed renewable policies in the future. The company* ***cannot*** *increase your premiums because* ***you are*** *older or* ***your*** *health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. What Is Your Premium?

The agent/company has quoted you a premium of [$_____] for this policy. This is **not** a final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you'll be required to pay for your policy will be [shown on the schedule page of] [will be attached to] your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Sections 28D(4) and 28D(6) of the regulation are applicable].

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

APPENDIX G

Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to report on statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals
Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX H.

Guidelines for Long-Term Care Independent Review Entities

In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.

b. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

c. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is not a physician holds a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.

f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilizes for benefit trigger determination reviews are in any manner related to, employed by or affiliated with the insurer, insured or with a person who previously provided medical care or long term care services to the insured.

g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm, or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e. g. , assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.

k. The independent review organization shall provide a description of its quality assurance program.

l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any such ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.

m. The independent review organization shall provide the names and resumes of all directors, officers and executives of the independent review organization.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).
1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 484-493 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 545-556 (amended and reprinted).
1990 Proc. II 7, 16, 600, 617, 649 (amended).
1991 Proc. I 9, 17-18, 609-610, 662, 672-687 (amended and reprinted).
1992 Proc. I 86, 95, 914, 954, 963, 967-982, 987 (amended and reprinted).
1992 Proc. II 9, 11, 672, 687, 696 (amended).
1993 Proc. I 8, 136, 819, 843-844, 846-848 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 451, 457-459 (amended).
1994 Proc. 4th Quarter 17, 26, 713-714, 722, 731, 737, 739-761 (amended and reprinted).
1995 Proc. 2nd Quarter 2, 36, 553, 651, 653-659 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 825 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 704-714 (amendments on life/long-term care).
1997 Proc. 1st Quarter 759, 771-772 (discussed amendments on personal worksheet).
1997 Proc. 2nd Quarter 25-26, 676 (amendments on personal worksheet adopted).
1998 Proc. 1st Quarter 15, 17, 769, 800, 894 (amended).
1999 Proc. 4th Quarter 18, 929, 969, 972, 978-991 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 292-309 (amended).
2001 Proc. 4th Quarter 6, 14, 208, 285, 304-306 (amended).
2006 Proc. 4th Quarter 44, 61-122 (amended).
2009 Proc. 3rd Quarter Vol. I 95-102, 114-119, 211-222, 312-315 (amended).
2014 Proc. 2nd Quarter, 3-4, 3-16 to 3-43 (amended).
2016 Proc. 3rd Quarter (amended).

LONG-TERM CARE INSURANCE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LONG-TERM CARE INSURANCE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-091-.01 to 482-1-091-.36 (1990/2009).	
Alaska			ALASKA ADMIN. CODE tit. 2, §§ 39.010 to 39.100 (1986/1993).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. ADMIN. CODE §§ R20-6-1001 to R20-6-1026 (1992/2017).	BULLETIN 2009-5 (2009).
Arkansas		ARK. ADMIN. CODE. §§ 054.00.13-1 to 054.00.13-34 (Rule 13) (1990/2008).	
California	CAL. INS. CODE §§ 10231 to 10237.6 (1988/2018) (portions of model).		
Colorado			3 COLO. CODE REGS. § 702-4:4-4-1 (1997/2011); 3 COLO. CODE REGS. § 702-4:4-4-4 (2010/2013) (partnerships); BULLETIN B-1-20 (2007); BULLETIN B-4.30 (2012).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Connecticut		CONN. AGENCIES REGS. §§ 38a-501-8 to 38a-501-24 (1994/2015) (individual); §§ 38a-528-1 to 38a-528-17 (1994/2013) (group).	BULLETIN 8-31-2007 (2007).
Delaware		18 DEL. CODE REGS. § 1404 (1990/2010).	DOMESTIC FOREIGN INSURERS BULLETIN 23 (2006).
District of Columbia			D.C. MUN. REGS. tit. 26, §§ 2600 to 2644 (2006/2008).
Florida		FLA. ADMIN. CODE ANN. r. 69O-157.001 to 69O-157.023 (1989/2008); §§ 69O-157.101 to 69O-157.301 (2003/2017).	MEMORANDUM 2003-002 (2003); MEMORANDUM 2006-16 (2006); MEMORANDUM 2007-011 (2007); MEMORANDUM 2008-002 (2008).
Georgia		GA. COMP. R. & REGS. 120-2-16-.01 to 120-2-16-.34 (1989/2009).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:10H-201 to 4 31:10H-402 (1999/2019).	
Idaho		IDAHO ADMIN. CODE r. 18.01.60 (1990/2016).	BULLETIN 2007-7; BULLETIN 2007-8 (2007); BULLETIN 2016-2 (2016).
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2012.10 to 2012.150 (1990/2018).	
Indiana		760 IND. ADMIN. CODE 2-1-1 to 2-20-43 (1992/2016).	
Iowa		IOWA ADMIN. CODE r. §§ 191-39.1 to 191-39.85 (1988/2018).	BULLETIN 2008-17 (2008); BULLETIN 2009-7 (2009); BULLETIN 2009-7 (Revised) (2009); BULLETIN 2014-1 (2014).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kansas		KAN. ADMIN. REGS. §§ 40-4-37 to 40-4-37v (1988/2015).	BULLETIN 1996-8 (1996).
Kentucky		806 KY. ADMIN. REGS. 17:081 (1993/2009).	806 KY. ADMIN. REGS. 17:083 (2009); BULLETIN 91-1 (1991); BULLETIN 92-2 (1992); BULLETIN 93-1 (1993); BULLETIN 94-1 (1994); BULLETIN 96-4 (1996); BULLETIN 98-4 (1998); KY. REV. STAT. §§ 304.14-600 to 304.14-625 (1992/2010).
Louisiana		LA. ADMIN. CODE tit. 37, §§ XIII.1901 to XIII.1969 (Regulation 46) (1993/2019).	BULLETIN 9-5-2006 #1 and #2 (2006); BULLETIN 12-28-2009 (2009).
Maine		425 ME. CODE R. §§ 1 to 35 (2004/2015).	BULLETIN 347 (2007); BULLETIN 362 (2009); BULLETIN 363 (2009); BULLETIN 417 2017); BULLETIN 418 (2017); BULLETIN 419 (2017).
Maryland		MD. CODE REGS. §§ 31.14.01.01 to 31.14.01.36 (1994/2017).	MD. CODE REGS. §§ 31.14.02.01 to 31.14.02.14 (1993/2019); MD. CODE REGS. §§ 31.14.03.01 to 31.14.03.10 (2008/2017) (partnerships); BULLETIN 13-2009 (2009); BULLETIN 2010-33 (2010).
Massachusetts		211 MASS. CODE REGS. 65.01 to 65.102 (1989/2005).	BULLETIN 2013-11 (2013).
Michigan		MICH. COMP. LAWS §§ 500.3901 to 500.3955 (1992/2006).	MEMORANDUM 1-27-2016 (2016); BULLETIN 2016-01-INS (2016).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. R. §§ 2745.0010 to 2745.0050 (1992) (non-qualified plans); BULLETIN 2007-4 (2007); BULLETIN 2007-4 (ADDENDUM) (2007); BULLETIN 2007-5 (2007); BULLETIN 2007-10 (2007); MINN. STAT. §§ 62S.01 to 62S.34 (1997/2019) (qualified policies); MINN. STAT. §§ 62A.46 to 62A.56 (1986/2003) (non-qualified policies).
Mississippi		19 MISS ADMIN. CODE PT. 3, R. §§ 8.01 to 8.19 (2012).	
Missouri		MO. CODE REGS. ANN. tit. 20, .§ 400-4.100 (1991/2007).	BULLETIN 2008-04 (2008); BULLETIN 2008-09 (2008).
Montana		MONT. ADMIN. R.6.6.3101 to 6.6.3131 (1991/2019).	Memorandum 9-7-2007 (2007); Memorandum 2-23-2010 (2010).
Nebraska		210 NEB. ADMIN. CODE ch. 46 (1989/2001).	BULLETIN CB-113 (2007); BULLETIN CB-114 (2007); BULLETIN CB-133 (#2) (2015).
Nevada		NEV. ADMIN. CODE §§ 687B.005 to 687B.140 (1988/2016).	
New Hampshire			N.H. CODE R. INS. 3601.01 to 3601.34 (2004/2018); BULLETIN 2010-020-AB (2010).
New Jersey		N.J. ADMIN. CODE §§ 11:4-34.1 to 11:4-34.32 (1989/2010).	BULLETIN 2008-5 (2008) (producer training); BULLETIN 2008-8 (2008) (partnerships); N.J. REV. STAT. §§ 17B:27E-1 to 17B:27E-12 (2004).
New Mexico		N.M. CODE R. §§ 13.10.15 (1997/2004).	
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.12 to 52.65 (Regulation 62) (1992/2019).	

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina		11 N.C. ADMIN. CODE §§ 12.1002 to 12.1030 (1990/2002); § 12.0555 (1989/2011).	BULLETIN 2011-B-6 (2011).
North Dakota		N.D. ADMIN. CODE 45-06-05-01 to 45-06-05-11 (1988/2004).	BULLETIN 2007-3 (2007); BULLETIN 2012-2 (2012); BULLETIN 2013-1 (2013); BULLETIN 2014-1 (2014).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE §§ 3901-4-01 to 3901-4-03 (1993/2018).	BULLETIN 2008-2 (2008).
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-5-40 to 365:10-5-56 (1989/2010).	BULLETIN 6-23-2008 #1 and #2 (2008).
Oregon		OR. ADMIN. R. §§ 836-052-0500 to 836-052-0790 (1991/2015).	BULLETIN 2014-3 (2014).
Pennsylvania		31 PA. CODE §§ 89a.101 to 89a.129 (2002).	40 PA. CONS. STAT. §§ 991.1101 to 991.1115 (1921/2010); NOTICE 7-30-2016 (2016).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 1025 to 10261 (2011).	
Rhode Island			230 R.I. CODE R. 20-35-1.1 to 1.34 (1989/2019); BULLETIN 2011-2 (2011); BULLETIN 2018-16 (2018).
South Carolina		S.C. CODE ANN. REGS. 69-44 (1989/2010).	BULLETIN 19-2008 (2008); BULLETIN 4-2009 (2009).
South Dakota	S.D. ADMIN. R. 20:06:21:01 to 20:06:21:108 (1990/2018) (portions of model).		BULLETIN 89-3 (1989); BULLETIN 95-2 (1995); BULLETIN 2007-4 (2007); BULLETIN 2007-7 (2007).
Tennessee		TENN. COMP. R. & REGS. 0780-1-61 (1991/2008)	BULLETIN 9-22-2008 (2008) (long-term care partnership); MEMORANDUM 9-29-2015 (2015) (partnerships).

LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas		28 TEX. ADMIN. CODE §§ 3.3801 to 3.3874 (1990/2009).	BULLETIN B-0018-15 (2015); BULLETIN B-0010-18 (2018).
Utah		UTAH ADMIN. CODE r. 590-148-1 to 590-148-30 (1992/2011).	BULLETIN 2014-7 (2014).
Vermont			VT. ADMIN. CODE §§ 4-5-16:1 to 4-5-16:38 (Rule H-2009-01) (2010); BULLETIN HCA-130 (2010).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		14 VA. ADMIN. CODE §§ 5-200-10 to 5-200-210 (1992/2015).	ADMIN. LETTER 1990-23 (1990) (NAIC Shopper's Guide); ADMIN. LETTER 2007-3 (2007).
Washington		WASH. ADMIN. CODE 284-54-010 to 284-54-900 (1989/2011).	WASH. ADMIN. CODE 284-83-005 to 284-83-425 (2008/2017).
West Virginia		W. VA. CODE R. §§ 114-32-1 to 114-32-33 (1993/2011); W. VA. CODE ANN. § 33-12-8a (2009).	INFORMATIONAL LETTER 182 (2012).
Wisconsin		WIS. ADMIN. CODE INS. § 3.455 (1991/2008); WIS. ADMIN. CODE INS. § 3.46 (1981/2014).	BULLETIN 7-23-2001 (2001); BULLETIN 11-19-2008 (2008); BULLETIN 11-21-2008 (2008).
Wyoming		WYO. CODE R. § 37 (1990/2003).	MEMORANDUM 01-2009 (2009) (partnerships).

PROJECT HISTORY - 2016

LONG-TERM CARE INSURANCE MODEL REGULATION (#641)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Long-Term Care Insurance Model Regulation* (#641) were made pursuant to the charge of the Long-Term Care Consumer Disclosure (B) Subgroup to: 1) review the existing requirements for consumer disclosures contained in the *Long-Term Care Insurance Model Act* (#640), Model #641 and the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* (Guidance Manual), and make recommendations for needed improvements to the Task Force; and 2) continue to consider all consumer disclosure requirements for long-term care insurance (LTCI), including those provided at the time of issue as well as those provided at the time of rate increase.

2. Name of Group Responsible for Drafting the Model and States Participating.

Long-Term Care Consumer Disclosure (B) Subgroup of the Senior Issues (B) Task Force.

California, Chair	Louisiana	South Carolina
Florida, Vice Chair	Maine	Texas
Indiana	North Carolina	Utah
Iowa	Oregon	Washington
Kentucky	Rhode Island	

3. Project Authorized by What Charge and Date First Given to the Group.

The Senior Issues (B) Task Force appointed the Long-Term Care Consumer Disclosure (B) Subgroup at the 2014 Summer National Meeting to update LTCI consumer disclosures, as they had not been reviewed in some time and may have needed important changes.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Long-Term Care Consumer Disclosure (B) Subgroup began with Appendix B (*Long-Term Care Insurance Personal Worksheet*) of Model #641 and made changes to various parts of said appendix. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. The Subgroup next examined Appendix F (*Long-Term Care Insurance Potential Premium Increase Disclosure Form*) of Model #641 and made changes to various parts of said appendix. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP), American Council of Life Insurers (ACLI), Brenda J. Cude of the University of Georgia and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The Long-Term Care Consumer Disclosure (B) Subgroup met 16 times via open conference call (April 26, 2016; March 24, 2016; Feb. 25, 2016; Jan. 21, 2016, Dec. 3, 2015; Oct. 29, 2015; Sept. 10, 2015; Aug. 4, 2015; July 16, 2015; June 29, 2015; May 11, 2015; April 9, 2015; March 5, 2015; Jan. 29, 2015, Dec. 18, 2014; and Oct. 28, 2014). The Subgroup adopted its changes on April 26, 2016. The Senior Issues (B) Task Force exposed the draft for public comment from May 16, 2016, to May 31, 2016. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Senior Issues (B) Task Force adopted the model revisions on June 9, 2016. The Health Insurance and Managed Care (B) Committee adopted the model revisions on Oct. 25, 2016.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2014

LONG-TERM CARE INSURANCE MODEL REGULATION (#641)

1. Description of the Project, Issues Addressed, etc.

These revisions make improvements to the "rate stability" standards contained in the *Long-Term Care Insurance Model Regulation* (#641). The improvements are intended to address the problem of rate increases on long-term care insurance policies and apply primarily to new policies sold after the effective date of the revisions.

Among the changes, the model revisions include:

- Expansion of the actuarial certification currently required by the model from a one-time statement at the time of initial filing to a more robust annual certification. The annual certification requirement is similar to one adopted by the IIPRC.
- New requirement that a minimum margin be incorporated into pricing calculations to encourage more conservative pricing.
- Improvements to consumer disclosure requirements, including a new disclosure required when consumers consider actions to mitigate rate increases that may impact Long-Term Care Partnership Program protections and Medicaid eligibility.
- Expansion of the contingent benefit upon lapse by requiring that consumers who have held the oldest policies (i.e., more than 20 years) will receive this benefit automatically.

2. Name of Group Responsible for Drafting the Model and States Participating

The Senior Issues (B) Task Force was chaired by Commissioner Scott J. Kipper (NV) and vice chaired by Commissioner Wayne Goodwin (NC). The Long-Term Care Rate Stability (B) Subgroup of the Senior Issues (B) Task Force was chaired by John Rink (NE). The Task Force and Subgroup relied heavily upon the work of the Health Actuarial (B) Task Force (chaired by Steve Ostlund (AL)) to make recommendations on the actuarial aspects of the model revisions, including its Long-Term Care Actuarial (B) Working Group (chaired by Perry Kupferman (CA)) and the Long-Term Care Pricing (B) Subgroup (chaired by Jan Graeber (TX)). Other members of the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force also participated.

3. Project Authorized by What Charge and Date First Given to the Group

At the 2012 Fall National Meeting, the Executive (EX) Committee approved a request by the Senior Issues (B) Task Force to amend the *Long-Term Care Insurance Model Act* (#640) and Model #641. At the 2013 Spring National Meeting, the Health Insurance and Managed Care (B) Committee granted the Task Force an extension to complete its work.

All changes are being proposed for Model #641 and no changes are required for Model #640.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

A draft of the model revisions was developed by the chair of the Senior Issues (B) Task Force and the chair of the Long-Term Care Rate Stability (B) Subgroup and was distributed to Task Force members prior to a June 2013 interim meeting of the Task Force. This draft was developed following prior discussions by the Task Force and with interested parties. The Health Actuarial (B) Task Force was asked to provide comments on the draft. The Long-Term Care Pricing (B) Subgroup developed multiple sets of recommendations that were each adopted by the Health Actuarial (B) Task Force and then considered by the Senior Issues (b) Task Force on various conference calls.

At the 2013 Fall National Meeting, the Task Force granted a request by the Health Actuarial (B) Task Force for additional time to work on outstanding issues and recommendations. These additional recommendations were completed and presented to the Task Force on a March 14, 2014, conference call. The model revisions were adopted by the Senior Issues (B) Task Force March 29, 2014, at the Spring National Meeting and then by the Health Insurance and Managed Care (B) Committee on a June 10, 2014, conference call.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Senior Issues (B) Task Force exposed the draft model for a public comment period in November 2013. The Health Actuarial (B) Task Force exposed the draft model for an additional public comment period in February 2014. The Health and Managed Care (B) Committee exposed the draft model for an additional public comment period prior to its adoption of the model on a June 10, 2014, conference call.

All drafts of the model were made available to interested parties by the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force, as well as by their subgroups and working groups. All drafts considered by the Senior Issues (B) Task Force were posted on the Task Force's Web page.

There were also opportunities for interested parties to provide comment on all conference calls, at each of the national meetings where the model was being discussed in 2013 and 2014, at the June 2013 interim meeting of the Senior Issues (B) Task Force and at the Senior Issues (B) Task Force's Public Hearing on Long-Term Care Insurance Issues, which was held Nov. 28, 2012.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

These model revisions would largely apply prospectively to rate increases on new policies. In order to quickly address the problem of rate increases on older policies (including older pre-rate-stabilized policies), the Task Force first worked to develop a model bulletin on long-term care premium increases that would apply to rate increases on existing policies. The Executive (EX) Committee and Plenary adopted this model bulletin in December 2013.

The model revisions do not make any changes to the dual loss-ratio structure currently contained in Model #641. When the rate stability amendments were first adopted in 2000, the previous 58% loss ratio requirement was replaced with a dual structure of 60% at the time of initial pricing and 85% if a rate increase is later required. When the Health Actuarial (B) Task Force considered its final recommendations, it adopted a provision to increase the 85% loss ratio requirement to 92%. The Senior Issues (B) Task Force rejected this proposal and, at the 2014 Spring National Meeting, adopted the model revisions without accepting this recommendation. A subsequent motion for the Task Force to amend the adopted model revisions, substituting 92% for the 85% loss ratio requirement, failed to win adoption. The Health Insurance and Managed Care (B) Committee discussed the 92% proposal during consideration of the model revisions on its March 29, 2014, conference call, but adopted the model revisions without any further changes. The Health Insurance and Managed Care (B) Committee and the Senior Issues (B) Task Force discussed that there may be opportunities to review the entire loss ratio structure at a future time.

7. Any Other Important Information (e.g., amending an accreditation standard)

The Senior Issues (B) Task Force and the Health Actuarial (B) Task Force are now working to update guidance to regulators contained in the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* in order to help the states implement the model revisions.

PROJECT HISTORY – 2009

APPENDIX E CLAIM DENIALS REVISIONS TO THE LONG-TERM CARE INSURANCE MODEL REGULATION (#641)

1. Description of the Project, Issues Addressed, etc.

Revisions relating to Appendix E (Claims Denial Reporting Form) of the Long-Term Care Insurance Model Regulation (#641).

2. Name of Group Responsible for Drafting the Model and States Participating

The Appendix E Subgroup of the Senior Issues (B) Task Force drafted the revisions. The participating states were: South Dakota, Florida, Wisconsin, Arkansas, Nebraska, Nevada, Texas, and Pennsylvania. South Dakota was the Chair.

3. Project Authorized by What Charge and Date First Given to the Group

The Health Insurance and Managed Care (B) Committee has the following ongoing charges, which are delegated to the Senior Issues Task Force.

> Develop appropriate regulatory standards and revisions to the NAIC models, consumer guides and training material, as necessary, on long term care insurance. Work with federal agencies as appropriate. Report annually (Delegated to Senior Issues Task Force);
>
> Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace. Report quarterly (Delegated to Senior Issues Task Force);

The Senior Issues Task Force authorized the formation of a Subgroup to work on revising the model regulation to address Appendix E in the Summer of 2009.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model revisions were drafted by a Subgroup of the Senior Issues Task Force chaired by South Dakota. The following interested parties, organizations, and consumer representatives were on the email list: Amanda Matthiesen (America's Health Insurance Plans), Miriam Krol (American Council of Life Insurers), Genworth Life Insurance, Prudential Life Insurance, Melissa Lawler (American Academy of Actuaries), PriceWaterhouseCoopers, Congressional Research Service, MetLife, Aegon USA, Unum Provident, Bonita Kallestad (Western Minnesota Legal Services), Barbara Cude (University of Georgia), Birny Birnbaum (Center for Economic Justice), and John Hancock Life
Insurance Company.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Senior Issues (B) Task Force appointed a Subgroup at the 2009 Summer National Meeting, to be chaired by South Dakota. The Subgroup held an open conference call on August 6, 2009. Notice for this conference call was emailed to Subgroup regulators and interested parties and posted on the NAIC website.

Prior to the August 6 conference call, Subgroup members and interested parties received and reviewed the current version of Appendix E. Industry representatives proposed draft revisions to Appendix E, which were also distributed to Subgroup members and interested parties. The Subgroup reviewed the industry's proposed revisions on the conference call, and also made additional revisions to Appendix E and to Section 15 of the model regulation. After the conference call, a final draft of the agreed-upon revisions was distributed to Subgroup members and interested parties. The Senior Issues (B) Task Force adopted the revisions at the 2009 Fall National Meeting, and they were exposed for a 30 day public comment period prior to consideration by the Health Insurance and Managed Care Committee.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

This project was in response to the discovery made during compilation of the 2008 LTC Data Call Analysis and Report, which was adopted by the Health Insurance and Managed Care Committee and the Market Regulation and Consumer Affairs (D) Committee, that companies were using different methodologies to report claim denial data on Appendix E, and therefore the usefulness of this reporting was limited. The Task Force agreed that *Appendix E* should be revised and created the Subgroup. Regulators, industry and consumer groups were in agreement regarding the need to make revisions to Appendix E.

There are two distinct methods of counting and reporting claim denials that are being used by companies – per claimant and per transaction. Neither method is predominantly used, as industry reported that roughly half the companies count and report by claimant and roughly half count and report by transaction. Therefore, industry suggested that the form be amended so that companies would indicate the manner of reporting. Some states were interested in requiring that companies be required to change their methodology so that all companies were using a uniform method. However, industry stated that this would be cost-prohibitive. The Subgroup agreed to make changes to Appendix E to include the manner of reporting.

Regulators also discussed the overall goal of improving tools for state regulators and others to assess the long-term care insurance marketplace. As such, the Subgroup decided to adopt additional revisions to Appendix E that would add a query regarding in-force policies by state and nationwide. This information is intended to assist in helping regulators better put the rest of the Appendix E data in context.

Additionally, the Subgroup noted that the current drafting note following Section 15F stated that the definition of claim denied in Appendix E was limited to HIPAA reporting purposes only. In accordance with the goal of making Appendix E more broadly useful to state regulators and others in assessing the marketplace, the Subgroup decided to delete this drafting note.

7. Any Other Important Information (e.g., amending an accreditation standard).

PROJECT HISTORY - 2006

LONG TERM CARE INSURANCE MODEL REGULATION (#641)

1. Description of the Project, Issues Addressed, etc.

The revisions to the model regulation incorporate revisions adopted by the Accident and Health Working Group of the Life and Health Actuarial Task Force addressing contingent benefit upon lapse. In addition, revisions were made to ensure that long-term care insurance policies pay for services in facilities in other states, even if those facilities are licensed or registered in a different way from facilities in the state in which the policy was sold. Language was also added to the model regulation addressing the availability of new services or providers and the right to reduce coverage and lower premiums.

2. Name of Group Responsible for Drafting the Model and States Participating

Long Term Care (B) Working Group (previously Senior Issues (B) Task Force)

Kansas - Chair, Florida – Vice Chair, Wisconsin – Vice Chair, Alabama, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Michigan, Minnesota, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The Health Insurance and Managed Care (B) Committee has a standing charge to "Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace." This charge was delegated to the Senior Issues Task Force until Spring 2006, when the charge was delegated to the Long-Term Care Working Group.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The task force has been working since 2003 to identify issues and draft language to revise the model regulation. Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified. However, many people move to a different state from where they purchased their long-term care insurance policy and not all states regulate these facilities in the same way. The model regulation was revised to reflect this reality and allow for the beneficiary to continue to receive benefits. Conforming revisions were made to: Section 5. Policy Definitions; Section 6. Policy Practices and Provisions; and Appendix C.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Long-Term Care Insurance Model Regulation was last updated in August 2000. At that time, rating practices and enhanced consumer disclosures were added to the model. After adopting the revisions to the model regulation, the task force decided to give states a few years to revise their laws before undertaking to revise the model regulation again. Because of the rapidly evolving nature of long-term care, the task force recognized the need to begin review of the model regulation. In 2003, the task force solicited input from the states about areas where states had "gone further" than the model regulation to protect consumers. The results were compiled into a list of issues for the task force to consider. Some issues were referred to the Life and Health Actuarial Task Force, while other issues remained with the Senior Issues Task Force to debate and consider. These revisions represent areas where consensus has been reached.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

These revisions represent those areas where the regulators, industry groups and consumer groups were able to reach consensus. More controversial issues are still the subject of debate and discussion by the Long-Term Care Working Group.

7. Any Other Important Information (e.g., amending an accreditation standard).

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of limited long-term care insurance policies, to protect applicants for limited long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for limited long-term care insurance, to facilitate public understanding and comparison of limited long-term care insurance policies, and to facilitate flexibility and innovation in the development of limited long-term care insurance coverage.

Drafting Note: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to limited long-term care insurance coverage.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to limited long-term care insurance.

Drafting Note: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Limited Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Applicant" means:

(1) In the case of an individual limited long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group limited long-term care insurance policy, the proposed certificate holder.

B. "Certificate" means, for the purposes of this Act, any certificate issued under a group limited long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

C. "Commissioner" means the Insurance Commissioner of this state.

D. "Limited long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for less than twelve (12) consecutive months for each covered person on an expense-incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Limited long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Limited long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Notwithstanding any other provision of this Act, any product advertised, marketed or offered as limited long-term care insurance shall be subject to the provisions of this Act.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(a) Is composed of individuals, all of whom are or were, actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have, at the outset, a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "limited long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a limited long-term care insurance policy are met. The Act is intended to permit limited long-term care insurance policies to cover diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

G. "Waiting Period" means, for the purposes of this Act, the time an insured must wait before some or all of their coverage comes into effect. "Elimination Period" means, for purposes of this Act, the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

Section 5. Extraterritorial Jurisdiction—Group Limited Long-Term Care Insurance

No group limited long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory limited long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Drafting Note: States should consider deletion of this section if they already have statutes or rules governing extraterritorial jurisdition that would automatically encompass limited long-term care policies.

Section 6. Disclosure and Performance Standards for Limited Long-Term Care Insurance

A. No limited long-term care insurance policy may:

(1) Be cancelled, non-renewed or otherwise terminated on the grounds of the age, gender or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

B. Preexisting condition.

(1) No limited long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No limited long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6B(1) and (2) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6B(2) expires. No limited long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6B(2).

C. Prior hospitalization/institutionalization.

(1) No limited long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) A limited long-term care insurance policy or rider shall not condition eligibility for non-institutional benefits on the prior or continuing receipt of skilled care services.

D. The Commissioner may adopt regulations establishing loss ratio standards for limited long-term care insurance policies provided that a specific reference to limited long-term care insurance policies is contained in the regulation.

E. Right of Return

(1) Limited long-term care insurance applicants shall have the right to return the policy, certificate or rider to the company or an agent/insurance producer of the company within thirty (30) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason.

(2) Limited long-term care insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. This requirement shall not apply to certificates issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act. The following free look statement or language substantially similar shall be included:

"You have 30 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the agent/insurance producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."

F. Outline of Coverage

(1) An outline of coverage shall be delivered to a prospective applicant for limited long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6F(2)(a) through (h) is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the Commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A description of the eligibility triggers for benefits and how those triggers are met;

(c) A statement of the principal exclusions, reductions and limitations contained in the policy;

(d) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(e) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(f) A description of the terms under which the policy or certificate may be returned and premium refunded;

(g) A brief description of the relationship of cost of care and benefits; and

(h) A statement that discloses to the policyholder or certficateholder that the policy is not long-term care insurance.

G. A certificate issued pursuant to a group limited long-term care insurance policy that is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

H. If an application for a limited long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

I. If a claim under a limited long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

J. Any policy, certificate or rider advertised, marketed or offered as limited long-term care insurance, as defined in Section 4A of this Act, shall comply with the provisions of this Act.

K. Any disclosure, statement, or written information and explanations required in this Act, whether in print or electronic form, will accommodate the communication needs of individuals with disabilities and persons with limited English proficiency as required by law.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months, an insurer may rescind a limited long-term care insurance policy or certificate or deny an otherwise valid limited long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind a limited long-term care insurance policy or certificate or deny an otherwise valid limited long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D. (1) A limited long-term care insurance policy or certificate may be field issued if the compensation to the field issuer is not based on the number of policies or certificates issued.

(2) For purposes of this section, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third party administrator by an insurer and using the insurer's underwriting guidelines.

E. If an insurer has paid benefits under the limited long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

Section 8. Nonforfeiture Benefits

A. A limited long-term care insurance policy may offer the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder does not purchase the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

B. When a group limited long-term care insurance policy is issued, any offer of a nonforfeiture benefit shall be made to the group policyholder. However, if the policy is issued as group limited long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, any offering shall be made to each proposed certificateholder.

C. The Commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of limited long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Producer Training Requirements [OPTIONAL]

Drafting Note: If a state believes that there is evidence that the limited long-term care insurance market is experiencing deficiencies in producer or agent training or abusive marketing practices, the state may wish to consider adopting the optional producer training requirements below.

A. (1) An individual may not sell, solicit or negotiate limited long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness or [include other lines of authority as applicable] and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B.

(2) An individual already licensed and selling, soliciting or negotiating limited long-term care insurance on the effective date of this Act may not continue to sell, solicit or negotiate short-term care insurance unless the individual has completed a one-time training course as set forth in Subsection B, within one year from [insert effective date of this legislation].

(3) In addition to the one-time training course required in Paragraphs (1) and (2) above, an individual who sells, solicits or negotiates limited long-term care insurance shall complete ongoing training as set forth in Subsection B.

(4) The training requirements of Subsection B may be approved as continuing education courses under [insert reference to applicable state law or regulation].

B. (1) The training required by Subsection A shall be no less than:

(a) An additional one (1) hour of one-time training for an individual who has completed the required training for long-term care insurance.

(b) Completion of four (4) hours of one-time training for an individual who does not sell long-term care insurance.

(c) And ongoing training of four (4) hours every 24 months for an individual thatdoes not sell long-term care insurance, or an additional one (1) hour every 24 months for an individual who has completed the ongoing training requirement for long term care.

(2) The training required under Paragraph (1) shall consist of topics related to similarities and differences between long-term care and limited long-term care insurance, and topics related to long-term care services and providers. Training materials shall include:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

(b) Alternatives to the purchase of private limited long-term care insurance;

(c) The effect of inflation on benefits and the importance of inflation protection; and

(d) Consumer suitability standards and guidelines.

(3) The training required by this section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. (1) Insurers subject to this Act shall obtain verification that a producer receives training required by Subsection A before a producer is permitted to sell, solicit or negotiate the insurer's limited long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Commissioner upon request.

(2) Insurers subject to this Act shall maintain records that verify its producers have completed the training required for short-term care policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the Commissioner upon request.

D. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

Section 10. Authority to Promulgate Regulations

The Commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties and reporting practices for limited long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

The Commissioner may adopt regulations regarding standards for full and fair disclosure that set forth the manner, content and required disclosures. Such disclosures may include, but are not limited to, the sale of limited long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Drafting Note: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

Section 11. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 12. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any producer found to have violated any requirement of this state relating to the regulation of limited long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the producer in the amounts suggested above.

Section 14. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

4th Quarter 2018 (adopted new model).
Technical Corrections (August 2019).

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		

LIMITED LONG-TERM CARE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH CODE ANN. 31A-22-2001 to 31A-22-2006 (2020) (portions of model).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2018

LIMITED LONG-TERM CARE INSURANCE MODEL ACT (#642)

1. Description of the Project, Issues Addressed, etc.

Changes were made to the *Long-Term Care Insurance Model Act* (#640) pursuant to the charge of the Short Duration Long-Term Care Policies (B) Subgroup.

2. Name of Group Responsible for Drafting the Model and States Participating

Short Duration Long-Term Care Policies (B) Subgroup of the Senior Issues (B) Task Force:

Connecticut, Chair	Kentucky	Oklahoma
California, Vice Chair	Missouri	Pennsylvania
Florida	Nebraska	Texas
Indiana	New Hampshire	Utah
Kansas	New Mexico	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The Senior Issues (B) Task Force first appointed the Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup at the 2016 Summer National Meeting to determine whether short-term health policies providing long-term care (LTC) benefits should be moved under the purview of LTC insurance. The Subgroup determined that a new model act and new model regulation should be adopted. The Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup was disbanded at the 2016 Fall National Meeting.

The Task Force appointed the Short Duration Long-Term Care Policies (B) Subgroup at the 2016 Fall National Meeting to address LTC products of short duration that are excluded from Model #640 and the *Long-Term Care Insurance Model Regulation* (#641), but do not quite fit under the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) and the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

The Short Duration Long-Term Care Policies (B) Subgroup made changes to various parts of Model #640. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP); Aetna; and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Short Duration Long-Term Care Policies (B) Subgroup met 14 times via open conference calls (March 7, 2018; Feb. 14, 2018; Jan. 24, 2018; Dec. 13, 2017, Nov. 15, 2017; Oct. 25, 2017; Oct. 4, 2017; Sept. 13, 2017; Aug. 16, 2017; July 12, 2017; June 21, 2017; May 31, 2017; May 10, 2017; and March 29, 2017). The Subgroup adopted the revisions to Model #640 on March 7, 2018.

The Senior Issues (B) Task Force held an exposure period from March 24, 2018, to May 4, 2018. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Task Force adopted the revisions to Model #640 on June 7, 2018.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC *Limited Long-Term Care Insurance Model Act* (#642)], to promote the public interest, to promote the availability of limited long-term care insurance coverage, to protect applicants for limited long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of limited long-term care insurance coverages, and to facilitate flexibility and innovation in the development of limited long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of law enacting the NAIC *Limited Long-Term Care Insurance Model Act* (#642) and establishing the commissioner's authority to issue regulations].

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all limited long-term care insurance policies delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Drafting Note: This regulation, like the NAIC *Limited Long-Term Care Insurance Model Act* (#642), is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Section 4. Definitions

For the purpose of this regulation, the terms "limited long-term care insurance," "group limited long-term care insurance," "commissioner," "applicant," "policy", and "certificate" shall have the meanings set forth in Section 4 of the NAIC *Limited Long-Term Care Insurance Model Act* (#642). In addition, the following definitions apply.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

A. "Benefit trigger", for the purposes of independent review, means a contractual provision in the insured's policy of limited long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment.

Drafting Note: This definition is not intended to be a required definitional element of a limited long-term care insurance policy, but rather intended to clarify the scope and intent of Section 31. The requirement for a description of the benefit trigger in the policy or certificate is currently found in Section 8.

B. "Licensed health care professional" means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured's actual functional or cognitive impairment.

C. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

D. "Similar policy forms" means all of the limited long-term care insurance policies and certificates issued by an insurer in the same limited long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Limited Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as limited long-term care insurance, but are similar to other comparable certificates with the same limited long-term care benefit classifications. For purposes of determining similar policy forms, limited long-term care benefit classifications are defined as follows: institutional limited long-term care benefits only, non-institutional limited long-term care benefits only, or comprehensive limited long-term care benefits.

Section 5. Policy Definitions

No limited long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies or registers the provider of services under another name.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to, or incorporation of, the individual state law may be required in structuring each definition.

Drafting Note: This section is intended to specify required definitional elements of several terms commonly found in limited long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Section 6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual limited long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 8 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the limited long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the limited long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as limited long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of cognitive impairment;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another limited long-term care insurance, long-term care insurance or health insurance policy;

(7) (a) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no limited long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(ii) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(b) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

Drafting Note: Paragraph (7) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates. However, the issuer of limited long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of issue, irrespective of any licensing, registration, or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved.

(8) This subsection is not intended to prohibit territorial limitations.

C. Extension of Benefits. Termination of limited long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the limited long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the limited long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group limited long-term care insurance issued in this state, on or after the effective date of this section, shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of limited long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another limited long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, an insured individual whose eligibility for group limited long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement

If a group limited long-term care policy is replaced by another group limited long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of limited long-term care services.

F. Premium Changes

(1) The premium charged to an insured shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 26, the portion of the premium attributable to the additional coverage shall be added to, and considered part of, the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 26, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

(1) In the case of a group defined in [insert reference to Section 4E(1) of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)], any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by [insert reference to state law comparable to Section 2W of the NAIC *Insurance Information and Privacy Protection Model Act* (#670)], is maintained.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Section 7. Unintentional Lapse

Each insurer offering limited long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual limited long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this limited long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a limited long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual limited long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing

B. Reinstatement. In addition to the requirement in Subsection A, a limited long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Section 8. Required Disclosure Provisions

A. Renewability. Individual limited long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable.

(2) A limited long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual limited long-term care insurance policy, all riders or endorsements added to an individual limited long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A limited long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a limited long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A limited long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6C(2) of the *Limited long-Term Care Insurance Model Act* (#642)] shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits. "

F. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for limited long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits. " Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any limited long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the regulation].

(2) For certificates issued on or after the effective date of this regulation under a group limited long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)], which policy was in force at the time this regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e. g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the limited long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a limited long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers, on or before the later of the effective date of this section, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.

Drafting Note: It is intended that the disclosures in Section 9B be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of, and review situations, where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If, due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the form in Appendix A to comply with the requirements of Subsections B and C of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least [forty-five (45) days] prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 10. Initial Filing Requirements

A. This section applies to any limited long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the regulation].

B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a limited long-term care insurance form available for sale.

(1) A copy of the disclosure documents required in Section 9;

(2) Complete rate schedule;

(3) An actuarial memorandum that shall include:

(a) A statement regarding actuary's qualifications;

(b) An explanation of the review performed by the actuary;

(c) A complete description of all pricing assumptions, including sources and credibility of data;

(d) Development of the anticipated life time loss ratio supported by an exhibit showing lifetime projection of earned premiums and incurred claims based upon the pricing assumptions;

(e) A statement that the premium rate schedule is expected to result in a lifetime loss ratio not less than 55%;

(f) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(g) A statement that the underwriting and claim adjudication processes have been reviewed and taken into consideration;

(h) A sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions (including sensitivity to the mix of business);

(i) A statement that the reserve requirements have been reviewed and taken in consideration;

(j) A description of the valuation assumptions with sufficient detail or sample calculation as to have a complete depiction of the reserve amounts to be held;

(k) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

(l) An actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.

C. Retention Requirements

(1) An insurer offering a limited long-term care policy shall retain sufficient documentation from the initial pricing that a qualified actuary could recreate the initial rates at a later date.

(a) The documentation shall be sufficient to provide actual to expected analyses of: claims; incidence rates, persistency, mix of business, and loss ratios at the same level of detail used in the initial pricing.

(b) If an insurer retains a consultant to price a limited long-term care product, the insurer shall require that the documentation be provided to the insurer, rather than being retained solely by the consultant.

(c) If an insurer sells (cedes) complete risk responsibility for a limited long-term care product, the insurer (cedant) shall provide the buyer (reinsurer) with the initial pricing documentation.

(2) An insurer that requests a future premium rate schedule increase but has not retained the initial pricing documentation shall be limited to a lifetime loss ratio not less than [80%].

(3) The insurer shall retain the initial pricing documentation at least until one year after the final policyholder is no longer eligible for benefits under the policy.

Section 11. Prohibition Against Post-Claims Underwriting

A. All applications for limited long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. (1) If an application for limited long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a limited long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the limited long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this limited long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

Section 12. Minimum Standards for Home and Community Care Benefits in Limited long-Term Care Insurance Policies

A. A limited long-term care insurance policy or certificate shall not, if it provides benefits for home care or community care services, limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

B. A limited long-term care insurance policy or certificate, if it provides for home or community care services, shall provide total home or community care coverage that is a dollar amount equivalent to at least one-half of the coverage available for nursing home benefits under the policy or certificate, at the time covered home or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home care coverage may be applied to the non-home care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home care benefits to be counted toward the maximum length of limited long-term care coverage under the policy. The subsection is not intended to restrict home care to a period of time which would make the benefit illusory.

Section 13. Requirement to Offer Inflation Protection

A. No insurer may offer a limited long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of limited long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than three percent (3%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least three percent (3%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group certificateholder.

C. (1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

D. Inflation protection benefit increases under a policy that contains these benefits and shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

E. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

F. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a limited long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another limited long-term care insurance policy or long-term care insurance policy, or certificate in force, or whether a limited long-term care policy, or long-term care insurance policy, or certificate is intended to replace any other accident and sickness, or limited long-term care policy, or long-term care insurance policy, or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by [insert reference to Section 4(E)(1) of the *Limited Long-Term Care Insurance Model Act* (#642)], the following questions may be modified only to the extent necessary to elicit information about health or limited long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another limited long-term care insurance policy, or long-term care insurance policy, or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another limited long-term care insurance policy, or long-term care insurance policy, or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or limited long-term care or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

D. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

E. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual limited long-term care insurance policy, a notice regarding replacement of accident and sickness or limited long-term care or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LIMITED LONG-TERM CARE INSURANCE OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or limited long-term care insurance or long-term care insurance and replace it with an individual limited long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or limited long-term care insurance or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this limited long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing limited long-term care insurance or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]
The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LIMITED LONG-TERM CARE INSURANCE OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or limited long-term care insurance or long-term care insurance and replace it with the limited long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or limited long-term care insurance or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this limited long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing limited long-term care insurance or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of limited long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix B)

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of limited long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix B)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix B)

F. For purposes of this section:

(1) "Policy" means only limited long-term care insurance;

(2) "Report" means on a statewide basis.

G. Reports required under this section shall be filed with the commissioner.

H. Annual rate certification requirements.

(1) This subsection applies to any limited long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the regulation].

(2) The following annual submission requirements apply subsequent to initial rate filings for individual limited long-term care insurance policies made under this section.

(a) An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(i) A statement of the sufficiency of the current premium rate schedule.

Drafting Note: In accordance with the 2014 amendments to Section 10 of the *Long-Term Care Insurance Model Regulation* (#641), in situations where the premium rates have been approved with less than the normal minimum margin for moderately adverse experience, any adverse experience should be reviewed to determine if the lower margins can be continued for new business.

(ii) For the rate schedules that are no longer marketed,

I. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

II. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

(iii) A description of the review performed that led to the statement.

(b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (2)(a).

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

Drafting Note: Actuarial Standard of Practice (ASOP) No. 18, the NAIC *Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* (#641) and the Academy of Actuaries Practice Note "Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability" all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

(iii) A description of the credibility of the experience data.

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

(c) The actuarial certification required pursuant to Paragraph (2)(a) must be based on calendar year data and submitted annually no later than May 1st of each year, starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to Paragraph (2)(b) must be submitted at least once every three (3) years with the certification.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not certify to the maintenance of margins.

Section 16. Licensing

A producer is not authorized to sell, solicit or negotiate with respect to limited long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC *Producer Licensing Model Act*. (#218)].

Section 17. Discretionary Powers of Commissioner

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific limited long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring limited long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community, or some other residential community for the elderly, and the modification or suspension is reasonably related to the special needs, or nature of such a community; or

(3) The modification or suspension is necessary to permit limited long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Drafting Note: This provision is intended to provide the commissioner with limited discretion and flexibility to accommodate specific and innovative limited long-term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

Section 18. Reserve Standards

A. When limited long-term care benefits are provided, reserves shall be determined in accordance with [insert reference to state law equivalent to the *Health Insurance Reserves Model Regulation* (#10)].

Section 19. Premium Rate Schedule Increases

A. This section applies to any limited long-term care policy or certificate issued in this state, on or after [insert date, that is six (6) months after adoption of the regulation].

B. No rate increase may be requested by an insurer until the projected lifetime loss ratio, under best estimate assumptions, exceeds the anticipated lifetime loss ratio plus 2%.

C. An insurer shall provide notice of a pending premium rate schedule increase to the commissioner at least [30] days prior to the notice to the policyholders and shall include: An actuarial memorandum that shall include:

(1) A revised rate schedule;

(2) An actuarial memorandum that shall include:

(a) A statement regarding the actuary's qualifications;

(b) An explanation of the review performed by the actuary;

(c) A complete description of all pricing assumptions and any changes from the initial and any prior filing;

(d) An exhibit showing policy count, actual incurred claims, and earned premiums by duration both on a state and nationwide basis, and any revised projections based on the revised pricing assumptions;

(e) An exhibit showing actual to expected loss ratios by duration;

(f) A statement that the revised premium schedule is expected to result in a lifetime loss ratio not less than 55%;

(g) A sensitivity analysis of the anticipated lifetime loss ratio to the changes in the individual assumptions, including any revised assumptions, including sensitivity to the mix of business;

(h) A description of the valuation assumptions, including any revisions since the initial and any prior filing, with sufficient detail or sample calculation to have a complete depiction of the reserve amounts to be held;

(i) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such statement cannot be made, a complete description of the situation where this does not occur; and

(j) An actuarial certification dated and signed by the actuary that all information presented in the actuarial memorandum is accurate and complete.

D. An insurer that is granted a premium rate schedule increase shall retain similar documentation related to the rate increase request as is required in Section 10C.

Section 20. Filing Requirement

Prior to an insurer or similar organization offering group limited long-term care insurance to a resident of this state pursuant to [cite state law equivalent to Section 5 of the *Limited Long-Term Care Insurance Model Act* (#642)], it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in this state.

Section 21. Filing Requirements for Advertising

A. Every insurer, health care service plan, or other entity providing limited long-term care insurance or benefits in this state shall provide a copy of any limited long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium to the commissioner, for review or approval by the commissioner, to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Section 22. Standards for Marketing

A. Every insurer, health care service plan, or other entity marketing limited long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(b) Excessive insurance is not sold or issued.

(2) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with limited long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(3) Provide copies of the disclosure form required in Section 9C (Appendix A) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for limited long-term care or long-term care insurance already has accident and sickness or limited long-term care insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing limited long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available, and the name, address, and telephone number of the program.

(7) For limited long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6A(3) of this regulation.

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 27D(3) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 27D(4).

B. In addition to the practices prohibited in [insert citation to NAIC model *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of, or tending to induce the purchase of, insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase, or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a limited long-term care insurance policy.

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC *Limited Long-Term Care Insurance Model Act*] (#642), when endorsing or selling limited long-term care insurance shall be to educate its members concerning limited long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding limited long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the

policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any limited long-term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees, and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing limited long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in limited long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales, or sent to members, regarding the policies or certificates.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group limited long-term care insurance policy or certificate may be issued to an association, unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a limited long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies, annually that the association has complied with the requirements set forth in this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of NAIC model *Unfair Trade Practices Act* (#880)].

Drafting Note: Remember that the NAIC model *Unfair Trade Practice Act* (#880) in your state applies to limited long-term care insurance policies and certificates.

Section 23. Suitability

A. Every insurer, health care service plan, or other entity marketing limited long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant.

(2) Include in its suitability standards and procedures:

(a) Consideration of the advantages and disadvantages of insurance to meet the needs of the applicant; and

(b) Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.

(3) Train its agents in its suitability standards and procedures; and

(4) Maintain a copy of its suitability standards and procedures and make them available for inspection upon request by the commissioner.

B. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

Section 24. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a limited long-term care insurance policy or certificate replaces another limited long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new limited long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 25. Availability of New Services or Providers

A. An insurer shall notify policyholders of the availability of a new limited long-term policy series that provides coverage for new limited long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months that the date of the new policy series is made available for sale in this state.

Drafting Note: New limited long-term care services or providers that are material in nature shall not include changes to policy structure; or benefits or provisions that are minor in nature. Examples of when notification need not be provided include: changes in elimination periods, benefit periods and benefit amounts.

B. Notwithstanding Subsection A above, notification is not required for any policy issued prior to the effective date of this section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

C. The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

Drafting Note: An example of an acceptable alternative program is underwriting concessions.

D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders who purchased such a new proprietary policy shall be notified when a new limited long-term care policy series that provides coverage for new limited long-term care services or providers material in nature is made available to that limited distribution channel.

E. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 14 and 24, and the reporting requirements of Section 15A through E of this regulation.

F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the offering entity. However, if the policy is issued to a group defined in Section 4E(4) of the *Limited Long-Term Care Insurance Model Act* (#642), the notification shall be made to each certificateholder.

G. Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

H. This section does not apply to life insurance policies or riders containing accelerated limited long-term care benefits.

I. This section shall become effective on or after [insert the effective date of the regulation].

Section 26. Right to Reduce Coverage and Lower Premiums

A. (1) Every limited long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly, or monthly benefit amount.

(2) The insurer may also offer other reduction options that are consistent with the policy or certificate design, or the carrier's administrative processes.

(3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the process for requesting and implementing a reduction in coverage.

C. The premium for the reduced coverage shall:

(1) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(2) Be consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this regulation.

F. The requirements of Subsections A through E shall apply to any limited long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

G. A premium increase notice required by Section 9E of this regulation shall include:

(1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) A disclosure stating that all options available to the policyholder may not be of equal value; and

H. The requirements of Subsection G shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

Drafting Note: Compliance with this section may be accomplished by policy replacement, exchange, or by adding the required provision via amendment or endorsement to the policy.

Section 27. Nonforfeiture Benefit Requirement

A. To comply with the option to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)]:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection D; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

B. Should the offer made under [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)] be rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection C(4) shall still apply.

C. (1) After rejection of the offer made under [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding 50% of the insured's initial annual premium. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

(4) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 26 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection D. This option may be elected at any time during the 120-day period referenced in Subsection C(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection C(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

D. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection C(3), are described in this subsection:

(1) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up limited long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(2) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection E.

(3) The nonforfeiture benefit shall begin no later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(4) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

E. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

F. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

G. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection C(3) or C(4), a replacing insurer that purchased or otherwise assumed a block or blocks of limited long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Section 28. Standards for Benefit Triggers

A. A limited long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Limited long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

Section 29. Appealing an Insurer's Determination that the Benefit Trigger is not Met.

A. For purposes of this section, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

(1) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

B. If an insurer determines that the benefit trigger of a limited long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

(1) The reason that the insurer determined that the insured's benefit trigger has not been met;

(2) The insured's right to internal appeal in accordance with subsection C, and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed, and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their State Department of Insurance and their State Health Insurance Program (SHIP) office.

Section 30. Prompt Payment of Clean Claims

A. For purposes of this section:

(1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

B. Within thirty (30) business days after receipt of a claim for benefits under a limited long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(1) The insurer is declining to pay all or part of the claim and the specific reason(s) for denial; or

(2) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

C. Within thirty (30) business days after receipt of all the requested additional information, an insurer shall pay a claim for benefits under a limited long-term care insurance policy or certificate if it is a clean claim or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

D. If an insurer fails to comply with Subsection B or C, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim with respect to Subsection B or all requested additional information with respect to Subsection C. The interest payable pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for

such interest.

E. The provisions of Section 30 shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

F. Any violation of this regulation by an insurer if committed flagrantly and in conscious disregard of the provisions of this regulation or with such frequency as to constitute a general business practice shall be considered a violation of the [insert reference to state law equivalent to the NAIC model *Unfair Trade Practices Act* (#880).]

G. The provisions of Section 30 supersede any other claim payment requirement found in [insert reference to state prompt payment law].

Section 31. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6F of the *Limited Long-Term Care Insurance Model Act* (#642)] [cite provision of law requiring the commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LIMITED LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this limited long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other

coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For limited long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

4. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT TRADITIONAL LONG-TERM CARE COVERAGE. THIS IS LIMITED LONG-TERM CARE COVERAGE AND DOES NOT MEET THE MINIMUM STANDARDS OF TRADITIONAL LONG-TERM CARE INSURANCE

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

8. LIMITED LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered limited long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for limited long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 5 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LIMITED LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of limited long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits, and the basis upon which benefits will be increased over time, if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER COGNITIVE IMPAIRMENTS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT YOUR STATE HEALTH INSURANCE ASSISTANCE PROGRAM OR STATE INSURANCE DEPARTMENT IF YOU HAVE GENERAL QUESTIONS REGARDING LIMITED LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LIMITED LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Section 32. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state, relating to the regulation of limited long-term care insurance or the marketing of such insurance, shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

Section [ ]. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a limited long-term care insurance policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders' fees.

Drafting Note: If a state believes that there is evidence that the limited long-term care insurance market is experiencing abusive marketing practices, the state may wish to consider adopting the optional agent compensation provision above.

The compensation provision, such as provided above, should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

APPENDIX A

Instructions: *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.*

As used in this Appendix:

"Policy" shall mean policy, certificate, or rider, as applicable.
"Premium" shall include premium schedules, as applicable.
Companies may substitute whichever term is appropriate to reflect the limited long-term care insurance for which the applicant is applying.

Limited long-Term Care Insurance
Potential Premium Increase Disclosure Form

Important Notice: Your limited long-term care insurance company **may** increase the premium for your policy **every year**. You have certain rights and it's important that you understand them before you buy a limited long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable*. Companies can increase the premiums for guaranteed renewable policies in the future. The company **cannot** increase your premiums because **you are** older or **your** health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. What Is Your Premium?

The agent/company has quoted you a premium of [$_____] for this policy. This is **not** a final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you'll be required to pay for your policy will be [shown on the schedule page of] [will be attached to] your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

APPENDIX B

Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to report, on a statewide basis, information regarding limited long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of limited long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of limited long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals
Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

4th Quarter 2018 (adopted new model).

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE R. 590-285 (2020).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2018

LIMITED LONG-TERM CARE INSURANCE MODEL REGULATION (#643)

1. Description of the Project, Issues Addressed, etc.

Changes were made to the *Long-Term Care Insurance Model Regulation* (#641) pursuant to the charge of the Short Duration Long-Term Care Policies (B) Subgroup.

2. Name of Group Responsible for Drafting the Model and States Participating

Short Duration Long-Term Care Policies (B) Subgroup of the Senior Issues (B) Task Force:

Connecticut, Chair	Kentucky	Oklahoma
California, Vice Chair	Missouri	Pennsylvania
Florida	Nebraska	Texas
Indiana	New Hampshire	Utah
Kansas	New Mexico	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The Senior Issues (B) Task Force first appointed the Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup at the 2016 Summer National Meeting to determine whether short-term health policies providing long-term care (LTC) benefits should be moved under the purview of LTC insurance. The Subgroup determined that a new model act and new model regulation should be adopted. The Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup was disbanded at the 2016 Fall National Meeting.

The Task Force appointed the Short Duration Long-Term Care Policies (B) Subgroup at the 2016 Fall National Meeting to address LTC products of short duration that are excluded from the *Long Term Care Insurance Model Act* (#640) and Model #641, but do not quite fit under the *Accident and Sickness Insurance Minimum Standards Model Act* (#170) and the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

The Short Duration Long-Term Care Policies (B) Subgroup made changes to various parts of Model #641. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: America's Health Insurance Plans (AHIP); Aetna; and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Short Duration Long-Term Care Policies (B) Subgroup met 14 times via open conference calls (March 7, 2018; Feb. 14, 2018; Jan. 24, 2018; Dec. 13, 2017, Nov. 15, 2017; Oct. 25, 2017; Oct. 4, 2017; Sept. 13, 2017; Aug. 16, 2017; July 12, 2017; June 21, 2017; May 31, 2017; May 10, 2017; and March 29, 2017). The Subgroup adopted the revisions to Model #641 on March 7, 2018.

The Senior Issues (B) Task Force held an exposure period from March 24, 2018, to May 4, 2018. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received. The Task Force adopted the revisions to Model #641 on June 7, 2018.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Definitions

A. "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Certificate" means, for the purposes of this Act, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

C. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

D. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

Drafting Note: It is intended that nonprofit hospital and medical service associations be subject to this model act. In those states where such associations are prohibited from issuing subscriber contracts that include all of the benefits required by Section 3 of this Act, they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefits required. In such event, the combination of contracts will be considered to have been issued in compliance with Section 3 of this Act.

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

F. "Medicare supplement policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.), or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Drafting Note: OBRA 1990 contained an exception from this definition for policies issued pursuant to an agreement under Section 1833 (42 U.S.C. 1395l) of the federal Social Security Act. The Social Security Act Amendments of 1994 eliminated the exemption for Section 1833 plans effective December 31, 1995. These plans, commonly know as health care prepayment plans (HCPPs), arrange for certain Part B services on a pre-paid basis. The federal law continues to authorize HCPP agreements. However, since they are now included in the federal definition of a Medicare supplement policy, HCPPs are subject to the requirements of this model, unless they are exempt under Section 2B. In states authorized for the Medicare Select program, these plans may be able to comply with Medicare supplement requirements.

G. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Section 2. Applicability and Scope

A. Except as otherwise specifically provided this Act shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Act, and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This Act shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

C. Except as otherwise specifically provided in section 5D, the provisions of this Act are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons when the policies are not marketed or held to be Medicare supplement policies or benefit plans.

Section 3. Standards for Policy Provisions and Authority to Promulgate Regulations

A. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

B. Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate shall not exclude or limit benefits for loss incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

C. The commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state, including Sections [insert the applicable statutory reference, if any, to the NAIC Uniform Accident and Sickness Policy Provision Law]. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this Act, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

Drafting Note: Wherever the term "commissioner" appears, the title of the chief insurance regulatory official of the state should be inserted.

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

D. The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices, for Medicare supplement policies and certificates.

E. The commissioner may adopt from time to time reasonable regulations necessary to confirm Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare Select policies and certificates.

F. The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 4. Loss Ratio Standards

Medicare supplement policies shall return to policyholders' benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Section 5. Disclosure Standards

A. In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

B. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age.

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

C. The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

D. The commissioner may adopt regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for Medicare, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

E. The commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

Section 6. Notice of Free Examination

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

Section 7. Filing Requirements for Advertising

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

Drafting Note: States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

Section 8. Administrative Procedures

Regulations adopted pursuant to this Act shall be subject to the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 9. Penalties

In addition to any other applicable penalties for violations of the Insurance Code, the commissioner may require issuers violating any provision of this Act or regulations promulgated pursuant to this Act to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take actions necessary to comply with the provisions of this Act, or both.

Section 10. Separability

If any provision of this Act or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of the provision to other persons or circumstances shall not be affected.

Section 11. Effective Date

The Act shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 588, 591, 593, 603-605 (adopted).
1981 Proc. I 47, 51, 420, 424, 446, 453-456 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652-654, 665-668 (amended and reprinted).
1988 Proc. II 5, 13, 568, 601, 604, 624-626 (amended and reprinted).
1989 Proc. I 14, 813-814, 836.1-836.4 (amended at special plenary session September 1988).
1990 Proc. I 6, 27-28, 477, 574-575, 577-580 (amended and reprinted).
1992 Proc. I 12, 12-16, 1085 (amended at special plenary in July 1991).
1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 588-591 (amended and reprinted).

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-19-50 to 27-19-59 (1981/2000).		
Alaska			ALASKA ADMIN. CODE tit. 3, §§ 28.410 to 28.510 (1982/2009).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-1133 (1981/1989) (authority to promulgate rules).
Arkansas	ARK. CODE ANN. §§ 23-79-401 to 23-79-410 (1992).		
California	CAL. INS. CODE §§ 10192.1 to 10192.23 (1981/2005).		CAL. HEALTH & SAFETY CODE §§ 1358.1 to 1358.24 (2001/2009).
Colorado	COLO. REV. STAT. §§ 10-18-101 to 10-18-109 (1981/2013).		3 COLO. CODE REGS. § 702-4:4-3-3 (1982/2015); BULLETIN B-4.33 (2010).
Connecticut	CONN. GEN. STAT. § 38a-495a (1992/2015).		CONN. GEN. STAT. § 38a-495 (2021); § 38a-495c (1993/2014).
Delaware	DEL. CODE ANN. tit. 18, §§ 3401 to 3410 (1992).		

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. CODE §§ 31-3701 to 31-3710 (1992/2000).		
Florida	FLA. STAT. ANN. §§ 627.671 to 627.675 (1980/2010) (portions of model).		MEMORANDUM 2009-005 (2009).
Georgia	GA. CODE ANN. §§ 33-43-1 to 33-43-9 (1992/2010).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. ANN. §§ 431:10A-301 to 431:10A-312 (1988/2003).		
Idaho	IDAHO CODE ANN. §§ 41-4401 to 41-4411 (1981/1999).		
Illinois	215 ILL. COMP. STAT. 5/363 (2008); 5/363a (1982/2003).		
Indiana	IND. CODE ANN. §§ 27-8-13-3 to 27-8-13-20 (1990/2003).		
Iowa			IOWA CODE ANN. § 509.13 (1981); § 514D.9 (1990) (authority to adopt regulation).
Kansas			KAN. STAT. ANN. § 40-2221 (1981/1996).
Kentucky	KY. REV. STAT. §§ 304.14-500 to 304.14-550 (1982/2010).		ADVISORY OPINION 2014-3 (2014).
Louisiana	LA. REV. STAT. ANN. § 22:1111(1981/1997).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 5001 to 5016 (1981/2013).		
Maryland	MD. CODE ANN. INS. §§ 15-901 to 15-928 (1980/2010); MD. CODE REGS. 31.10.05.01 to 31.10.05.11 (1982/2009).		
Massachusetts	NO CURRENT ACTIVITY		

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	MICH. COMP. LAWS §§ 500.3801 to 500.3861 (1992/2002) (includes regulation).		
Minnesota			MINN. STAT. ANN. §§ 62A.31 to 62A.44 (1981/2005); §§ 62A. 451 to 62A. 4528 (2005/2010) (Medicare Part D Plans).
Mississippi	MISS. CODE ANN. §§ 83-9-101 to 83-9-115 (1981/1996).		
Missouri	MO. REV. STAT. ANN. §§ 376.850 to 376.890 (1981/1996).		
Montana	MONT. CODE ANN. §§ 33-22-901 to 33-22-924 (1981/1993).		
Nebraska	NEB. REV. STAT. ANN. §§ 44-3601 to 44-3610 (1981/1996).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. §§ 415-F:1 to 415-F:8 (1995/1996).		
New Jersey	N.J. REV. STAT. ANN. §§ 17B:26A-1 to 17B:26A-17 (1982/1992).		
New Mexico	N.M. STAT. ANN. §§ 59A-24A-1 to 59A-24A-16 (1989/1992).		
New York			N.Y. INS. LAW § 3218 (1984).
North Carolina	N.C. GEN. STAT. §§ 58-54-1 to 58-54-50 (1989/1998).		N.C. GEN. STAT. § 58-3-215 (2009).

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota	N.D. CENT. CODE §§ 26.1-36.1-01 to 26.1-36.1-09 (1991/1997).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3923.33 to 3923.339 (1992).		
Oklahoma	OKLA. STAT. tit. 36, § 3611.1 (1982/1994).		
Oregon	OR. REV. STAT. §§ 743.680 to 743.689 (1989/1997).		OR. ADMIN. R. 836-052-0103 to 836-052-0194 (1989/2014).
Pennsylvania			40 PA. STAT. ANN. §§ 3101 to 3111 (1982).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-18.2-1 to 27-18.2-11 (1984/2005).		
South Carolina			S.C. CODE ANN. § 38-71-730(6) (1988/1992) (authority to adopt regulation); S.C. CODE ANN. REGS. 69-46 (2018).
South Dakota	S.D. CODIFIED LAWS ANN. §§ 58-17A-1 to 58-17A-17 (1982/2005).		
Tennessee	TENN. CODE ANN. §§ 56-7-1501 to 56-7-1511 (1992/2010).		
Texas	TEX. CODE ANN. INS. §§ 1652.001 to 1652.252 (2005).		
Utah	UTAH CODE ANN. § 31A-22-620 (1992/2005).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 1451 to 1461 (1990/1992).		
Virginia			VA. CODE ANN. §§ 38.2-3600 to 38.2-3610 (1986/1996).

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	WASH. REV. CODE ANN. §§ 48.66.010 to 48.66.920 (1982/2005).		WASH. REV. CODE ANN. §§ 48.21A.010 to 48.21A.900 (1965) (Extended Health Disability Insurance).
West Virginia	W. VA. CODE § 33-16-3d (1992/2006); § 33-28-5b (1992/1996) (individual).		
Wisconsin			WIS. STAT. § 632.81 (1981/1990); BULLETIN 10-17-2006 (2006).
Wyoming	WYO. STAT. §§ 26-38-201 to 26-38-209 (1990/1997).		

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite appropriate section of state law providing authority for minimum benefit standards regulations or the NAIC *Medicare Supplement Insurance Minimum Standards Model Act* (#650)].

Editor's Note: Wherever the term "commissioner" appears, the title of the chief insurance regulatory official of the state should be inserted.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purposes of this regulation:

A. "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificate holder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F. (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulation; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addresses separate, non-coordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, creditable coverage has been addressed in an interim final rule (62 Fed. Reg. at 16960-16962 (April 8, 1997)) issued by the Secretary pursuant to HIPAA, and may be addressed in subsequent regulations.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Drafting Note: If the state law definition of insolvency differs from the above definition, please insert the state law definition.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare Advantage plan in 42 U.S.C. 1395w-28(b)(1)], and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

Drafting Note: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) redesignates "Medicare + Choice" as "Medicare Advantage" effective January 1, 2004.

L. "Medicare supplement policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

Drafting Note: Under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) must comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act.

M. "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to [insert effective date on which the state made its revisions to conform to the Omnibus Budget Reconciliation Act of 1990].

N. "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after [insert effective date of 1990 plan] and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

O. "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

P. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Q. "Secretary" means the Secretary of the United States Department of Health and Human Services.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. (1) Subject to Sections 7A(4), (5) and (7), and 8A(4) and (5) of this regulation, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Drafting Note: After December 31, 2005, MMA prohibits issuers of Medicare supplement policies from renewing outpatient prescription drug benefits for both pre-standardized and standardized Medicare supplement policyholders who enroll in Medicare Part D. Before May 15, 2006, these beneficiaries have two options: retain their current plan with outpatient prescription drug coverage removed and premiums adjusted appropriately; or enroll in a different policy as guaranteed for beneficiaries affected by these changes mandated by MMA and outlined in Section 12, "Guaranteed Issue for Eligible Persons." After May 15, 2006, however, these beneficiaries will only retain a right to keep their original policies, stripped of outpatient prescription drug coverage, and lose the right to guaranteed issue of the plans described in Section 12.

Section 7. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by state]

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

Drafting Note: This section has been retained for transitional purposes. The purpose of this section is to govern all policies issued prior to the date a state makes its revisions to conform to the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508).

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based upon the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision so as to coincide with their particular authority.

(4) A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or non-renewed by the issuer solely on the grounds of deterioration of health.

(5) (a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1B of this regulation.

Drafting Note: Group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This section is not intended to impair such obligations.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$240];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state] and Prior to June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after [insert effective date] and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

Drafting Note: This Section has been retained for transitional purposes. The purpose of this section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010, are included in Section 8.1 of this regulation.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c), or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): "and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan." This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase "for any period that may be provided by federal law" has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her [1990 Standardized plan] (as described in Section 9 of this regulation) to a [2010 Standardized plan] (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the [commissioner] if the insured replaces a [1990 Standardized] policy or certificate with an issue age rated [2010 Standardized] policy or certificate at the insured's original issue age [and duration]. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner [----- according to the state's rate filing procedure -----].

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged [1990 Standardized] policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new [2010 Standardized] policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

Drafting Note: The options an issuer may offer its policyholders or certificate holders may be (a) to only selected existing Plans or (b) to only certain new Plans for a particular existing Plan. For example, an exchange of a new Plan F for an old Plan F is an acceptable option. An offer to only policyholders with existing Plans with no reduction in benefits is also acceptable.

B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The "or other appropriate Medicare standard of payment" provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay "$0," and the provider cannot balance bill the insured.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) (a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

(ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. Section 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The NAIC discussed including inflation protection for at-home recovery benefits, and preventive care benefits. However, because of the lack of an appropriate mechanism for indexing these benefits, NAIC has not included indexing at this point in time. However, NAIC is committed to evaluating the effectiveness of these benefits without inflation protection, and will revisit the issue. NAIC has determined that OBRA does not authorize NAIC to delegate the authority for indexing these benefits to a federal agency without an amendment to federal law.

D. Standards for Plans K and L.

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(a) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) below;

(i) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j) but substituting $2000 for $4000.

Section 8.1 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of [insert proper citation].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010, effective date of 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement policies and certificates issued prior to June 1, 2010, be retained and that this section of the regulation be adopted in its entirety as a new section to govern policies issued on and after June 1, 2010.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): "and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan." This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the period that may event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase "for any be provided by federal law" has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The "or other appropriate Medicare standard of payment" provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay "$0," and the provider cannot balance bill the insured.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

Drafting Note: Benefits for Plans K and L are set by The Medicare Prescription Drug, Improvement and Modernization. Act of 2003, and can be found in Sections 9.1E(8) and (9) of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. Section 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The descriptions of Plans K and L are contained in Section 9.1E(8) and (9) of this regulation.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010

Drafting Note: This section has been retained for transitional purposes. The purpose of this Section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010, are included in Section 9.1 of this regulation.

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C,or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only plans "A," "B," "D," "F (including F with a high deductible)" and "H" (for example) are authorized in a state, these plans should retain these alphabetical designations. However, an issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9D of this regulation.

E. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8 D(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8 D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Drafting Note: Use of new or innovative benefits may be appropriate to add coverage or access if they offer uniquely different or significantly expanded coverage.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. The core benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a state. In no event, however, may a state authorize the sale of more than 10 standardized Medicare supplement benefit plans (that is, 9 plus the core policy), plus the two (2) high deductible plans, and the two (2) benefit plans K and L, mandated by MMA at the same time. Further, the modified versions of plans H, I, J as required by MMA after December 31, 2005, will not count as additional plans toward the limitations on the total number of plans discussed above.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Drafting Note: After December 31, 2005, MMA prohibits Medicare supplement issuers from offering policies with outpatient prescription drug coverage, and from renewing outpatient prescription drug coverage for insureds enrolled in Medicare Part D. Consequently, plans with an outpatient prescription drug benefit will not be offered to new enrollees after that time.

Drafting Note: Pursuant to the enactment of MMA, two new benefit packages, called K and L, were added to plans A through J. The two new packages have higher co-payments and coinsurance contributions from the Medicare beneficiary.

Section 9.1 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of [insert proper citation].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010, effective date of the 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement benefit plans for policies and certificates issued prior to June 1, 2010, be retained and that this section of the Model be adopted in its entirety as a new section to govern policies and certificates issued on and after June 1, 2010. (The benefit plan standards of the Medicare Supplement Model Regulation for policies issued prior to June 1, 2010, are found in Section 9 of this regulation.)

A. (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only Plans A, B, D, F, F with High Deductible, and K (for example) are authorized in a state, these plans must retain their alphabetical designations. An issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9.1D of this regulation.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 8.1B of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2 A. (4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Part A Hospitalization After Lifetime Reserve Days are Exhausted: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j);

(i) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payments in the following amounts:

(a) The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Drafting Note: The NAIC expects to periodically review the co-payment levels for Medicare supplement Plan N and make adjustments to this regulation as necessary.

F. New or Innovative Benefits: An issuer may, with the prior approval of the [commissioner], offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual.. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. Plan A, which consists of the basic (core) benefits must be made available by all issuers. Therefore, Plan A must be one of the authorized benefit plans adopted by a state. If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by a state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by a state. Except where a new or innovative benefit is approved by the [commissioner] for sale in a state, a state may not authorize the sale of any Medicare supplement plan other than the standardized Medicare supplement benefit plans (that is, Plans A, B, C, D, F, F With High Deductible, G, K, L, M and N) set forth in this regulation.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Section 9.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of [-insert proper state citation-].

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1E(3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1E(5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1E(6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

Drafting Note: Subsection A(4), above implements the High Deductible Plan G as a redesignation of the prior High Deductible Plan F because federal law "deems" any reference to Plan F as Plan G for "newly eligible" Medicare beneficiaries. High Deductible Plan G is the same as the High Deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the High Deductible Plan G. Federal law prohibits the sale or issuance of any Medigap policy that provides coverage (i.e. third party payment) of the Part B deductible to a "newly eligible" Medicare beneficiary and was enacted for the purpose of increasing cost-sharing and reducing "first dollar coverage". Treating the Medicare Part B deductible as an out-of-pocket expense of the beneficiary under Plan G High Deductible meets this purpose.

(5) The reference to Plans C or F contained in Section 9.1A(2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) By reason of attaining age 65 on or after January 1, 2020; or

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Section 9.1E of this regulation.

Drafting Note: The standardized benefit plans described in Subparagraphs A(1) and A(2), above in this Section are also included as benefit plans D and G in Section 9.1E(4) and (7).

Section 10. Medicare Select Policies and Certificates

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

Drafting Note: This section should be adopted by all states approving Medicare Select policies.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the commissioner.

F. (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. (1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

Drafting Note: The Secretary has developed regulations pursuant to HIPAA regarding methods of counting creditable coverage, which govern the way the reduction is to be applied in Section 11B(2).

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

Drafting Note: Paragraph (1) above uses the federal legislative language from the Balanced Budget Act of 1997 (P.L. 105-33) that defines an eligible person as an individual with respect to whom an employee welfare benefit plan terminates, or ceases to provide "all" health benefits that supplement Medicare. There was protracted discussion among the drafters about the interpretation of "all" in this context: if the employer drops some supplemental benefits, but not all such benefits, from its welfare plan, should the individual be eligible for a guaranteed issue Medicare supplement product? This question may become crucial to certain individuals depending on the benefits dropped by the employer. Federal legislative history appears to indicate the intention that the word "all" be strictly construed so as to require termination or cessation of all supplemental health benefits. States, however, can provide greater protections to beneficiaries and may wish to include, as eligible persons, individuals who have lost "some or all" or "substantially all" of their supplemental health benefits, to encompass situations where a change is made in an employee welfare benefit plan that reduces the amount of supplemental health benefits available to the individual. States that consider alternative language are reminded to consider the impact of issues such as plan changes that result in adverse selection, duplicate coverage, triggering the requirement for plan administrator notice (see Section 12D) and other issues.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated;

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3) (a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(iii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

Drafting Note: Paragraph (3)(a)(iv) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare Select policies or certificates.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a) (i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

(b) The issuer of the policy substantially violated a material provision of the policy; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Drafting Note: The reference to "insolvency of the issuer" in Paragraph 4(a) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare supplement policies or certificates.

(5) (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under Subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

Drafting Note: Federal law provides a guaranteed issue right to a Medicare supplement insurance product to individuals who enroll in Medicare Part B at age 65. States may wish to consider extending this right to other classes of individuals, such as those who postpone enrollment in Medicare Part B until after age 65 because they are working and are enrolled in a group health insurance plan.

Drafting Note: Paragraph (7) does not preclude an individual from applying for a new Medigap policy without drug coverage while still enrolled in the policy with drug coverage. The issuer will terminate the drug policy when it issues the new policy without drug coverage.

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Subsection B but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods.

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) (a) Subject to Subparagraph (b), Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this Subparagraph is:

(i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Section 12B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

Drafting Note: Under federal law, for states that have an alternative form of standardization under a federal waiver and offer benefit packages other than Plans A, B, C, D, F, F with High Deductible, G, K, L, M and N, the references to benefit packages above are deemed references to comparable benefit packages offered in that state. Those states should amend the language accordingly.

F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Drafting Note: States should ensure that educational and public information materials it develops related to Medicare includes a thorough description of the rights outlined in Section 12F.

Section 13. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 14. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards.

(1) (a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

Drafting Note: Subsection A(3) replicates language contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508). It allows direct mail group policies sold on an individual basis to meet the minimum loss ratio required of individual business (65%) rather than that required of group business (75%). The NAIC eliminated this concept from this regulation in 1987 (I *Proceedings of the NAIC*, pp. 651, 673 (1988)). At that time, NAIC required direct mail group business to meet the same loss ratio requirement as other group business, regardless of whether the business was sold on an individual basis. The NAIC encourages states to apply the 75% loss ratio to all group business. Although NAIC is restricted from making revisions to its models that are not in conformance with OBRA 1990, states are free to impose more stringent requirements than OBRA.

(4) For policies issued prior to [insert effective date from Section 26 of this model, the effective date of the state's regulation implementing the requirements of OBRA 1990], expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with [insert effective date of this revision] to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

Drafting Note: The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) for all group policies subject to an individual loss ratio standard when issued is 65 percent. States may amend Section 13A(4) to permit or require aggregation of closed blocks of business upon approval of CMS.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to [insert effective date from Section 26 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the [insert effective date of this amendment]. The first report shall be due by May 31, [insert (effective year + 2) of this amendment].

Drafting Note: Subsection B(3) implements the requirements of Section 171 of the Social Security Act Amendments of 1994 that require a refund or credit calculation for pre-standardized Medicare supplement policies, but only for experience subsequent to the date the state amends its regulation.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of [insert citation to state's regulation] in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) (a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of [insert citation to state's regulation] if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

Drafting Note: This section does not in any way restrict a commissioner's statutory authority, elsewhere granted, to approve or disapprove rates.

Section 15. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

D. (1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

Drafting Note: As a result of MMA, issuers now may have H, I, and J (including J with a high deductible) both with and without outpatient prescription drug coverage. The language in Subsection D is flexible enough to allow the issuer and regulator to incorporate this factor to allow for additional policy forms.

Drafting Note: The filing of 2010 Standardized plans policy forms to take the place of 1990 Standardized plans policy forms prior to the actual withdrawal of the 1990 standardized plans policy forms should be permitted.

E. (1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in [insert citation to Section 14 of NAIC Medicare Supplement Insurance Model Regulation].

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Drafting Note: It has come to the attention of the NAIC that the use of attained age rating in the determination of rates in Medicare supplement policies may result in situations to which a regulatory response is desirable. States should assess their Medicare supplement marketplace to determine whether a regulatory response is needed. The following provisions may be included as a new subsection to Section 15. The first option prohibits insurers from attained age rating as a methodology for setting rates. The second option does not prohibit the use of attained age rating but requires Medicare supplement insurers who do use attained age rating as a rate setting methodology to apply the age component to its rates annually. The effective date of the regulation should provide sufficient time for insurers to re-rate approved policy forms in accordance with Section 15A and for the insurance department to approve (according to its rate filing practices and procedures), such re-ratings prior to the effective date of the regulation.

Option 1.

G. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon attained age rating as a structure or methodology.

Option 2.

G. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

Drafting Note: State insurance regulators are encouraged to consider whether it is necessary to require issuers to file new forms where the only changes in the forms reflect year-to-year modifications in Medicare deductible and coinsurance amounts.

Section 16. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders' fees.

Section 17. Required Disclosure Provisions

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) (a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization –**Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses –**Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood –**First three pints of blood each year.
- **Hospice—** Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[7060]; paid at 100% after limit reached	Out-of-pocket limit $[3530]; paid at 100% after limit reached		

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2800] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2800]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2022][2]					**[$7060][2]**	**[$3530][2]**				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [$2800] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$0	$[1632] (Part A deductible)
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	$0	Up to $[204] a day
101st day and after	$0	$0	All costs

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (Part A deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	$0	Up to $[204] a day
101st day and after	$0	$0	All costs

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (Part A deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:	All but $[816] a day	$[816] a day	$0
– While using 60 lifetime reserve days			
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (Part A deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2800] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2800]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (Part A deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2800] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2800]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,*] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$[240] (Part B deductible)	$0
-Remainder of Medicare — Approved Amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2800] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2800]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (PartA deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2800] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2800]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES —IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,]** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2800] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2800] DEDUCTIBLE,]** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[7060] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[816] (50% of Part A deductible)	$[816] (50% of Part A deductible)♦
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts.	$0	
21st thru 100th day	All but $[204] a day	Up to $[102] a day (50% of Part A Coinsurance)	Up to $[102] a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts****	$0	$0	$[240] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$7060])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[240] of Medicare Approved Amounts****	$0	$0	$[240] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[7060] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*****	$0	$0	$[240] (Part B deductible) ♦
-Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[3530] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1224] (75% of Part A deductible)	$[408] (25% of Part A deductible)♦
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[153] a day (75% of Part A Coinsurance)	Up to $[51] a day (25% of Part A Coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance ♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts****	$0	$0	$[240] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$3530])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[240] of Medicare Approved Amounts****	$0	$0	$[240] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[3530] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*****	$0	$0	$[240] (Part B deductible) ♦
-Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[816] (50% of Part A deductible)	$[816] (50% of Part A deductible)
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN M

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1632]	$[1632] (Part A deductible)	$0
61st thru 90th day	All but $[408] a day	$[408] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[816] a day	$[816] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[204] a day	Up to $[204] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[240] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[240] of Medicare Approved Amounts*	$0	$0	$[240] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 18. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

**NOTICE TO APPLICANT REGARDING REPLACMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

____ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative) *
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature

_____
(Date)
*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Section 19. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

Drafting Note: States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

Section 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:
"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to Medicare supplement insurance policies and certificates.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) Policy and certificate number; and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Drafting Note: Appendix B contains a reporting form for compliance with this section.

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Drafting Note: Although NAIC is restricted from making revisions to its models that do not conform to the Omnibus Budget Reconciliation Act of 1990, states are encouraged to consider deletion of the words "for similar benefits" in Subsection A and the words "for benefits similar to those contained in the original policy or certificate" in Subsection B. States should eliminate Paragraphs (1) and (2) (applicable to preexisting conditions) of the replacement notice required by Section 16E.

Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. An issuer of a Medicare supplement policy or certificate;

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that –

(a) Compliance with the request is voluntary; and

(b) Non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

Drafting Note: Not all states currently regulate third-party administrators. However, the Genetic Information Nondiscrimination Act of 2008 requires that third-party administrators be included in the definition of an issuer of a Medicare supplement policy or certificate.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(a) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) The computation of premium or contribution amounts under the policy;

(c) The application of any pre-existing condition exclusion under the policy; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Section 25. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 26. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 588, 591, 593, 595-603 (adopted).
1981 Proc. I 47, 51, 420, 422, 424, 466-447, 470-481 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652-654, 668-677 (amended and reprinted).
1988 Proc. II 5, 13, 568, 601, 604, 615-624 (amended and reprinted).
1989 Proc. I 14, 813-814, 836, 4-836.26 (amended at special plenary session September 1988).
1989 Proc. I 9, 25, 703, 753-754, 757-760 (appendices amended at regular plenary session).
1990 Proc. I 6, 27-28, 477, 574-576, 580-599 (amended and reprinted).
1990 Proc. II 7, 16, 599, 656, 657 (adopted reporting form).
1992 Proc. I 12, 16-75, 1084-1085 (amended at special plenary session in July 1991).
1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 592-615 (amended and most of model reprinted).
1998 Proc. 1st Quarter 769, 772-799, 905 (amended).
1998 Proc. 3rd Quarter 15, 576, 697, 701, 702-717 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 273, 275-288 (amended).
2001 Proc. 2nd Quarter 13, 14, 118, 171, 176, 181-187 (amended).
2004 Proc. 3rd Quarter 84, 679-681, 747, 748-866 (amended and reprinted).
2007 Proc. 1st Quarter (amended).
2008 Proc. 3rd Quarter 3-114 to 3-116, 4-24 to 4-26 (amended and reprinted).
2010 Proc. 1st Quarter (technical corrections).
2014 1st Quarter (technical revisions).
2015 1st Quarter (technical revisions).
2016 1st Quarter (technical revisions).
2016 Proc. 2nd Quarter, Vol. I 113, 137-142, 325-456, 518 (amended).
2017 1st Quarter (technical revisions).
2018 1st Quarter (technical revisions).
2018 4th Quarter (technical revisions).
Fall 2019 (technical revisions).
Fall 2020 (technical revisions).
Fall 2021 (technical revisions).
Fall 2022 (technical revisions).
Fall 2023 (technical revisions).

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Years' Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
3 Includes Modal Loadings and Fees Charged
4 Excludes Active Life Reserves
5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B

**FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES**

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Hospice care
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.
This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-071-.01 to 482-1-071-.26 (1992/2017).		BULLETIN 9-1-2009 (2009).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.410 to 28.510 (1982/2019) (portions of model).		BULLETIN 2019-6 (2019).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE §§ R20-6-1101 (2009/2019).		
Arkansas	054-00-27 ARK. CODE R. §§ 1 to 27 (1981/2018).		
California	CAL. HEALTH & SAFETY CODE §§ 1358 to 1358.24 (1992/2019) (HMOs); CAL. INS. CODE §§ 10192.1 to 10192.24 (1981/2019).		CAL. CODE REGS. tit. 10, §§ 2220.50 to 2220.58 (1983/2000).
Colorado	3 COLO. CODE REGS. § 702-4:4-3-1 (1992/2018).		BULLETIN B-4.23 (2008); BULLETIN B-4.33 (2010).
Connecticut	CONN. AGENCIES REGS. §§ 38a-495a-1 to 38a-495a-21 (1992/2019).		CONN. AGENCIES REGS §§ 38a-474-1 to 38a-474-4 (1995/2012) (review of rates).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	18 DEL. CODE REGS. § 1501 (1990/2019).		
District of Columbia		D.C. MUN. REGS. tit. 26, §§ 22.2200 to 22.2299 (1993/2012).	
Florida		FLA. ADMIN. CODE ANN. r. 69O-156.001 to 69O-156.050 (1981/2010).	MEMORANDUM 2009-005 (2009).
Georgia		GA. COMP. R. & REGS. 120-2-8-.01 to 120-2-8-.25 (1992/2011).	
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-12-1 to 16-12-12 (1982/2019).		
Idaho	IDAHO ADMIN. CODE r. 18.01.54.000 to 18.01.54.032 (1992/2019).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2008.10 to 2008.110 (1983/2019).		BULLETIN 2011-15 (2011).
Indiana	760 IND. ADMIN. CODE 3-1-1 to 3-20-1 (2007/2019).		
Iowa	IOWA ADMIN. CODE r. 191-37.1 to 191-37.51; Apps. A to F. (1992/2019).		
Kansas	KAN. ADMIN. REGS. § 40-4-35 (1982/2017).		
Kentucky	806 KY. ADMIN. REGS. 17:570 (2018).		ADVISORY OPINION 2014-4 (2014).
Louisiana	LA. ADMIN. CODE tit. 37, § XIII.501 to XIII.599 (Regulation 33) (1992/2018).		
Maine	02-031-275 ME. CODE R. §§ 1 to 26; Apps. A to C (1992/2018).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland	MD. CODE REGS. §§ 31.10.06.01 to 31.10.06.31 (1992/2019).		
Massachusetts			211 MASS. CODE REGS. 71.01 to 71.24 (1996/2019).
Michigan	MICH. COMP. LAWS §§ 500.3801 to 500.3861 (1992/2018).		
Minnesota			MINN. STAT. §§ 62A.31 to 62A.44 (1981/2019); BULLETIN 2009-1 (2009).
Mississippi	19 MISS CODE R. Pt. 3, §§ 10.01 to 10.29 (2009/2019).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-3.650 (1992/2019).		
Montana	MONT. ADMIN. R. §§ 6.6.503 to 6.6.527 (1982/2018).		MONT. ADMIN. R. §§ 6.6.601 to 6.6.614 (1996/2017).
Nebraska	210 NEB. ADMIN. CODE §§ 36-001 to 36-002 (1992/2018) (adopted by reference).		
Nevada	LCB File No. R041-17 (2019).	NEV. ADMIN. CODE §§ 687B.200 to 687B.330 (1989/2009).	BULLETIN 92-002 (1992).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. §§ 1905.01 to 1905.27; Apps. A to C (1992/2018).		N.H. CODE ADMIN. R. ANN. INS. § 1902.06 (2016); N.H. CODE ADMIN. R. ANN. INS. § 1903.04 (2006); BULLETIN 06-039-AB (2006).
New Jersey		N.J. ADMIN. CODE §§ 11:4-23.1 to 11:4-23.24 (1991/2009).	N.J. ADMIN. CODE §§ 11:4-23A.2 to 11:4-23A.12 (1996/2004) (disability).
New Mexico	N.M. CODE R. §§ 13.10.25 (2019).		N.M. CODE R. §§ 13.10.24 (2009).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.11 to 52.95 (1982/2019).	
North Carolina	11 N.C. ADMIN. CODE 12.0843 (2005) (incorporates model by reference).		N.C. GEN. STAT. § 58-3-215 (2009).
North Dakota		N.D. ADMIN. CODE §§ 45-06-01.1-01 to 45-06-01.1-22; Apps. A to C (1994/2009).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-8-08 (2018).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-120 to 365:10-5-143 (1993/2019).		
Oregon	OR. ADMI. R. 836-052-0103 to 836-052-0194 (1982/2018).		
Pennsylvania	31 PA. CODE §§ 89.770 to 89.791 (1990/2018).		
Puerto Rico		P.R. REGS. § 7747 (Rule L) (1982/2009).	
Rhode Island	230 R.I. CODE R. §§ 20-30-7.1 to 20-30-7.28 (2018).		
South Carolina	S.C. CODE ANN. REGS. 69-46 §§ 1 to 26 (1992/2018).		S.C. CODE ANN. REGS. 69-34.2 (1980) (replacement coverage); BULLETIN 6-2012 (2012).
South Dakota	S.D. ADMIN. R. 20:06:13:02 to 20:06:13:92 (1982/2018).		BULLETIN 90-2 (1990).
Tennessee	TENN. COMP. R. & REGS. 0780-1-58 (1992/2019).		BULLETIN 7-29-2013 (2013).
Texas	28 TEX. ADMIN. CODE §§ 3.3301 to 3.3326 (1982/2018).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah	UTAH ADMIN. CODE R590-146 (1996/2019).		UTAH ADMIN. CODE R590-85 (1989/2006).
Vermont	VT. ADMIN. CODE §§ 4-5-14:1 to 4-5-14:26 (H-2009-04) (2019).		
Virgin Islands		V.I. REG. §§ 1453-1 to 1453-25 (1990/2007).	
Virginia	14 VA. ADMIN. CODE §§ 5-170-10 to 5-170-220; Apps. A to D (1992/2018).		
Washington	WASH. ADMIN. CODE 284-66-010 to 284-66-400 (1990/2019).		
West Virginia		W. VA. CODE R. §§ 114-24-1 to 114-24-22; Apps. A to G (1981/2010).	
Wisconsin	WIS. ADMIN. CODE INS. § 3.39 (1989/2019) (emergency rule amended regulation).		BULLETIN 10-17-2006.
Wyoming		35 WYO. CODE R. §§ 1 to 26; Apps. A to C (1980/2009).	

PROJECT HISTORY - 2016

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT (#651)

1. Description of the Project, Issues Addressed, etc.

Changes were made to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) in response to a federal law, the Medicare Access and CHIP Reauthorization Act of 2015 (Public law 114-10). The law prohibits first dollar Part B coverage on Medicare Supplement (Medigap) Plan C & Plan F to new eligible Medicare beneficiaries on or after Jan. 1, 2020.

2. Name of Group Responsible for Drafting the Model and States Participating

Medigap (B) Subgroup of the Senior Issues (B) Task Force

Missouri, Chair	Florida	Mississippi
Nebraska, Vice Chair	Iowa	New Hampshire
Alabama	Illinois	New York
Arizona	Kentucky	Oregon
Delaware	Maryland	Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The Senior Issues (B) Task Force appointed the Medigap Subgroup at the 2015 Summer National Meeting to address the changes to Medigap as mandated by Public law 114-10. The charge given to the Subgroup called to make the necessary changes to the *Medicare Supplement Insurance Minimum Standards Model Act* (#650), Model #651 and other materials on Medigap to comply with the law.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Subgroup determined no changes were necessary to Model #650. Changes were made to Section 9.1 and Section 9.2 of Model #651. The Centers for Medicare and Medicaid Services (CMS) was consulted during the drafting process. Interested parties, including industry and consumer groups, were able to comment on each draft. The Subgroup considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included: CMS; America's Health Insurance Plans (AHIP); UnitedHealth Group; and California Health Advocates (CHA).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Subgroup met nine (9) times via open conference calls (Feb. 22, 2016; Feb. 8, 2016; Feb. 1, 2016; Jan. 4, 2016; Dec. 14, 2015; Nov. 30, 2015; Nov. 2, 2015; Oct. 19, 2015; and Oct. 5, 2015). The Subgroup adopted its changes on Feb. 22, 2016 and forwarded the revised draft Model #651 to the Senior Issues (B) Task Force for tis consideration. The Senior Issues (B) Task Force held an exposure period from March 2, 2016 to March 18, 2016. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received.

The Senior Issues (B) Task Force adopted the revised drafts of Model #651 at the 2016 Spring National Meeting on April 3, 2016. The Health Insurance and Managed Care (B) Committee adopted the revised drafts of Model #651 on April 4, 2016.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

The changes made by Public Law 114-10 to first dollar Part B coverage on Medigap Plans C & F to new eligible Medicare beneficiaries on or after Jan. 1, 2020 also apply to the waiver states (Massachusetts, Minnesota, and Wisconsin).

For high deductible plans, if a policyholder meets the high deductible amount with all Part A out of pocket expenses and then incurs Part B deductible expenses these expenses will not count toward the policyholder's high deductible nor be covered expenses.

PROJECT HISTORY - 2008

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT (#651)

1. Description of the Project, Issues Addressed, etc.

Revision of the Medicare supplement model regulation to comply with the requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Both laws require NAIC action to revise the model regulation by October 31, 2008.

2. Name of Group Responsible for Drafting the Model and States Participating

Senior Issues (B) Task Force

Wisconsin	Iowa	North Carolina
Louisiana	Kansas	North Dakota
Alabama	Kentucky	Ohio
Arkansas	Maine	Oklahoma
California	Maryland	Oregon
Colorado	Michigan	Pennsylvania
Connecticut	Minnesota	Rhode Island
Delaware	Mississippi	South Dakota
Florida	Nebraska	Texas
Hawaii	Nevada	Utah
Idaho	New Hampshire	Vermont
Illinois	New Mexico	Virginia
Indiana	New York	West Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The Senior Issues Task Force has a standing charge to "Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law and revise if necessary."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Senior Issues Task Force drafted both sets of revisions to the model simultaneously. The Centers for Medicare and Medicaid Services (CMS) was consulted during the drafting process. Interested parties, including industry and consumer groups, were able to comment on each draft. The Task Force considered and accepted several comments made to the draft, including comments from industry and consumer groups. Interested parties that commented on the drafts included CMS, America's Health Insurance Plans (AHIP) and UnitedHealth Group.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Senior Issues Task Force held an exposure period from July 17, 2008, to July 29, 2008. A draft was circulated to interested parties, including industry and consumer groups, and was posted to the NAIC website. The Task Force considered each comment that was received.

The Senior Issues Task Force approved the revisions on an open conference call on August 5, 2008. The Health and Managed Care (B) Committee then approved the model revisions on an open conference call on September 10, 2009.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard).

The implementation date for GINA Medigap requirements is May 21, 2009. However, GINA states that states will not be considered out of compliance with federal Medicare supplement requirements until July 1, 2009. States must adopt the GINA-related revisions to the model (contained in Section 24) by July 1, 2009, or they may be pre-empted by the federal government in this area.

The model revisions required by MIPPA, as well as the model revisions approved by the NAIC in March 2007, must be adopted by states by September 24, 2009 (with the exception of Massachusetts, Minnesota and Wisconsin,). The effective date for new (modernized) plans to be sold is June 1, 2010.

PROJECT HISTORY - 2007

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT (#651)

1. Description of the project, issues addressed, etc.

The President signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) on Dec. 8, 2003. Among other things, it added Part D to Medicare, providing prescription drug benefits. It also required the NAIC to make several changes to the Medicare Supplement Model Regulation to conform to the federal law.

These are the specific revisions to the model regulation required by MMA:

1. Add two new plans (called K and L in the amendments) to the standard Medigap plans A through J;

2. Revise the standard H, I and J plans to eliminate prescription drug coverage for those who enroll in Medicare Part D;

3. Prohibit the sale of prescription drug coverage in Medigap after Dec. 30, 2005 (i.e. when Part D comes into effect);

4. Make any other changes to the model regulation that might be required as a result of the legislation.

The task force only considered changes that are directly related to the unambiguous changes NAIC needs to make as a result of the bill, with some minor exceptions for clarification purposes.

2. Name of group responsible for draft the model:

Senior Issues (B) Task Force

States Participating:

Wisconsin, Chair
Florida, Vice-Chair
Alabama
Arkansas
California
Colorado
Connecticut
Delaware
Illinois
Iowa
Kansas
Kentucky
Louisiana
Michigan
Missouri
Mississippi
Nebraska
New Mexico
North Dakota
Ohio
Oklahoma
Pennsylvania
Rhode Island
Utah
Vermont
Virginia
West Virginia

3. Project authorized by what charge and date first given to the group:

The task force has the following charges:

Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law. Report by Winter 2003 National Meeting.

Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law and revise if necessary. Report by 2004 Winter National Meeting.

These are standing charges for the task force. The bill was signed on Dec. 8, 2003, and the task force began discussions immediately. The bill provided a nine-month time frame for the NAIC to amend its model regulation to conform to MMA.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the task force, in consultation with a "statutory working group." Under MMA, by reference to the Social Security Act, the NAIC was directed to "consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balance representation among the interested groups."

The task force appointed the following members to the statutorily required working group:

AARP (represented by Gerry Smolka)
California Health Advocates (represented by Bonnie Burns)
Center for Medicare Advocacy (represented by Vicky Gottlich)
Consumers Union (represented by Gail Shearer)
Families USA/Health Assistance Partnership (represented by Kevin Simpson)
Medicare Rights Center (represented by Diane Archer)
National Association of Health Underwriters (represented by Janet Trautwein)
National Council on Aging (represented by Howard Bedlin)
SHIP Steering Committee (represented by Carla Obiol)

Blue Cross Blue Shield of Florida (represented by Randy Kammer)
Central States Health & Life Company of Omaha (represented by Rebecca Smart)
Highmark, Inc. (represented by Candy Gallaher)
Mutual of Omaha Insurance Company (represented by Galen Ullstrom)
United American Insurance Company (represented by Stephen Still)
UnitedHealth Group (represented by Dotti Outland)
WellPoint Health Networks (represented by Peggy Storey)

Numerous other interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), and others.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There were six drafts of the proposed amendments. Each draft was circulated for comment to interested parties prior to discussion at NAIC quarterly meetings. The task force also held one two-day interim meeting, and additional conference calls. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the force.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

Several issues began as controversial during the revision process but were ultimately resolved. Initially, technical concerns were expressed regarding the imprecise language used in the text of MMA. In particular, the addition of the two new Medigap plans conflicted with provisions in §1882 of the Social Security Act that expressly limited the total number of Medigap plans to "10 + 2 (high deductible plans F and J)." Thus, the task force had to consider whether the addition of the two new plans would require the elimination of two current Medigap plans, to comport with SSA. With the support of legislative history and the endorsement of CMS, the task force elected to simply add the two new plans to the existing ones, relegating the omission of amendments to SSA in this regard as a technical error, whose consequences exceeded the scope of intent by Congress in enacting MMA. Future consideration of whether to consolidate similar existing Medigap policies is pending.

Next, the task force decided against allowing current Medigap policies with prescription drug coverage to continue offering such benefits to new enrollees after December 31, 2005. Again, the text of MMA did not express the clear intent of Congress to prohibit Medigap policies from offering drug benefits after the Medicare Part D program commenced. The rationale used by the task force in refusing to exploit the ambiguity in MMA was the desire to avoid a potentially disruptive conflict between the states and CMS over interpretation of the relevant statutory language, and the ensuing confusion would harm Medigap insureds and issuers.

In another statutory interpretation conflict, the task force concluded that MMA does not prohibit issuers from offering "innovative benefits" with Medigap plans K and L, against initial CMS arguments to the contrary. CMS ultimately agreed with the task force interpretation.

Last, several of the interested parties advocated for wholesale revision of the standard Medigap plans, citing language in the Conference Committee report accompanying the enacted MMA legislation. The task force concluded that given the short timeframe involved in making these amendments (nine months from the date the president signed the bill), it would be more prudent to make only the changes clearly necessitated by MMA. As noted previously, however, the task force did agree to consider, after this amendment process was complete, additional changes to the Medigap model act and regulation to modernize the Medigap market.

7. Any other important information (e.g., amending an accreditation standard).

States need to adopt the amendments by Sept. 8, 2005, in order to maintain an approved regulatory program and prevent federal takeover of Medigap enforcement.

PROJECT HISTORY - 2001

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT (#651

1. Description of the project, issues addressed, etc.

Amendments to the model regulation have been adopted to include changes made to the Social Security Act by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), as well as technical amendments to provisions added to the model regulation by the Balanced Budget Refinement Act of 1999 (BBRA).

2. Name of group responsible for drafting the model:

Medicare Supplement Working Group of the Senior Issues (B) Task Force

3. States Participating:

Florida, Chair, Alaska, Arkansas, Connecticut, Delaware, Indiana, Iowa, Kansas, Louisiana, Maine, Montana, New Mexico, North Dakota, Ohio, Oklahoma, Wisconsin

4. Project authorized by what charge and date first given to the group:

The following charge was given to the Seniors Issues (B) Task Force in 2001: Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law. Report by Winter 2001 National Meeting.

5. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The working group drafted the amendments to the model regulation. The Centers for Medicare and Medicaid Services (Formerly HCFA) participated in the process. Medicare supplement insurance carriers, including UnitedHealth Group, American Republic Insurance Company, and Physicians Mutual Insurance Company participated in the process. An NAIC consumer representative also participated.

6. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The draft amendments were exposed prior to the Spring 2001 National Meeting. The draft amendments were reviewed and discussed at the Spring 2001 and Summer 2001 National Meetings. All drafts of the model were exposed for comment. Comment letters were received and considered throughout the drafting process.

7. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

There were no substantive issues of controversy.

NAIC MODEL RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE WITH INTERPRETIVE GUIDELINES

Table of Contents

Preamble

The proper expansion of Medicare supplement insurance coverage is in the public interest. Appropriate advertising can broaden the distribution of insurance among those eligible for Medicare. Advertising can increase the awareness of beneficial forms of coverage and thereby encourage product competition. Advertising can also provide the insurance-buying public with the means by which it can compare the advantages of competing forms of coverage.

Insurance advertising has become increasingly important in the years since the 1956 NAIC Rules Governing Advertisement of Accident and Sickness Insurance were developed. The increasing availability of coverage under group insurance plans and the advent of governmental benefit programs have complicated the decisions the insurance-buying public must make to avoid duplication of benefits and gaps in coverage. The consequent need for detailed information about insurance products is reflected in the requirements for disclosure established by the 1972 NAIC Rules (as amended) Governing Advertisements of Accident and Sickness Insurance. This need for detailed disclosure is especially critical in helping to assure that individuals eligible for Medicare receive full and truthful advertising for Medicare supplement insurance. The NAIC has, therefore, determined that, while the 1972 NAIC Rules (as amended) Governing Advertisements of Accident and Sickness Insurance did address Medicare supplement insurance, these new Rules and Interpretive Guidelines addressed solely to Medicare supplement insurance advertising are needed to replace the previous 1972 Rules and Interpretive Guidelines with respect to Medicare supplement insurance advertising.

Although modern insurance advertising patterns much of its design after advertising for other goods and services, the uniqueness of insurance as a product must always be kept in mind in developing advertising. This is particularly true with respect to Medicare supplement insurance advertising. By the time an insured discovers that a particular insurance product is unsuitable for his or her needs, it may be too late to return to the marketplace to find a more satisfactory product. Hence, the insurance-buying public should be afforded a means by which it can determine, in advance of purchase, the desirability of the competing insurance products proposed to be sold. This can be accomplished by advertising which accurately describes the advantages and disadvantages of the insurance product without either exaggerating the benefits or minimizing the limitations. Properly designed advertising can provide such description and disclosure without sacrificing the sales appeal which is essential to its usefulness to the insurance-buying public and the insurance business. The purpose of the new NAIC Rules Governing Advertisements of Medicare Supplement Insurance is to establish minimum criteria to assure proper and accurate description and disclosure.

Section 1. Purpose

The purpose of these rules is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance; to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance agents and companies.

Section 2. Applicability

A. These rules shall apply to any "advertisement" of Medicare supplement insurance as that term is defined herein, unless otherwise specified in these rules, that the insurer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer or solicitor, as those terms are defined in the Insurance Code of this state.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all of its Medicare supplement insurance advertisements. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurers benefiting directly or indirectly from their dissemination.

C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Section 3. Definitions

A. (1) An advertisement for the purpose of these rules shall include:

(a) Printed and published material, audio visual material and descriptive literature used by or on behalf of an insurer in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays;

(b) Descriptive literature and sales aids of all kinds issued by an insurer, agent, producer, broker or solicitor for presentation to members of the insurance-buying public; including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and lead generating devices of all kinds as defined in this rule; and

(c) Prepared sales talks, presentations and material for use by agents, brokers, producers and solicitors, whether prepared by the insurer or the agent, broker, producer or solicitor.

(2) The definition of "advertisement" includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

(3) The definition of "advertisement" does not include:

(a) Material to be used solely for the training and education of an insurer's employees, agents or brokers;

(b) Material used in-house by insurers;

(c) Communications within an insurer's own organization not intended for dissemination to the public;

(d) Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

(e) Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

(f) Court approved material ordered by a court to be disseminated to policyholders; or

(g) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided, the announcement must clearly indicate that it is preliminary to the issuance of a booklet.

B. "Medicare supplement insurance" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

C. "Certificate" means, for the purposes of these rules, any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

D. "Insurer," for the purpose of these rules, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an "insurer" in the Insurance Code of this state and is engaged in the advertisement of itself, or Medicare supplement insurance.

E. "Exception," for the purpose of these rules, means any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

F. "Reduction," for the purpose of these rules, means any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.

G. "Limitation," for the purpose of these rules, means any provision that restricts coverage under the policy other than an exception or a reduction.

H. "Institutional advertisement," for the purpose of these rules, means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

I. "Invitation to inquire," for the purpose of these rules, means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, and that shall contain a provision in the following or substantially similar form:

> "This policy has [exclusions] [limitations] [reductions of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

J. "Invitation to contract," for the purpose of these rules, means an advertisement that is neither an institutional advertisement nor an invitation to inquire.

K. "Person," for the purpose of these rules, means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

L. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and popularly known as the "Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

M. "Lead-generating device," for the purpose of these rules, means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

Section 4. Method of Disclosure of Required Information

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous manner or fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

Section 5. Form and Content of Advertisements

A. The format and content of a Medicare supplement insurance advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner of insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases whose meanings are clear only by implication or by the consumer's familiarity with insurance terminology shall not be used.

C. An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words. . . "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

D. No insurer, agent, broker, producer, solicitor or other person shall solicit a resident of this state for the purchase of Medicare supplement insurance in connection with or as the result of the use of any advertisement by such person or any other person, where the advertisement:

(1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of such person or the true purpose of the advertisement; or

(2) Otherwise violates the provisions of these rules.

E. No insurer, agent, broker, solicitor or other person shall solicit residents of this state for the purchase of Medicare supplement insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the person or the true purpose of the advertisement.

Section 6. Advertisements of Benefits, Losses Covered or Premiums Payable

A. Deceptive Words, Phrases or Illustrations Prohibited

(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of the information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "this policy pays all that Medicare doesn't" or similar words and phrases, in a manner which exaggerates any benefit beyond the terms of the policy.

(3) An advertisement that also is an invitation to join an association, trust or discretionary group shall solicit insurance coverage on a separate and distinct application that requires separate signatures for each application. The separate and distinct application required for an advertisement which is also an invitation to join an association, trust or discretionary group need not be on a separate document or contained in a separate mailing. The insurance program shall be presented so as not to mislead or deceive the prospective members that they are purchasing insurance as well as applying for membership, if that is the case.

(4) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after six (6) months. " Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.

(5) An advertisement of Medicare supplement insurance sold by direct response shall not state or imply that "because no insurance agent will call and no commissions will be paid to 'agents' that it is a low cost plan" or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in marketing by direct response.

B. Exceptions, Reductions and Limitations

(1) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall disclose the existence of these periods.

(3) An advertisement shall not use the words "only," "just," "merely," "minimum," or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions. "

C. Preexisting Conditions

(1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

(2) When a Medicare supplement insurance policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue. " If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

> Do you understand that this policy will not pay benefits during the first six (6) months after the issue date for a disease or physical condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the policy issue date?
> YES

Or substantially the following statement:

> I understand that the policy applied for will not pay benefits for any loss incurred during the first six (6) months after the issue date due to a disease or physical condition for which I received medical advice or for which treatment was recommended by or received from a physician within six (6) months before the issue date.

Section 7. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancelability and Termination

An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancelability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

Section 8. Testimonials or Endorsements by Third Parties

A. Testimonials and endorsements used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained therein, and the advertisement, including the statement, is subject to all the provisions of these rules. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement:

(1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

(2) Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

(3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

(4) Is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence thereto. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, that fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement. " The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement; whichever is larger. In the case of television or radio advertising, the required disclosure must be accomplished in the introductory portion of the advertisement and must be given prominence.

D. The disclosure requirements of this rule shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually for the scale for TV or radio performances.

E. An advertisement shall not state or imply that an insurer or a Medicare supplement insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organization, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, that fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact shall be disclosed.

F. When a testimonial refers to benefits received under a Medicare supplement insurance policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

Section 9. Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that the statistics are derived from a policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

(1) An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised.

(2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, must be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for Medicare supplement insurance that refers to the amount of life insurance that the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or state or imply that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in the advertisement.

Section 10. Disparage Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

A. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits. "

B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are unacceptable unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.

C. Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.

Section 11. Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status; or the payment of its claims; or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or the United States government.

C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial conditions.

Section 12. Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that with or without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that is tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are so similar to those used by governmental agencies or other insurers are not permitted if they may lead the public to believe:

(1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

(2) That the advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

D. No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

E. No advertisement in the form of envelopes or stationary of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement is connected with a governmental agency, such as the Social Security Administration.

F. No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. Such an advertisement, however shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

G. No advertisement shall be used that fails to include the disclaimer to the effect of "Not Connected with or endorsed by the U. S. government or the federal Medicare program. "

H. No advertisement may imply that the reader may lose a right or privilege or benefit under federal, state or local law if he fails to respond to the advertisement.

I. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.

J. The use of the name of an agency or "_____ Underwriters" or "_____ Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

K. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.

L. No insurer may use, in the trade name of it's insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

M. All advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used.

N. An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead generating device, shall disclose that fact in the initial contact with the consumer.

Section 13. Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless that is the fact.

B. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements that state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

Section 14. Introductory, Initial or Special Offers

A. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, i. e. , mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

Drafting Note: The number of months was left blank in this rule because several states currently permit six months, several states allow three months, and other states currently prohibit such periods of enrollment. Whether enrollment periods should be permissible and the period of time between enrollments are items on which each state should make its own decision. Each state should modify the time limit in this guideline to comply with the rule adopted by the particular state.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.

(4) The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term "juxtaposition" means side by side or immediately above or below.

Drafting Note: Some states prohibit a reduced initial premium. Section 14B does not imply that the states that prohibit an initial premium are not in conformity with the NAIC rules. This item is indicated in the rules as an item to be decided on a state-by-state basis.

C. Special awards, such as a "safe drivers award" shall not be used in connection with advertisements of Medicare supplement insurance.

Section 15. Statements About an Insurer

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

Section 16. Enforcement Procedures

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each advertisement that shall indicate the manner and extent of distribution and the form number of any policy advertised. The file shall be available for inspection by this Department. All such advertisements shall be maintained in the file for a period of either four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance. Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these rules must file with this Department, with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this state as implemented and interpreted by these rules.

Drafting Note: Where the rules were adopted on other than January 1 of the year, the required certification that all advertisements used in the preceding annual statement year complied with these rules cannot be given. The respective insurance departments should consider remedying the problem in the Certificate of Compliance used for the calendar year in which the rules were adopted.

Section 17. Severability Provision

If any section or portion of a section of these rules, or its applicability to any person or circumstance is held invalid by a court, the remainder of the rules, or the applicability of the provision to other persons or circumstances, shall not be affected.

Section 18. Filing for Prior Review

The commissioner may, at his or her discretion, require the filing with this Department, for review prior to use, of any Medicare supplement insurance advertising material. The advertising material shall be filed by the insurer with this Department not less than thirty (30) days prior to the date the insurer desires to use the advertisement.

Appendix

INTERPRETIVE GUIDELINES FOR RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE

Guideline 1

Disclosure is one of the principal objectives of the rules and this section states specifically that the rules shall assure truthful and adequate disclosure of all material and relevant information. The rules specifically prohibit some previous advertising techniques.

Guideline 2

These rules apply to any "advertisement" as that term is defined in Section 3, Subsections A, H, I and J unless otherwise specified in the rules. These rules apply to group, blanket and individual Medicare supplement insurance advertisements. Certain distinctions, however, are applicable to these categories. Among them is the level of conversance with insurance, a factor which is covered by Section 5A of the rules.

Guideline 3-A

The scope of the term "advertisement" extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to use of all media for communications by agents, brokers, producers and solicitors.

Guideline 3-I

A "brief description of coverage" in an invitation to inquire may consist of an explanation of Medicare benefits, minimum benefits, standards for Medicare supplement policies, the manner in which the advertised Medicare supplement insurance policy supplements the benefits of Medicare and meets or exceeds the minimum benefit requirements. An invitation to inquire shall not refer to cost or the maximum dollar amount of benefits payable.

As with all Medicare supplement insurance advertisements, an invitation to inquire must not:

(1) Employ devices that are designed to create undue anxiety in the minds of the elderly or excite fear of dependence upon relatives or charity;

(2) Exaggerate the gaps in Medicare coverage;

(3) Exaggerate the value of the benefits available under the advertised policy;

(4) Otherwise violate the provisions of these rules.

Guideline 4

The rule permits the use of either of the following alternative methods of disclosure:

(1) The first alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions conspicuously and in close conjunction with the statements to which the information relates. This may be accomplished by disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits.

(2) The second alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions Not Covered," and "Exceptions and Reductions. " The use of captions such as, or similar to, the following are not acceptable because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions," or "Minimum Limitations. "

In considering whether an advertisement complies with the disclosure requirements of this rule, the rule must be applied in conjunction with the form and content standards contained in Section 5.

Guideline 5-A

The rule must be applied in conjunction with Section 1 and 4 of the rules. The rule refers specifically to "format and content" of the advertisement and the "overall" impression created by the advertisement. This involves factors such as, but not limited to, the size, color and prominence of type used to describe benefits. The word "format" means the arrangement of the text and the captions.

The rule requires distinctly different advertisements for publication in newspapers or magazines of general circulation, as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this rule.

Guideline 5-B

The rule prohibits the use of incomplete statements and words or phrases that have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology. Therefore, words, phrases and illustrations used in an advertisement must be clear and unambiguous. if the advertisement uses insurance terminology, sufficient description of a word, phrase or illustration shall be provided by definition or description in the context of the advertisement. As implied in Guideline 5-A, distinctly different levels of comprehension to the subscribers of various publications may be anticipated.

Guideline 6-A(1)

The rule prohibits the use of incomplete statements and words or phrases that create deception by omission or commission. The following examples are illustrations of the prohibitions created by the rule:

(1) An advertisement that describes any benefits that vary by age must disclose the fact.

(2) An advertisement that uses a phrase such as "no age limit" must disclose that premiums may vary by age or that benefits may vary by age if such is the case.

(3) Advertisements, applications, requests for additional information and similar materials are unacceptable if they state or imply that the recipient has been individually selected to be offered insurance, or has had his eligibility for insurance individually determined in advance, when in fact the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

(4) Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless such is the fact.

(5) It is unacceptable to use terms such as "enroll" or "join" with reference to group or blanket insurance coverage when such is not the case.

(6) An advertisement that states or implies immediate coverage is provided is unacceptable unless suitable administrative procedures exist so that the policy is issued within fifteen working days after the application is received by the insurer.

(7) Applications, request forms for additional information, and similar related materials are unacceptable if they resemble paper currency, bonds or stock certificates; or use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.

(8) An advertisement that uses the word "plan" without identifying it as a Medicare supplement insurance policy is not permissible.

(9) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining Medicare supplement insurance is not permissible.

(10) An advertisement that fails to disclose any waiting or elimination periods is unacceptable.

(11) Examples of benefits payable under a policy shall not disclose only maximum benefits unless the maximum benefits are paid for loss from common or probable illnesses or accidents, rather than exceptional or rare illnesses or accidents or periods of confinement for these exceptional or rare accidents or illnesses.

(12) When a range of benefit levels is set forth in an advertisement, it must be made clear that the insured will receive only the benefit level written or printed in the policy selected and issued.

(13) Advertisements for policies whose premiums are modest because of their limited amount of benefits shall not describe premiums as "low," "low-cost," "budget" or use qualifying words of similar import. This rule also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain.

(14) An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that these provisions are unique to the advertised policy is unacceptable. For example, the phrase, "Money Back Guarantee," is an exaggerated description of the thirty-day right to examine the policy and is not acceptable.

(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough," or is otherwise unusual is unacceptable. Also, the addition of a novel method of premium payment to an otherwise common plan of insurance does not render it "new. "

(16) An advertisement may not omit the word "covered" when referring to benefits payable under its policy. Continued reference to "covered" is not necessary where this fact has been prominently disclosed in the advertisement.

(17) An advertisement must state that benefits payable under the policy are based upon Medicare eligible expenses, if such is the case.

(18) An advertisement that fails to disclose that the definition of "hospital" does not include a nursing home, convalescent home or extended care facility, as the case may be, is unacceptable.

(19) A television, radio, mail or newspaper advertisement, or lead generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company, or a subsequent advertisement prior to contact must include information disclosing that an insurance agent may contact the applicant if such is the fact.

(20) Advertisements for policies designed to supplement Medicare shall not employ devices that are designed to create undue anxiety in the minds of the elderly. Such phrases as "here is where most people over sixty-five learn about the gaps in Medicare," or "Medicare is great, but…" or which otherwise exaggerate the gaps in Medicare coverage are unacceptable. Phrases or devices that unduly excite fear of dependence upon relatives or charity are unacceptable. Phrases or devices that imply that long sicknesses or hospital stays are common among the elderly are unacceptable.

(21) An advertisement that is an invitation to contract implying that the coverage is supplemental to Medicare, if it does not explain the manner in which it is supplemental to Medicare coverage, is not acceptable.

(22) An advertisement that is an invitation to contract for Medicare supplement insurance is unacceptable if the advertisement:

(a) Fails to disclose in clear language which of the Medicare benefits the policy is not designed to supplement or if it otherwise implies that Medicare provides only those benefits that the policy is designed to supplement;

(b) Describes the in-patient hospital coverage of Medicare as "Medicare hospital," or "Medicare Part A" when the policy does not supplement the non-hospital or the psychiatric hospital benefits of Medicare Part A;

(c) Fails to describe clearly the operation of the part or parts of Medicare that the policy is designed to supplement; or

(d) Describes those Medicare benefits not supplemented by the policy in such a way as to minimize their importance relative to the Medicare benefits that are supplemented.

(23) Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population, or that particular segments of the population are acceptable risks, when such distinctions are not maintained in the issuance of policies, are not acceptable.

(24) An advertisement that contains statements such as "anyone can apply," or "anyone can join," other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is unacceptable.

(25) An advertisement that uses a phrase or term such as "here is all you do to apply," "simply," or "merely" to refer to the act of applying for a policy that in not a guaranteed issue policy is unacceptable unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

(26) Advertisements that state or imply that premiums will not be changed in the future are not acceptable unless the advertised policies so provide.

(27) An advertisement that does not require the premium to accompany the application must not overemphasize that fact and must make the effective date of that coverage clear.

(28) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any co-insurance factor is not acceptable.

Guideline 6-A(2)

The rule recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised policy. Consequently, the terms (and those specified in the rules do not represent a comprehensive list but only examples) must be used with caution to avoid any tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases based on such terms or having the same effect must be similarly restricted: "pays hospital, surgical, etc. , bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," or "pays for financial needs. " Other phrases may or may not be acceptable depending upon the nature of the coverage being advertised.

The rule also prohibits words or phrases that exaggerate the effect of benefit payment on the insured's general well-being, such as "worry-free savings plan," "guaranteed savings," "financial peace of mind," and "you will never have to worry about hospital bills again. "

Advertisements that are an invitation to contract for policies designed to supplement Medicare benefits are unacceptable if they fail to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period for which Medicare pays all hospital confinement expenses (currently sixty days) other than the initial deductible if the policy so provides. The length of the period must be stated in days.

Guideline 6-A(4)

Explanations must not minimize nor describe restrictive provisions in a positive manner. Negative features must be accurately set forth. Any limitation on benefits precluding preexisting conditions must also be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed elsewhere in the advertisement. (See Guideline 6-C for additional comments on preexisting conditions.)

Guideline 6-A(5)

The rule should be applied in conjunction with Section 10. Phrases such as "we cut cost to the bone" or "we deal direct with you so our costs are lower" shall not be used.

Guideline 6-B(1)

An advertisement that is an invitation to contract as defined in Section 3J must recite the exceptions, reductions and limitations as required by the rule and in a manner consistent with Section 4.

If an exception, reduction or limitation is important enough to use in a policy, it is of sufficient importance that its existence in the policy should be referred to in the advertisement regardless of whether it may also be the subject matter of a provision of the Uniform Individual Accident and Sickness Policy Provision Law.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy that it obscures the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner that does not minimize, render obscure or otherwise make them appear unimportant.

Guideline 6-C(1)

The rule implements the objective of Section 6A(4)(a) by requiring in negative terms a description of the effect of a preexisting condition exclusion because such an exclusion is a restriction on coverage. The subdivision also prohibits the use of the phrase "preexisting condition" without an appropriate definition or description of the term and prohibits stating a reduction in the statutory time limit as an affirmative benefit. The words "appropriate definition or description" mean that the term "preexisting condition" must be defined as it is used by the company's claims department.

Guideline 6-C(2)

The phrase "no health questions" or words of similar import shall not be used if the policy excludes preexisting conditions.

Use of a phrase such as "guaranteed issue," or "automatic issues," if the policy excludes preexisting conditions for a certain period, must be accompanied by a statement disclosing that fact in a manner which does not minimize, render obscure or otherwise make it appear unimportant and is otherwise consistent with Section 4.

Guideline 6-C(3)

Some states require approval of the application even when the application is not attached to the policy when issued. The rule does not change such a requirement. The text of this guideline should be modified to reflect the rule applicable in the particular state.

Guideline 7

Advertisements of cancelable Medicare supplement policies must state that the contract is cancelable or renewable at the option of the company as the case may be. With respect to noncancellable policies and guaranteed renewable policies, the policy provisions, with respect to renewability, must be set forth and defined where appropriate.

The rule also requires a statement of the qualifying conditions that constitute limitations on the permanent nature of the coverage. These customarily fall into three categories: (1) age limits, (2) reservation of a right to increase premiums, and (3) the establishment of aggregate limits. For example, "noncancellable and guaranteed renewable" does not fulfill the requirements of the rule if the policy contains a terminal age. In such a case, a proper statement would be "Noncancellable and guaranteed renewable to age __. " If a guaranteed renewable policy reserves the right to increase premiums, the statement

must be expanded into language similar to "guaranteed renewable to age _," but the company reserves the right to increase premium rates on a class basis. " If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase "subject to a maximum aggregate amount of $50,000" or similar language. A Medicare supplement insurance policy may have one or more of the three basic limitations and an advertisement must describe each of those which the policy contains. Over fifty percent of new individual policy issues are guaranteed renewable; therefore, the fact that a policy is guaranteed renewable shall not be exaggerated.

An advertisement for a Medicare supplement insurance policy that provides for age step-rated premium rates based upon the policy year or the insured's attained age must disclose the rate increases and the times or ages at which the premium increases.

Guideline 8-A

The rule must be applied in conjunction with Section 9 and requires that all such statements must be genuine and not fictitious. Under the rule, the manufacturing, substantive editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading to the insurance-buying public. However, language that would be unacceptable under these rules must be edited out of a testimonial.

Guideline 8-C

The rule requires that both approval or endorsement of a policy by an individual, group or individuals, society, association or other organization be factual and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example, if the dividend under an association group case is payable to the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed. This guideline also applies to Section 8E.

Guideline 9-A

An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given that are applicable to a different policy, it must be stated clearly that the data does not relate to the policy being advertised.
An advertisement that states the dollar amount of claims paid must also indicate the period over which the claims have been paid.

If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement and, unless the state has issued a regulation otherwise defining the term, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

Guideline 9-C

The rule does not require that statistics for this state be used since such statistics as hospital charges and average stays may vary from state to state. When nationwide statistics are used, that fact should be noted, unless the statistics on the particular point are substantially the same in a state to which the advertisement is directed. Statistics may only be used if they are current and credible.

Guideline 10

The rule prohibits disparaging, unfair or incomplete comparisons of policies or benefits that would have a tendency to decline or mislead the public. The rule does not preclude the use of comparisons by health maintenance organizations, prepaid health plans and other direct service organizations that describe the difference between their prepaid health benefits coverage and indemnity insurance coverage.

Guideline 11-A

The rule prohibits advertisements that imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement that contains testimonials from persons who reside in a state in which the insurer is not licensed or that refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states; and, therefore, is in violation of this rule unless the advertisement states that the insurer is not licensed in those states.

Guideline 11-B

Although the rule permits a reference to an insurer being licensed in a state where the advertisement appears, it does not allow exaggeration of the fact of that licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

Terms such as "official," or words of similar import, used to describe any policy or application form are not permissible because of the potential for deceiving or misleading the public. This guideline also applies to Section 11C.

Guideline 14-A(1)

The rule prohibits advertising representing that a product is offered on an introductory, initial or special offer basis or otherwise which (a) will not be available later; or (b) is available only to certain individuals, unless such is the fact. This rule prohibits the repetitive use of such advertisements. Where an insurer uses enrollment periods as the usual method of advertising these policies, the rule prohibits describing an enrollment period as a special opportunity or offer for the applicant.

Guideline 14-A(2)

The rule restricts the repetitive use of enrollment periods. The requirement of reasonable closing dates and waiting periods between enrollment periods was adopted to eliminate the abuses that formerly existed. This rule does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in the state until [insert number] months from the close of the enrollment period. Thus, an insurer must choose whether to use enrollment periods or open enrollment for a product. (See Section 14A(4) for the definition of "a particular insurance product. ")

The rule does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within this state as long as the enrollment periods for all such advertisements have the same expiration date.

The rule does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of [insert months] since the close of a preceding enrollment period that was open to the general public for the same product.

The rule does not require separation by [insert number] months of enrollment periods for the same insurance product in this state if the advertising material is directed by an admitted insurer to persons by direct mail on the basis that a common relationship exists with an entity. Examples would be a bank and its depositors, a department store to its charge account customers, or an oil company to its credit card holders, and more than one of these organizations is sponsoring an insurance product at different times if providing the insurance under such a method is not otherwise prohibited by law. However, the [insert number] month rule does apply to one specific sponsor to the same persons in this state on the basis of their status as customers of that one specific entity only.

Drafting Note: The number of months was left blank in the rule because several states currently permit six months; several states allow three months, and other states currently prohibit such periods of enrollment. Whether such enrollment periods should be permissible and the period of time between enrollments are items on which each state should make its decision on an individual basis and each state should modify the time limit in this Guideline to comply with the rule adopted by the particular state.

Guideline 14-A(4)

The rule defines the meaning of "a particular insurance product" in Section 14A(2) and prohibits advertising of products having minor variations such as different periods or different amounts of daily hospital indemnity benefits, in a succession of enrollment periods.

Guideline 15

The rule is closely related to the requirements of Section 9 concerning the use of statistics. The rule prohibits insurers that have been organized for only a brief period of time advertising that they are "old" and also prohibits emphasizing the size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations is irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors of an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession. For

example, it is unacceptable for an insurance company to advertise a policy offered to the general public as "the physicians' policy" or "the doctors' plan" simply because there is a preponderance of physicians or doctors on the board of directors of the insurer. The rule prohibits the use of recommendation of a commercial rating system unless the purpose, meaning and limitations of the recommendation are clearly indicated.

Guideline 16

The text of Subsection A is identical to the text of the first paragraph of the enforcement section of previous drafts of the rules except the last sentence of the subsection has been revised to require that the advertising file be maintained either for a period of four years (rather than three as previously) or until the next regular examination of the insurer, whichever is the longer period of time.

Guideline 18

Filing of all Medicare supplement advertisements is required by this model and by the Medicare Catastrophic Coverage Act of 1988 (P. L. 100-360).

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1988 Proc. I 9, 20-21, 629-630, 654-655, 679-695 (adopted).
1989 Proc. I 14, 814 (amended).
1989 Proc. II 13, 23-24, 467-468, 518, 570 (technical amendment).

NAIC MODEL RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE WITH INTERPRETIVE GUIDELINES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

NAIC MODEL RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE WITH INTERPRETIVE GUIDELINES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			BULLETIN 2-16-2006 (2006); BULLETIN 6-8-2007 (2007).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	CODE ARK. R. 054.00.41. (1989).		
California			CAL. INS. CODE § 787 (1991) (senior insurance).
Colorado	3 COLO. CODE REGS. § 702-4:4-3-2 (2018).		BULLETIN 13-2005 (2005).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-156.101 to 69O-156.123 (1988).		
Georgia	NO CURRENT ACTIVITY		

NAIC MODEL RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE WITH INTERPRETIVE GUIDELINES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			BULLETIN 2010-1 (2010).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2010.10 to 2010.170 (1990).		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-15.3 (1963/2009).
Kansas	KAN. ADMIN. REGS. 40-9-126 (2014) (adopted by reference with exceptions).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. ADMIN CODE. tit. 37, Pt XI, §§ 101 to 137 (1991).		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN. INS. § 27-224 (2014).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	19 MISS. ADMIN. CODE Pt. 1, R. 16.01 to 16.19 (88-105) (1989).		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. CODE ADMIN. RULES INS. §§ 2603.01 to 2603.17 (2016).		

NAIC MODEL RULES GOVERNING ADVERTISEMENTS OF MEDICARE SUPPLEMENT INSURANCE WITH INTERPRETIVE GUIDELINES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York			CIRCULAR LETTER 2006-7 (2006).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Ohio			OHIO ADMIN. CODE 3901-8-09 (2011/2012).
Oklahoma	NO CURRENT ACTIVITY		
Oregon			BULLETIN 2005-3 (2005).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-30-8.1 to 20-30-8.19 (2018).		
South Carolina			BULLETIN 3-2007 (2007).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			BULLETIN B-0047-09 (2009).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

INSURANCE DATA SECURITY MODEL LAW

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the "Insurance Data Security Law."

Section 2. Purpose and Intent

A. The purpose and intent of this Act is to establish standards for data security and standards for the investigation of and notification to the Commissioner of a Cybersecurity Event applicable to Licensees, as defined in Section 3.

B. This Act may not be construed to create or imply a private cause of action for violation of its provisions nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this Act.

Drafting Note: The drafters of this Act intend that if a Licensee, as defined in Section 3, is in compliance with N.Y. Comp. Codes R. & Regs. tit.23, § 500, *Cybersecurity Requirements for Financial Services Companies*, effective March 1, 2017, such Licensee is also in compliance with this Act.

Section 3. Definitions

As used in this Act, the following terms shall have these meanings:

A. "Authorized Individual" means an individual known to and screened by the Licensee and determined to be necessary and appropriate to have access to the Nonpublic Information held by the Licensee and its Information Systems.

B. "Commissioner" means the chief insurance regulatory official of the state.

C. "Consumer" means an individual, including but not limited to applicants, policyholders, insureds, beneficiaries, claimants, and certificate holders who is a resident of this State and whose Nonpublic Information is in a Licensee's possession, custody, or control.

D. "Cybersecurity Event" means an event resulting in unauthorized access to, disruption or misuse of, an Information System or information stored on such Information System.

The term "Cybersecurity Event" does not include the unauthorized acquisition of Encrypted Nonpublic Information if the encryption, process or key is not also acquired, released or used without authorization.

Cybersecurity Event does not include an event with regard to which the Licensee has determined that the Nonpublic Information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

E. "Department" means the [insert name of insurance regulatory body].

F. "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

G. "Information Security Program" means the administrative, technical, and physical safeguards that a Licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle Nonpublic Information.

H. "Information System" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system such as industrial/process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

I. "Licensee" means any Person licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered pursuant to the insurance laws of this State but shall not include a purchasing group or a risk retention group chartered and licensed in a state other than this State or a Licensee that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

J. "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors:

(1) Knowledge factors, such as a password; or

(2) Possession factors, such as a token or text message on a mobile phone; or

(3) Inherence factors, such as a biometric characteristic.

K. "Nonpublic Information" means information that is not Publicly Available Information and is:

(1) Business related information of a Licensee the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of the Licensee;

(2) Any information concerning a Consumer which because of name, number, personal mark, or other identifier can be used to identify such Consumer, in combination with any one or more of the following data elements:

(a) Social Security number,

(b) Driver's license number or non-driver identification card number,

(c) Account number, credit or debit card number,

(d) Any security code, access code or password that would permit access to a Consumer's financial account, or

(e) Biometric records;

(3) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer and that relates to

(a) The past, present or future physical, mental or behavioral health or condition of any Consumer or a member of the Consumer's family,

(b) The provision of health care to any Consumer, or

(c) Payment for the provision of health care to any Consumer.

L. "Person" means any individual or any non-governmental entity, including but not limited to any non-governmental partnership, corporation, branch, agency or association.

M. "Publicly Available Information" means any information that a Licensee has a reasonable basis to believe is lawfully made available to the general public from: federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

For the purposes of this definition, a Licensee has a reasonable basis to believe that information is lawfully made available to the general public if the Licensee has taken steps to determine:

(1) That the information is of the type that is available to the general public; and

(2) Whether a Consumer can direct that the information not be made available to the general public and, if so, that such Consumer has not done so.

N. "Risk Assessment" means the Risk Assessment that each Licensee is required to conduct under Section 4C of this Act.

O. "State" means [adopting state].

P. "Third-Party Service Provider" means a Person, not otherwise defined as a Licensee, that contracts with a Licensee to maintain, process, store or otherwise is permitted access to Nonpublic Information through its provision of services to the Licensee.

Section 4. Information Security Program

A. Implementation of an Information Security Program

Commensurate with the size and complexity of the Licensee, the nature and scope of the Licensee's activities, including its use of Third-Party Service Providers, and the sensitivity of the Nonpublic Information used by the Licensee or in the Licensee's possession, custody or control, each Licensee shall develop, implement, and maintain a comprehensive written Information Security Program based on the Licensee's Risk Assessment and that contains administrative, technical, and physical safeguards for the protection of Nonpublic Information and the Licensee's Information System.

B. Objectives of Information Security Program

A Licensee's Information Security Program shall be designed to:

(1) Protect the security and confidentiality of Nonpublic Information and the security of the Information System;

(2) Protect against any threats or hazards to the security or integrity of Nonpublic Information and the Information System;

(3) Protect against unauthorized access to or use of Nonpublic Information, and minimize the likelihood of harm to any Consumer; and

(4) Define and periodically reevaluate a schedule for retention of Nonpublic Information and a mechanism for its destruction when no longer needed.

C. Risk Assessment

The Licensee shall:

(1) Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the Licensee who is responsible for the Information Security Program;

(2) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of Nonpublic Information, including the security of Information Systems and Nonpublic Information that are accessible to, or held by, Third-Party Service Providers;

(3) Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the Nonpublic Information;

(4) Assess the sufficiency of policies, procedures, Information Systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the Licensee's operations, including:

(a) Employee training and management;

(b) Information Systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and

(c) Detecting, preventing, and responding to attacks, intrusions, or other systems failures; and

(5) Implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the safeguards' key controls, systems, and procedures.

D. Risk Management

Based on its Risk Assessment, the Licensee shall:

(1) Design its Information Security Program to mitigate the identified risks, commensurate with the size and complexity of the Licensee's activities, including its use of Third-Party Service Providers, and the sensitivity of the Nonpublic Information used by the Licensee or in the Licensee's possession, custody, or control.

(2) Determine which security measures listed below are appropriate and implement such security measures.

(a) Place access controls on Information Systems, including controls to authenticate and permit access only to Authorized Individuals to protect against the unauthorized acquisition of Nonpublic Information;

(b) Identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy;

(c) Restrict access at physical locations containing Nonpublic Information, only to Authorized Individuals;

(d) Protect by encryption or other appropriate means, all Nonpublic Information while being transmitted over an external network and all Nonpublic Information stored on a laptop computer or other portable computing or storage device or media;

(e) Adopt secure development practices for in-house developed applications utilized by the Licensee and procedures for evaluating, assessing or testing the security of externally developed applications utilized by the Licensee;

(f) Modify the Information System in accordance with the Licensee's Information Security Program;

(g) Utilize effective controls, which may include Multi-Factor Authentication procedures for any individual accessing Nonpublic Information;

(h) Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, Information Systems;

(i) Include audit trails within the Information Security Program designed to detect and respond to Cybersecurity Events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the Licensee;

(j) Implement measures to protect against destruction, loss, or damage of Nonpublic Information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures; and

(k) Develop, implement, and maintain procedures for the secure disposal of Nonpublic Information in any format.

(3) Include cybersecurity risks in the Licensee's enterprise risk management process.

(4) Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

(5) Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the Licensee in the Risk Assessment.

E. Oversight by Board of Directors

If the Licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(1) Require the Licensee's executive management or its delegates to develop, implement, and maintain the Licensee's Information Security Program;

(2) Require the Licensee's executive management or its delegates to report in writing at least annually, the following information:

(a) The overall status of the Information Security Program and the Licensee's compliance with this Act; and

(b) Material matters related to the Information Security Program, addressing issues such as risk assessment, risk management and control decisions, Third-Party Service Provider arrangements, results of testing, Cybersecurity Events or violations and management's responses thereto, and recommendations for changes in the Information Security Program.

(3) If executive management delegates any of its responsibilities under Section 4 of this Act, it shall oversee the development, implementation and maintenance of the Licensee's Information Security Program prepared by the delegate(s) and shall receive a report from the delegate(s) complying with the requirements of the report to the Board of Directors above.

F. Oversight of Third-Party Service Provider Arrangements

(1) A Licensee shall exercise due diligence in selecting its Third-Party Service Provider; and

(2) A Licensee shall require a Third-Party Service Provider to implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information that are accessible to, or held by, the Third-Party Service Provider.

G. Program Adjustments

The Licensee shall monitor, evaluate and adjust, as appropriate, the Information Security Program consistent with any relevant changes in technology, the sensitivity of its Nonpublic Information, internal or external threats to information, and the Licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to Information Systems.

H. Incident Response Plan

(1) As part of its Information Security Program, each Licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any Cybersecurity Event that compromises the confidentiality, integrity, or availability of Nonpublic Information in its possession, the Licensee's Information Systems, or the continuing functionality of any aspect of the Licensee's business or operations.

(2) Such incident response plan shall address the following areas:

(a) The internal process for responding to a Cybersecurity Event;

(b) The goals of the incident response plan;

(c) The definition of clear roles, responsibilities and levels of decision-making authority;

(d) External and internal communications and information sharing;

(e) Identification of requirements for the remediation of any identified weaknesses in Information Systems and associated controls;

(f) Documentation and reporting regarding Cybersecurity Events and related incident response activities; and

(g) The evaluation and revision as necessary of the incident response plan following a Cybersecurity Event.

I. Annual Certification to Commissioner of Domiciliary State

Annually, each insurer domiciled in this State shall submit to the Commissioner, a written statement by February 15, certifying that the insurer is in compliance with the requirements set forth in Section 4 of this Act. Each insurer shall maintain for examination by the Department all records, schedules and data supporting this certificate for a period of five years. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address such areas, systems or processes. Such documentation must be available for inspection by the Commissioner.

Section 5. Investigation of a Cybersecurity Event

A. If the Licensee learns that a Cybersecurity Event has or may have occurred the Licensee or an outside vendor and/or service provider designated to act on behalf of the Licensee, shall conduct a prompt investigation.

B. During the investigation, the Licensee, or an outside vendor and/or service provider designated to act on behalf of the Licensee, shall, at a minimum determine as much of the following information as possible:

(1) Determine whether a Cybersecurity Event has occurred;

(2) Assess the nature and scope of the Cybersecurity Event;

(3) Identify any Nonpublic Information that may have been involved in the Cybersecurity Event; and

(4) Perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event in order to prevent further unauthorized acquisition, release or use of Nonpublic Information in the Licensee's possession, custody or control.

C. If the Licensee learns that a Cybersecurity Event has or may have occurred in a system maintained by a Third-Party Service Provider, the Licensee will complete the steps listed in Section 5B above or confirm and document that the Third-Party Service Provider has completed those steps.

D. The Licensee shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event and shall produce those records upon demand of the Commissioner.

Section 6. Notification of a Cybersecurity Event

A. Notification to the Commissioner

Each Licensee shall notify the Commissioner as promptly as possible but in no event later than 72 hours from a determination that a Cybersecurity Event has occurred when either of the following criteria has been met:

(1) This State is the Licensee's state of domicile, in the case of an insurer, or this State is the Licensee's home state, in the case of a producer, as those terms are defined in [insert reference to Producer Licensing Model Act]; or

(2) The Licensee reasonably believes that the Nonpublic Information involved is of 250 or more Consumers residing in this State and that is either of the following:

(a) A Cybersecurity Event impacting the Licensee of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body pursuant to any state or federal law; or

(b) A Cybersecurity Event that has a reasonable likelihood of materially harming:

(i) Any Consumer residing in this State; or

(ii) Any material part of the normal operation(s) of the Licensee.

B. The Licensee shall provide as much of the following information as possible. The Licensee shall provide the information in electronic form as directed by the Commissioner. The Licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the Commissioner concerning the Cybersecurity Event.

(1) Date of the Cybersecurity Event;

(2) Description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Third-Party Service Providers, if any;

(3) How the Cybersecurity Event was discovered;

(4) Whether any lost, stolen, or breached information has been recovered and if so, how this was done;

(5) The identity of the source of the Cybersecurity Event;

(6) Whether Licensee has filed a police report or has notified any regulatory, government or law enforcement agencies and, if so, when such notification was provided;

(7) Description of the specific types of information acquired without authorization. Specific types of information means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the Consumer;

(8) The period during which the Information System was compromised by the Cybersecurity Event;

(9) The number of total Consumers in this State affected by the Cybersecurity Event. The Licensee shall provide the best estimate in the initial report to the Commissioner and update this estimate with each subsequent report to the Commissioner pursuant to this section;

(10) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(11) Description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

(12) A copy of the Licensee's privacy policy and a statement outlining the steps the Licensee will take to investigate and notify Consumers affected by the Cybersecurity Event; and

(13) Name of a contact person who is both familiar with the Cybersecurity Event and authorized to act for the Licensee.

C. Notification to Consumers. Licensee shall comply with [insert state's data breach notification law], as applicable, and provide a copy of the notice sent to Consumers under that statute to the Commissioner, when a Licensee is required to notify the Commissioner under Section 6A.

D. Notice Regarding Cybersecurity Events of Third-Party Service Providers

(1) In the case of a Cybersecurity Event in a system maintained by a Third-Party Service Provider, of which the Licensee has become aware, the Licensee shall treat such event as it would under Section 6A.

(2) The computation of Licensee's deadlines shall begin on the day after the Third-Party Service Provider notifies the Licensee of the Cybersecurity Event or the Licensee otherwise has actual knowledge of the Cybersecurity Event, whichever is sooner.

(3) Nothing in this Act shall prevent or abrogate an agreement between a Licensee and another Licensee, a Third-Party Service Provider or any other party to fulfill any of the investigation requirements imposed under Section 5 or notice requirements imposed under Section 6.

E. Notice Regarding Cybersecurity Events of Reinsurers to Insurers

(1) (a) In the case of a Cybersecurity Event involving Nonpublic Information that is used by the Licensee that is acting as an assuming insurer or in the possession, custody or control of a Licensee that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected Consumers, the assuming insurer shall notify its affected ceding insurers and the Commissioner of its state of domicile within 72 hours of making the determination that a Cybersecurity Event has occurred.

(b) The ceding insurers that have a direct contractual relationship with affected Consumers shall fulfill the consumer notification requirements imposed under [insert the state's breach notification law] and any other notification requirements relating to a Cybersecurity Event imposed under Section 6.

(2) (a) In the case of a Cybersecurity Event involving Nonpublic Information that is in the possession, custody or control of a Third-Party Service Provider of a Licensee that is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the Commissioner of its state of domicile within 72 hours of receiving notice from its Third-Party Service Provider that a Cybersecurity Event has occurred.

(b) The ceding insurers that have a direct contractual relationship with affected Consumers shall fulfill the consumer notification requirements imposed under [insert the state's breach notification law] and any other notification requirements relating to a Cybersecurity Event imposed under Section 6.

F. Notice Regarding Cybersecurity Events of Insurers to Producers of Record

In the case of a Cybersecurity Event involving Nonpublic Information that is in the possession, custody or control of a Licensee that is an insurer or its Third-Party Service Provider and for which a Consumer accessed the insurer's services through an independent insurance producer, the insurer shall notify the producers of record of all affected Consumers as soon as practicable as directed by the Commissioner.

The insurer is excused from this obligation for those instances in which it does not have the current producer of record information for any individual Consumer.

Section 7. Power of Commissioner

A. The Commissioner shall have power to examine and investigate into the affairs of any Licensee to determine whether the Licensee has been or is engaged in any conduct in violation of this Act. This power is in addition to the powers which the Commissioner has under [insert applicable statutes governing the investigation or examination of insurers]. Any such investigation or examination shall be conducted pursuant to [insert applicable statutes governing the investigation or examination of insurers].

B. Whenever the Commissioner has reason to believe that a Licensee has been or is engaged in conduct in this State which violates this Act, the Commissioner may take action that is necessary or appropriate to enforce the provisions of this Act.

Section 8. Confidentiality

A. Any documents, materials or other information in the control or possession of the Department that are furnished by a Licensee or an employee or agent thereof acting on behalf of Licensee pursuant to Section 4I, Section 6B(2), (3), (4), (5), (8), (10), and (11), or that are obtained by the Commissioner in an investigation or examination pursuant to Section 7 of this Act shall be confidential by law and privileged, shall not be subject to [insert reference to state open records, freedom of information, sunshine or other appropriate law], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties.

B. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Section 8A.

C. In order to assist in the performance of the Commissioner's duties under this Act, the Commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Section 8A, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information;

(3) May share documents, materials or other information subject to Section 8A, with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material or other information; and

(4) May enter into agreements governing sharing and use of information consistent with this subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in Section 8C.

E. Nothing in this Act shall prohibit the Commissioner from releasing final, adjudicated actions that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

Drafting Note: States conducting an investigation or examination under their examination law may apply the confidentiality protections of that law to such an investigation or examination.

Section 9. Exceptions

A. The following exceptions shall apply to this Act:

(1) A Licensee with fewer than ten employees, including any independent contractors, is exempt from Section 4 of this Act;

(2) A Licensee subject to Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996 (Health Insurance Portability and Accountability Act) that has established and maintains an Information Security Program pursuant to such statutes, rules, regulations, procedures or guidelines established thereunder, will be considered to meet the requirements of Section 4, provided that Licensee is compliant with, and submits a written statement certifying its compliance with, the same;

(3) An employee, agent, representative or designee of a Licensee, who is also a Licensee, is exempt from Section 4 and need not develop its own Information Security Program to the extent that the employee, agent, representative or designee is covered by the Information Security Program of the other Licensee.

B. In the event that a Licensee ceases to qualify for an exception, such Licensee shall have 180 days to comply with this Act.

Section 10. Penalties

In the case of a violation of this Act, a Licensee may be penalized in accordance with [insert general penalty statute].

Section 11. Rules and Regulations [OPTIONAL]

The Commissioner may, in accordance with [the state statute setting forth the ability of the Department to adopt regulations] issue such regulations as shall be necessary to carry out the provisions of this Act.

Drafting Note: This provision is applicable only to states requiring this language.

Section 12. Severability

If any provisions of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Effective Date

This Act shall take effect on [insert a date]. Licensees shall have one year from the effective date of this Act to implement Section 4 of this Act and two years from the effective date of this Act to implement Section 4F of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2017 4th Quarter (adopted by Executive/Plenary via conference call)

INSURANCE DATA SECURITY MODEL LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE DATA SECURITY MODEL LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-62-1 to 27-62-12 (2019).		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. GEN. STAT. ANN. § 38a-38 (2020).		
Delaware	DEL. CODE ANN. tit. 18, §§ 8601 to 8611 (2019).		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3B-101 to 431:3B-306 (2021).		

INSURANCE DATA SECURITY MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	215 Ill. COMP. STAT. ANN. 215 (2024).		
Indiana	IND. CODE ANN. §§ 27-2-27-1 to 27-2-27-32 (2020) (portions of model).		
Iowa	IOWA CODE ANN. §§ 507F.1 to 507F.16 (2021) (portions of model).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	KY. REV. STAT. §§ 304.3-750 to 304.3-768(2022).		
Louisiana	LA. REV. STAT. §§ 22:2501 to 22:2511 (2020).		
Maine	24-A ME. REV. STAT. ANN. §§ 2261 to 2272 (2021).		
Maryland	MD. CODE ANN., INS. §§ 33-101 to 33-109 (2022).		MD. CODE ANN., INS. § 4-406 (2019); BULLETIN 2019-14 (2019).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	MICH. COMP. LAWS §§ 500.550 to 500.565 (2018).		
Minnesota	MINN. STAT. ANN. §§ 60A.985 to 60A.9858 (2021).		
Mississippi	MISS. CODE ANN. §§ 83-5-801 to 83-5-825 (2019).		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		

INSURANCE DATA SECURITY MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire	N.H. REV. STAT. ANN. §§ 420-P:1 to 420-P:14 (2019); §§ 309:2 to 309:3 (2019).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. COMP. CODES R. & REGS. tit. 23, § 500 (2017).
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. CENT. CODE ANN. §§ 26.1-02.2-01 to 26.1-02.2-11 (2021).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3965.01 to 3965.11 (2018).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	H.B. No. 739 (2023).		
Puerto Rico			CIRCULAR LETTER AF-1889-2016 (2016).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. §§ 38-99-10 to 38-99-100 (2018).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. CODE ANN. §§ 56-2-1001 to 56-2-1011 (2021) (portions of model).		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	VT. STAT. ANN. tit. 8, § 4728 (2023).		
Virgin Islands	NO CURRENT ACTIVITY		

INSURANCE DATA SECURITY MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-621 to 38.2-629 (2020); 14 VA. ADMIN. CODE 5-430 (2021).		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. STAT. ANN. §§ 601.95 to 601.956 (2021).		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2017

INSURANCE DATA SECURITY MODEL LAW (#668)

1. Description of the Project, Issues Addressed, etc.

The Cybersecurity (EX) Working Group, previously known as the Cybersecurity (EX) Task Force, was established by the NAIC's Executive (EX) Committee in 2014 to consider issues concerning cybersecurity as they pertain to the role of state insurance regulators. In 2015, the Working Group created two documents that were adopted by the NAIC: 1) *Principles for Effective Cybersecurity: Insurance Regulatory Guidance*, adopted in April 2015; and 2) *NAIC Roadmap for Cybersecurity Consumer Protections*, adopted in December 2015. Also, in 2015, Congress introduced a bill, the Data Security Act of 2015 (H.R. 2205). The NAIC and interested parties had concerns about this legislation and determined that the best way to proceed was with a model law specific to the insurance industry. Before determining that one new model was the appropriate course of action, the Working Group considered amending four different model laws related to data privacy: 1) the *NAIC Insurance Information and Privacy Protection Model Act* (#670); 2) the *Privacy of Consumer Financial and Health Information Regulation* (#672); 3) the *Standards for Safeguarding Consumer Information Model Regulation* (#673); and 4) the *Insurance Fraud Prevention Model Act* (#680).

The Working Group began drafting the Insurance Data Security Model Law in early 2016. The major provisions of the model include requiring insurers and other entities licensed by the department of insurance to: implement an information security program (Section 4); investigate a cybersecurity event (Section 5); and notify the state insurance commissioner of a cybersecurity event (Section 6).

The Working Group adopted the Insurance Data Security Model Law on Aug. 7 at the 2017 Summer National Meeting and presented it to the Innovation and Technology (EX) Task Force. The Task Force adopted the Insurance Data Security Law on Aug. 8 at the 2017 Summer National Meeting.

2. Name of Group Responsible for Drafting Model and States Participating

The Cybersecurity (EX) Working Group, previously known as the Cybersecurity (EX) Task Force, drafted the model law. The members of that Task Force at the time of adoption were: South Carolina, Chair; Rhode Island, Vice Chair; Alaska; Arkansas; California; Colorado; Connecticut; Delaware; District of Columbia; Florida; Idaho; Illinois; Kansas; Kentucky; Maine; Maryland; Michigan; Minnesota; Missouri; Montana; Nebraska; Nevada; New Hampshire; New Jersey; New Mexico; North Dakota; Northern Mariana Islands; Ohio; Oklahoma; Oregon; Pennsylvania; South Dakota; Tennessee; Texas; Utah; Vermont; Virginia; Washington; and Wisconsin.

In November 2016, the Working Group formed a drafting group, consisting of industry, consumer representatives and state insurance regulators. This group included representatives from the following interested parties: American Council of Life Insurers (ACLI), America's Health Insurance Plans (AHIP), the American Insurance Association (AIA), the American Land Title Association (ALTA), the Independent Insurance Agents and Brokers of America (IIABA), the National Association of Mutual Insurance Companies (NAMIC), the Professional Insurance Agents (PIA), the Property Casualty Insurers Association of America (PCI), the Reinsurance Association of America (RAA), the Center for Economic Justice (CEJ) and Peter Kochenburger (University of Connecticut School of Law). The drafting group also included state insurance regulators from California, Florida, Illinois, Maine, New York, Rhode Island and Texas.

3. Project Authorized by What Charge and Date Given to the Group

The original charge of the Cybersecurity (EX) Working Group, previously known as the Cybersecurity (EX) Task Force, was to: review the following models and make recommendations to the Executive (EX) Committee: the *NAIC Insurance Information and Privacy Protection Model Act* (#670); the *Privacy of Consumer Financial and Health Information Regulation* (#672); the *Standards for Safeguarding Consumer Information Model Regulation* (#673); and the *Insurance Fraud Prevention Model Act* (#680).

During the Working Group's meeting at the 2016 Spring National Meeting, on April 4, the Working Group determined that it would be simpler to draft one new model law and address any revisions to the other models at a later date, if necessary.

4. A General Description of Drafting Process and Due Process

The Cybersecurity (EX) Working Group, previously known as the Cybersecurity (EX) Task Force, released the first draft of the Insurance Data Security Model Law on March 2, 2016. Following a 30-day exposure period, interested stakeholders presented comments during the Working Group's April 4, 2016, conference call.

The Working Group held an interim meeting May 24–25, 2016, and received section-by-section oral comments regarding the first draft of the model law.

The Working Group met via conference call Aug. 4, Aug. 11 and Aug. 16, 2016, in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. The second draft of the model law was released on Aug. 17, 2016. Oral comments regarding the second draft were received on Aug. 27 via conference call, and written comments were received by Sept. 16, 2016, following a 30-day exposure period.

The Working Group met via conference call Oct. 17, 2016, to discuss the second draft of the model law, as well as to receive additional oral comments. Subsequently, the Working Group met via conference call Nov. 8, 2016. During this meeting, the Working Group formed a drafting group to continue drafting the model law. The drafting group included state insurance regulators and interested parties. Between versions two and three of the model, the drafting group met via conference call on following dates in 2016: Nov. 15, Nov. 22, Nov. 29 and Dec. 20. It also met on the following dates in 2017: Jan. 10, Jan. 24, Feb. 7 and Feb. 21.

The drafting group released a third version of the draft model law on Feb. 27, 2017. The drafting group met via conference call March 7 to continue discussion regarding the third draft of the model law. Written comments were received from interested stakeholders through April 17.

The drafting group released a fourth draft of the model law on April 26. The drafting group met via conference call May 9 to discuss the fourth version of the model. Oral comments were received on the May 9 conference call, and written comments were received from stakeholders by May 16, following a 20-day exposure period.

The drafting group released the fifth draft of the model law July 7. Written comments were received from interested stakeholders by July 31 following a 24-day exposure period. The Working Group adopted the fifth version of the model law with some minor changes at the Summer National Meeting. Due to the changes made, the Working Group adopted it as the sixth version of the model law.

The final version of the draft model law, the sixth draft, was adopted by the Innovation and Technology (EX) Task Force at the Summer National Meeting. Prior to consideration of adoption by the Executive (EX) Committee and the joint Executive (EX) Committee and Plenary, two technical corrections will be noted for incorporation into the final version of the model: 1) removal of a cross-reference to a provision that had been deleted from version five; and 2) clarification regarding implementation of security measures at Section 4D(2).

All drafts and comments were posted on the Working Group's web page on the NAIC website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The first version of the model was drafted by incorporating key provisions of the legislation pending in Congress, H.R. 2205 and a draft model law submitted by a group of several insurance trade associations. Key provisions of the first version included requiring a licensee to: 1) implement an information security program; 2) investigate a potential data breach; 3) notify consumers of their rights before a data breach; and 4) notify consumers following a data breach. It also provided the state insurance commissioner with authority to prescribe the appropriate level of consumer protection following a data breach.

Following a two-day in-person meeting with interested parties, the second version of the model law was released. Comments received following the exposure of the second version made it apparent there were six important issues on which the Working Group would need to reach consensus: 1) how to address state uniformity and exclusivity of the law; 2) whether and how to include an exemption for licensees subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the federal Gramm-Leach-Bliley Act (GLBA); 3) whether to include a harm trigger in the definition of "data breach"; 4) how to define "personal information"; 5) how to address scalability of information security requirements for

smaller licensees; and 6) how to address licensee oversight of third-party service providers.

Considering the complexity of these issues, the Working Group created a drafting group to hold a number of in-depth discussions in an attempt to reach consensus. Following drafting group calls held between November 2016 and February 2017, a third version of the model was exposed. Comments received on the third version revealed that drafting group members still disagreed on how to address several of the key issues.

At the 2017 Spring National Meeting, Superintendent Maria T. Vullo (NY) urged the Working Group to adopt New York's *Cybersecurity Requirements for Financial Services Companies*, N.Y. Comp. Codes R. & Regs. tit. 23, § 500, as the NAIC's model law. At the Working Group's meeting on April 9 at the 2017 Spring National Meeting, drafting group chair Superintendent Elizabeth Kelleher Dwyer (RI) invited all interested parties to submit additional comments on the third version of the draft, as well as thoughts regarding Superintendent Vullo's proposal to redraft the model law to look more like the New York regulation.

After receiving letters from interested parties, a fourth draft was released that incorporated many of the provisions found in the New York regulation. Like the New York regulation, the fourth version of the model law delegates consumer notification of a cybersecurity event (data breach) to be done in compliance with the state's already-existing generally applicable data breach notification law, rather than create insurance-specific rules regarding consumer notification. Some of the provisions in version four of the model that were similar to the New York regulation included: 1) the same definition of "non-public information" that must be protected; 2) a similar definition of "cybersecurity event"; 3) risk management standards based on the licensee's own risk assessment; 4) similar language regarding oversight of third-party service provider arrangements; and 5) requirement of an incident response plan. The NAIC model also added exceptions to the law, which were similar to those found in the New York regulation, including: 1) licensees with fewer than 10 employees; and 2) licensees using the information security program of another licensee. The NAIC model also added an exemption for licensees compliant with HIPAA data security laws, which is not found in the New York regulation.

After receiving comments on version four of the model, several provisions were redrafted, including the addition of a drafting note to Section 2, stating that the intent of the drafters is that if a licensee is in compliance with the New York regulation, it is also in compliance with this model law. In response to industry comments that the provision addressing oversight of third-party service providers was burdensome, the provision was revised to require licensees to exercise due diligence in selecting its third-party service providers and to require those provides to implement appropriate measures to protect consumer data. The requirement of an annual report was revised to become a requirement of annual certification, which more closely mirrors language from the New York regulation.

The drafting group determined that certain issues raised by interested parties did not warrant changes to the model. Several interested parties requested reinstatement of language stating the model law is an "exclusive state standard." The original concern was related to inconsistencies regarding consumer notices, reflecting that approximately 48 states have specific and often differing laws on consumer notices applicable across industries. Since the model no longer requires consumer notice, apart from that already required by state law, the need for a statement of exclusivity was no longer present. Additionally, some interested parties suggested there was a need for stronger confidentiality protections, similar to those found in the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505). But the heightened confidentiality protections of the Model #505 were drafted to protect information that includes trade secret and proprietary information, which is not the type of information provided to the state insurance commissioner under this model. The Working Group noted that the same confidentiality language that appears in this model law has been included in multiple NAIC models.

7. Any Other Important Information (e.g., amending an accreditation standard)

No other items are identified at this time.

NAIC INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

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Preamble

The purpose of this Act is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

Section 1. Scope

A. The obligations by this Act shall apply to those insurance institutions, agents or insurance support organizations which, on or after the effective date of this Act:

(1) In the case of life, health and disability insurance:

(a) Collect, receive or maintain information in connection with insurance transactions which pertains to natural persons who are residents of this state, or

(b) Engage in insurance transactions with applicants, individuals or policyholders who are residents of this state, and

(2) In the case of property or casualty insurance:

(a) Collect, receive or maintain information in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state, or

(b) Engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state.

B. The rights granted by this Act shall extend to:

(1) In the case of life, health or disability insurance, the following persons who are residents of this state:

(a) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions, and

(b) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions, and

(2) In the case of property or casualty insurance, the following persons:

(a) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state, and

(b) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in this state.

C. For purposes of this section, a person shall be considered a resident of this state if the person's last known mailing address, as shown in the records of the insurance institution, agent or insurance support organization, is located in this state.

D. Notwithstanding Subsections A and B above, this Act shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this state.

Section 2. Definitions

As used in this Act:

A. "Adverse underwriting decision" means:

(1) Any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:

(a) A declination of insurance coverage;

(b) A termination of insurance coverage;

(c) Failure of an agent to apply for insurance coverage with a specific insurance institution which the agent represents and which is requested by an applicant;

(d) In the case of a property or casualty insurance coverage:

(i) Placement by an insurance institution or agent of a risk with a residual market mechanism, an unauthorized insurer or an insurance institution which specializes in substandard risks; or

(ii) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished;

Drafting Note: The use of the term "substandard" in Section 2A(d)(i) is intended to apply to those insurance institutions whose rates and market orientation are directed at risks other than preferred or standard risks. To facilitate compliance with this Act, Commissioners should consider developing a list of insurance institutions operating in their state which specialize in substandard risks and make it known to insurance institutions and agents.

(e) In the case of a life, health or disability insurance coverage, an offer to insure at higher than standard rates.

(2) Notwithstanding Paragragh (1) above, the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(a) The termination of an individual policy form on a class or statewide basis;

(b) A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or

(c) The rescission of a policy.

B. "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

C. "Agent" means [make reference here to every appropriate statutory category of producer, including brokers, authorized to do business in the state. This is necessary because in many states different types of producers, or producers for certain types of insurance institutions are referred to by specific statutory terms in the insurance code.]

D. "Applicant" means a person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

E. "Commissioner" means [insert the appropriate title and statutory reference for the principal insurance regulatory official of the State.]

F. "Consumer report" means a written, oral or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or expected to be used in connection with an insurance transaction.

G. "Consumer reporting agency" means a person who:

(1) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(2) Obtains information primarily from sources other than insurance institutions; and

(3) Furnishes consumer reports to other persons.

H. "Control," including the terms "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

I. "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

J. "Individual" means a natural person who:

(1) In the case of property or casualty insurance, is a past, present or proposed named insured or certificateholder;

(2) In the case of life, health or disability insurance, is a past, present or proposed principal insured or certificateholder;

(3) Is a past, present or proposed policyowner;

(4) Is a past or present applicant;

(5) Is a past or present claimant; or

(6) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to this Act.

K. "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution or insurance support organization, other than:

(1) An agent;

(2) The individual who is the subject of the information; or

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

L. "Insurance institution" means any corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance, including health maintenance organizations, medical service plans and hospital service plans as defined in [insert the applicable section of the State insurance code which defines health maintenance organizations or medical or hospital service plans.] "Insurance institution" shall not include agents or insurance support organizations.

M. "Insurance support organization" means:

(1) Any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including:

(a) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction, or

(b) The collection of personal information from insurance institutions, agents or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(2) Notwithstanding Paragraph (1) above, the following persons shall not be considered "insurance support organizations" for purposes of this Act: agents, government institutions, insurance institutions, medical care institutions and medical professionals.

N. "Insurance transaction" means any transaction involving insurance primarily for personal, family or household needs rather than business or professional needs which entails:

(1) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

(2) The servicing of an insurance application, policy, contract or certificate.

O. "Investigative consumer report" means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

P. "Medical-care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to: health-maintenance organizations home-health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies and skilled nursing facilities.

Q. "Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a chiropractor, clinical dietician, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker or speech therapist.

R. "Medical record information" means personal information which:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment; and

(2) Is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent or legal guardian.

S. "Person" means any natural person, corporation, association, partnership or other legal entity.

T. "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. "Personal information" includes an individual's name and address and "medical record information" but does not include "privileged information".

U. "Policyholder" means any person who:

(1) In the case of individual property or casualty insurance, is a present named insured;

(2) In the case of individual life, health or disability insurance, is a present policyowner; or

(3) In the case of group insurance which is individually underwritten, is a present group certificateholder.

V. "Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(1) Pretends to be someone he or she is not;

(2) Pretends to represent a person he or she is not in fact representing;

(3) Misrepresents the true purpose of the interview; or

(4) Refuses to identify himself or herself upon request.

W. "Privileged information" means any individually identifiable information that:

(1) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual; and

(2) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual; provided, however, information otherwise meeting the requirements of this subsection shall nevertheless be considered "personal information" under this Act if it is disclosed in violation of Section 13 of this Act.

Drafting Note: The phrase "in reasonable anticipation of a claim" contemplates that the insurance institution has knowledge of a loss but has not received formal notice of the claim.

X. "Residual market mechanism" means an association, organization or other entity defined or described in Sections(s) [insert those sections of the state insurance code authorizing the establishment of a FAIR Plan, assigned risk plan, reinsurance facility, joint underwriting association, etc.]

Drafting Note: Those states having a reinsurance facility may want to exclude it from this definition if the state's policy is not to disclose to insureds the fact that they have been reinsured in the facility.

Y. "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

Z. "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the Commissioner to transact the business of insurance in this state.

Drafting Note: Each state must make sure that this definition is consistent with its surplus lines laws.

Section 3. Pretext Interviews

No insurance institution, agent or insurance support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction; provided, however, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim where, based upon specific information available for review by the Commissioner, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure in connection with the claim.

Drafting Note: Some states may desire to eliminate the exception in this section and thereby prohibit pretext interviews in all instances. Other states may desire to broaden the exception so that pretext interviews can be utilized in underwriting and rating situations as well as claim situations. States may either expand or limit the prohibition against pretext interviews suggested in this section to accommodate their individual needs and circumstances. Deviation from the standard developed here should not seriously undermine efforts to achieve uniform rules for insurance information practices throughout the various states.

Section 4. Notice of Insurance Information Practices

A. An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below:

(1) In the case of an application for insurance, a notice shall be provided no later than:

(a) At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; or

(b) At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records;

(2) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:

(a) Personal information is collected only from the policyholder or from public records; or

(b) A notice meeting the requirements of this section has been given within the previous twenty-four (24) months; or

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

B. The notice required by Subsection A above shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;

(3) The types of disclosures identified in Subsections B, C, D, E, F, I, K, L and N of Section 13 of this Act and the circumstances under which such disclosures may be made without prior authorization; provided, however, only those circumstances need be described which occur with such frequency as to indicate a general business practice;

(4) A description of the rights established under Sections 8 and 9 of this Act and the manner in which such rights may be exercised; and

(5) That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

C. In lieu of the notice prescribed in Subsection B, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in Subsection B will be furnished to the applicant or policyholder upon request.

D. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

Drafting Note: If permitted under Section 4A, an insurance institution or agent may include the notice in the insurance policy or certificate.

Section 5. Marketing and Research Surveys

An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction.

Section 6. Content of Disclosure Authorization Forms

Notwithstanding any other provision of law of this state, no insurance institution, agent or insurance support organization may utilize as its disclosure authorization form in connection with insurance transactions a form or statement which authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent or insurance support organization unless the form or statement:

A. Is written in plain language;

B. Is dated;

C. Specifies the types of persons authorized to disclose information about the individual;

D. Specifies the nature of the information authorized to be disclosed;

E. Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;

F. Specifies the purposes for which the information is collected;

G. Specifies the length of time such authorization shall remain valid, which shall be no longer than:

(1) In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits:

(a) Thirty (30) months from the date the authorization is signed if the application or request involves life, health or disability insurance;

(b) One (1) year from the date the authorization is signed if the application or request involves property or casualty insurance;

(2) In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy,

(a) The term of coverage of the policy if the claim is for a health insurance benefit;

(b) The duration of the claim if the claim is not for a health insurance benefit; and

H. Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

Drafting Note: The standard established by this section for disclosure authorization forms is intended to supersede any existing requirements a state may have adopted even if such requirements are more specific or applicable to particular authorizations such as medical information authorizations. This section is intended to be the exclusive statutory standard for all authorization forms utilized by insurance institutions, agents or insurance support organizations. This section does not preclude the inclusion of a disclosure authorization in an application form nor invalidate any disclosure authorizations in effect prior to the effective date of this Act. Nor does this section preclude an insurance institution, agent or insurance support organization from obtaining, in addition to its own authorization form which complies with this section, an additional authorization form required by the person from whom disclosure is sought.

Section 7. Investigative Consumer Reports

A. No insurance institution, agent or insurance support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the insurance institution or agent informs the individual:

(1) That he or she may request to be interviewed in connection with the preparation of the investigative consumer report; and

(2) That upon a request pursuant to Section 8, he or she is entitled to receive a copy of the investigative consumer report.

B. If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

C. If an investigative consumer report is to be prepared by an insurance support organization, the insurance institution or agent desiring such report shall inform the insurance support organization whether a personal interview has been requested by the individual. The insurance support organization shall institute reasonable procedures to conduct such interviews, if requested.

Section 8. Access to Recorded Personal Information

A. If any individual, after proper identification, submits a written request to an insurance institution, agent or insurance support organization for access to recorded personal information about the individual which is reasonably described by the individual and reasonably locatable and retrievable by the insurance institution, agent or insurance support organization, the insurance institution, agent or insurance support organization shall within thirty (30) business days from the date such request is received:

(1) Inform the individual of the nature and substance of such recorded personal information in writing, by telephone or by other oral communication, whichever the insurance institution, agent or insurance support organization prefers;

(2) Permit the individual to see and copy, in person, such recorded personal information pertaining to him or her or to obtain a copy of such recorded personal information by mail, whichever the individual prefers, unless such recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

(3) Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent or insurance support organization has disclosed such personal information within two (2) years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance support organizations or other persons to whom such information is normally disclosed; and

(4) Provide the individual with a summary of the procedures by which he or she may request correction, amendment or deletion of recorded personal information.

B. Any personal information provided pursuant to Subsection A above shall identify the source of the information if such source is an institutional source.

C. Medical-record information supplied by a medical care institution or medical professional and requested under Subsection A, together with the identity of the medical professional or medical care institution which provided such information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution, agent or insurance support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, agent or insurance support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

D. Except for personal information provided under Section 10, an insurance institution, agent or insurance support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

E. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under Subsection A, an insurance institution, agent or insurance support organization may make arrangements with an insurance support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

F. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

G. For purposes of this section, the term "insurance support organization" does not include "consumer reporting agency" except to the extent this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

Section 9. Correction, Amendment or Deletion of Recorded Personal Information

A. Within thirty (30) business days from the date of receipt of a written request from an individual to correct, amend or delete any recorded personal information about the individual within its possession, an insurance institution, agent or insurance support organization shall either:

(1) Correct, amend or delete the portion of the recorded personal information in dispute; or

(2) Notify the individual of:

(a) Its refusal to make such correction, amendment or deletion;

(b) The reasons for the refusal, and

(c) The individual's right to file a statement as provided in Subsection C.

B. If the insurance institution, agent or insurance support organization corrects, amends or deletes recorded personal information in accordance with Subsection A(1) above, the insurance institution, agent or insurance support organization shall so notify the individual in writing and furnish the correction, amendment or fact of deletion to:

(1) Any person specifically designated by the individual who may have, within the preceding two (2) years, received such recorded personal information;

(2) Any insurance support organization whose primary source of personal information is insurance institutions if the insurance support organization has systematically received such recorded personal information from the insurance institution within the preceding seven (7) years; provided, however, that the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains recorded personal information about the individual; and

(3) Any insurance support organization that furnished the personal information that has been corrected, amended or deleted.

C. Whenever an individual disagrees with an insurance institution's, agent's or insurance support organization's refusal to correct, amend or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent or insurance support organization:

(1) A concise statement setting forth what the individual thinks is the correct, relevant or fair information; and

(2) A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's or insurance support organization's refusal to correct, amend or delete recorded personal information.

D. In the event an individual files either statement as described in Subsection C above, the insurance institution, agent or insurance support organizations shall:

(1) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it; and

(2) In any subsequent disclosure by the insurance institution, agent or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed; and

(3) Furnish the statement to the persons and in the manner specified in Subsection B above.

E. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

F. For purposes of this section, the term "insurance support organization" does not include "consumer reporting agency" except to the extent that this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

Section 10. Reasons for Adverse Underwriting Decisions

A. In the event of an adverse underwriting decision the insurance institution or agent responsible for the decision shall:

(1) Either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such person that upon written request he or she may receive the specific reason or reasons in writing; and

(2) Provide the applicant, policyholder or individual proposed for coverage with a summary of the rights established under Subsection B and Sections 8 and 9 of this Act.

B. Upon receipt of a written request within ninety (90) business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one (21) business days from the date of receipt of such written request:

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to Subsection A(1);

(2) The specific items of personal and privileged information that support those reasons; provided, however:

(a) The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Commissioner, that the applicant, policyholder or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure, and

(b) Specific items of medical-record information supplied by a medical care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers, and

Drafting Note: The exception in Section 10B(2)(a) to the obligation of an insurance institution or agent to furnish the specific items of personal and privileged information that support the reasons for an adverse underwriting decision extends only to information about criminal activity, fraud, material misrepresentation or material nondisclosure that is privileged information and not to all information.

(3) The names and addresses of the institutional sources that supplied the specific items of information pursuant to Subsection B(2); provided, however, that the identity of any medical professional or medical care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

C. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

D. When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by Subsection A may be given orally.

Section 11. Information Concerning Previous Adverse Underwriting Decisions

No insurance institution, agent or insurance support organization may seek information in connection with an insurance transaction concerning:

A. Any previous adverse underwriting decision experienced by an individual; or

B. Any previous insurance coverage obtained by an individual through a residual market mechanism, unless such inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

Section 12. Previous Adverse Underwriting Decisions

No insurance institution or agent may base an adverse underwriting decision in whole or in part:

A. On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism; provided, however, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision;

B. On personal information received from an insurance support organization whose primary source of information is insurance institutions; provided, however, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as a result of information received from such insurance support organization.

Section 13. Disclosure Limitations and Conditions

An insurance institution, agent or insurance support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

A. With the written authorization of the individual, provided:

(1) If such authorization is submitted by another insurance institution, agent or insurance support organization, the authorization meets the requirements of Section 6 of this Act; or

(2) If such authorization is submitted by a person other than an insurance institution, agent or insurance support organization, the authorization is:

(a) Dated;

(b) Signed by the individual; and

(c) Obtained one (1) year or less prior to the date a disclosure is sought pursuant to this subsection; or

B. To a person other than an insurance institution, agent or insurance support organization, provided such disclosure is reasonably necessary:

(1) To enable such person to perform a business, professional or insurance function for the disclosing insurance institution, agent or insurance support organization and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(a) Would otherwise be permitted by this section if made by an insurance institution, agent or insurance support organization; or

(b) Is reasonably necessary for such person to perform its function for the disclosing insurance institution, agent or insurance support organization; or

(2) To enable such person to provide information to the disclosing insurance institution, agent or insurance support organization for the purpose of:

(a) Determining an individual's eligibility for an insurance benefit or payment; or

(b) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction; or

C. To an insurance institution, agent, insurance support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(2) For either the disclosing or receiving insurance institution, agent or insurance support organization to perform its function in connection with an insurance transaction involving the individual; or

D. To a medical care institution or medical professional for the purpose of:

(1) Verifying insurance coverage or benefits;

(2) Informing an individual of a medical problem of which the individual may not be aware; or

(3) Conducting an operations or services audit to verify the individuals treated by the medical professional or at the medical care institution; provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

E. To an insurance regulatory authority; or

F. To a law enforcement or other governmental authority:

(1) To protect the interests of the insurance institution, agent or insurance support organization in preventing or prosecuting the perpetration of fraud upon it; or

(2) If the insurance institution, agent or insurance support organization reasonably believes that illegal activities have been conducted by the individual; or

G. Otherwise permitted or required by law; or

H. In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

I. Made for the purpose of conducting actuarial or research studies, provided:

(1) No individual may be identified in any actuarial or research report;

(2) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and

(3) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance support organization; or

J. To a party or representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurance institution, agent or insurance support organization, provided:

(1) Prior to the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation; and

(2) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance support organization; or

K. To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(1) No medical record information, privileged information or personal information relating to an individual's character, personal habits, mode of living or general reputation is disclosed, and no classification derived from such information is disclosed;

(2) The individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed; and

(3) The person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

L. To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

M. By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent; or

N. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

O. To a professional peer review organization for the purpose of reviewing the service or conduct of a medical care institution or medical professional; or

P. To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

Q. To a certificateholder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

R. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance, provided that:

(1) No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and

(2) The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interests in such policy.

Section 14. Power of Commissioner

A. The Commissioner shall have power to examine and investigate into the affairs of every insurance institution or agent doing business in this state to determine whether the insurance institution or agent has been or is engaged in any conduct in violation of this Act.

B. The Commissioner shall have the power to examine and investigate into the affairs of every insurance support organization acting on behalf of an insurance institution or agent which either transacts business in this state or transacts business outside this state that has an effect on a person residing in this state in order to determine whether such insurance support organization has been or is engaged in any conduct in violation of this Act.

Section 15. Hearings, Witnesses, Appearances, Production of Books and Service of Process

A. Whenever the Commissioner has reason to believe that an insurance institution, agent or insurance support organization has been or is engaged in conduct in this state which violates this Act, or if the Commissioner believes that an insurance support organization has been or is engaged in conduct outside this state which has an effect on a person residing in this state and which violates this Act, the Commissioner shall issue and serve upon such insurance institution, agent or insurance support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be not less than [insert number] days after the date of service.

B. At the time and place fixed for such hearing the insurance institution, agent or insurance support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the Commissioner shall permit any adversely affected person to intervene, appear and be heard at such hearing by counsel or in person.

C. At any hearing conducted pursuant to this section the Commissioner may administer oaths, examine and cross-examine witnesses and receive oral and documentary evidence. The Commissioner shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence and other documents which are relevant to the hearing. A stenographic record of the hearing shall be made upon the request of any party or at the discretion of the Commissioner. If no stenographic record is made and if judicial review is sought, the Commissioner shall prepare a statement of the evidence for use on the review. Hearings conducted under this section shall be governed by the same rules of evidence and procedure applicable to administrative proceedings conducted under the laws of this state.

D. Statements of charges, notices, orders and other processes of the Commissioner under this Act may be served by anyone duly authorized to act on behalf of the Commissioner. Service of process may be completed in the manner provided by law for service of process in civil actions or by registered mail. A copy of the statement of charges, notice, order or other process shall be provided to the person or persons whose rights under this Act have been allegedly violated. A verified return setting forth the manner of service, or return postcard receipt in the case of registered mail, shall be sufficient proof of service.

Section 16. Service of Process - Insurance Support Organizations

For the purpose of this Act, an insurance support organization transacting business outside this state which has an effect on a person residing in this state shall be deemed to have appointed the Commissioner to accept service of process on its behalf; provided the Commissioner causes a copy of such service to be mailed forthwith by registered mail to the insurance support organization at its last known principal place of business. The return postcard receipt for such mailing shall be sufficient proof that the same was properly mailed by the Commissioner.

Section 17. Cease and Desist Orders and Reports

A. If, after a hearing pursuant to Section 15, the Commissioner determines that the insurance institution, agent or insurance support organization charged has engaged in conduct or practices in violation of this Act, the Commissioner shall reduce his or her findings to writing and shall issue and cause to be served upon such insurance institution, agent or insurance support organization a copy of such findings and an order requiring such insurance institution, agent or insurance support organization to cease and desist from the conduct or practices constituting a violation of this Act.

B. If, after a hearing pursuant to Section 15, the Commissioner determines that the insurance institution, agent or insurance support organization charged has not engaged in conduct or practices in violation of this Act, the Commissioner shall prepare a written report which sets forth findings of fact and conclusions of law. Such report shall be served upon the insurance institution, agent or insurance support organization charged and upon the person or persons, if any, whose rights under this Act were allegedly violated.

C. Until the expiration of the time allowed under Section 19 of this Act for filing a petition for review or until such petition is actually filed, whichever occurs first, the Commissioner may modify or set aside any order or report issued under this section. After the expiration of the time allowed under Section 19 of this Act for filing a petition for review, if no such petition has been duly filed, the Commissioner may, after notice and opportunity for hearing, alter, modify or set aside, in whole or in part, any order or report issued under this section whenever conditions of fact or law warrant such action or if the public interest so requires.

Section 18. Penalties

A. In any case where a hearing pursuant to Section 15 results in the finding of a knowing violation of this Act, the Commissioner may, in addition to the issuance of a cease and desist order as prescribed in Section 17, order payment of a monetary penalty of not more than [$500] for each violation but not to exceed [$10,000] in the aggregate for multiple violations.

B. Any person who violates a cease and desist order of the Commissioner under Section 17 of this Act may, after notice and hearing and upon order of the Commissioner, be subject to one or more of the following penalties, at the discretion of the Commissioner:

(1) A monetary fine of not more than [$10,000] for each violation;

(2) A monetary fine of not more than [$50,000] if the Commissioner finds that violations have occurred with such frequency as to constitute a general business practice; or

(3) Suspension or revocation of an insurance institution's or agent's license.

Section 19. Judicial Review of Orders and Reports

A. Any person subject to an order of the Commissioner under Section 17 or Section 18 or any person whose rights under this Act were allegedly violated may obtain a review of any order or report of the Commissioner by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of such order or report, a written petition requesting that the order or report of the Commissioner be set aside. A copy of such petition shall be simultaneously served upon the Commissioner, who shall forthwith certify and file in such court a transcript of the entire record of the proceeding giving rise to the order or report which is the subject of the petition. Upon filing of the petition and transcript the [insert title] Court shall have jurisdiction to make and enter a decree modifying, affirming or reversing any order or report of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts supporting any order or report, if supported by clear and convincing evidence, shall be conclusive.

B. To the extent an order or report of the Commissioner is affirmed, the Court shall issue its own order commanding obedience to the terms of the order or report of the Commissioner. If any party affected by an order or report of the Commissioner shall apply to the court for leave to produce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there are reasonable grounds for the failure to produce such evidence in prior proceedings, the court may order such additional evidence to be taken before the Commissioner in such manner and upon such terms and conditions as the court may deem proper. The Commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken and shall file such modified or new findings along with any recommendation, if any, for the modification or revocation of a previous order or report. If supported by clear and convincing evidence, the modified or new findings shall be conclusive as to the matters contained therein.

C. An order or report issued by the Commissioner under Section 17 or 18 shall become final:

(1) Upon the expiration of the time allowed for the filing of a petition for review, if no such petition has been duly filed; except that the Commissioner may modify or set aside an order or report to the extent provided in Section 17C; or

(2) Upon a final decision of the [insert title] Court if the court directs that the order or report of the Commissioner be affirmed or the petition for review dismissed.

D. No order or report of the Commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order or report from any liability under any law of this state.

Section 20. Individual Remedies

A. If any insurance institution, agent or insurance support organization fails to comply with Section 8, 9 or 10 of this Act with respect to the rights granted under those sections, any person whose rights are violated may apply to the [insert title] Court of this state, or any other court of competent jurisdiction, for appropriate equitable relief.

B. An insurance institution, agent or insurance support organization which discloses information in violation of Section 13 of this Act shall be liable for damages sustained by the individual about whom the information relates; provided, however, that no individual shall be entitled to a monetary award which exceeds the actual damages sustained by the individual as a result of a violation of Section 13 of this Act.

C. In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

D. An action under this section must be brought within two (2) years from the date the alleged violation is or should have been discovered.

E. Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provisions of this Act.

Section 21. Immunity

No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with this Act, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent or insurance support organization; provided, however, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

Section 22. Obtaining Information Under False Pretenses

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent or insurance support organization under false pretenses shall be fined not more than [$10,000] or imprisoned for not more than one year, or both.

Section 23. Severability

If any provisions of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 24. Effective Date

A. This Act shall take effect on [insert a date which allows at least a one year interval between the date of enactment and the effective date].

B. The rights granted under Sections 8, 9 and 13 of this Act shall take effect on [insert effective date] regardless of the date of the collection or receipt of the information which is the subject of such sections.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. I 34, 38, 281, 319, 320-335 (adopted).
1981 Proc. I 47, 51, 255, 259, 290-313 (revised and reprinted).
1982 Proc. I 19, 27, 155, 198 (amended).

INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. ANN. §§ 45.48.010 to 45.48.995 (2009) (not specific to insurance).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-2101 to 20-2122 (1981/2010).		
Arkansas			ARK. CODE ANN. §§ 4-110-101 to 4-110-108 (2005) (not specific to insurance); BULLETIN 1-2006 (2006).
California	CAL. INS. CODE §§ 791.01 to 791.29 (1981/2013).		
Colorado			COLO. REV. STAT. ANN. §§ 6-1-1301 to 6-1-1313 (2021) (not specific to insurance).
Connecticut	CONN. GEN. STAT. §§ 38a-975 to 38a-999a (1981/1983).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia	GA. CODE ANN. §§ 33-39-1 to 33-39-23 (1982/1985).		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:2-209 (2009).
Idaho	NO CURRENT ACTIVITY		
Illinois	215 ILL. COMP. STAT. 5/1001 to 5/1024 (1981/1997).		
Indiana	NO CURRENT ACTIVITY		IND. CODE ANN. §§ 4-1-6-1 to 4-1-6-9 (1977) (applies to state agencies).
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. §§ 40-2,111 to 40-2,113 (1981/2013) (adverse underwriting portions of model).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2201 to 2220 (1999).		
Maryland			Md. Code Ann., Com. Law §§ 14-3501 to 14-3508 (2007) (not specific to insurance).
Massachusetts	MASS. GEN. LAWS ch.175I, §§ 1 to 22 (1992).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. STAT. §§ 72A.49 to 72A.505 (1989/2014).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		

INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. CODE ANN. §§ 33-19-101 to 33-19-409 (1982/2003).		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NEV. ADMIN. CODE §§ 679B.560 to 679B.750 (1989/1997).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. REV. STAT. §§ 17:23A-1 to 17:23A-22 (1985).		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-39-1 to 58-39-76 (1981/2002).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3904.01 to 3904.22 (1994/1997).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	OR. REV. STAT. §§ 746.600 to 746.690 (1981/2013).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		10 LAWS P.R. ANN. §§ 4061 to 4067 (2012) (not specific to insurance).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		

INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-600 to 38.2-619 (1986/2003).		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. STAT. § 610.70 (1997/2000) (portions of model).		
Wyoming			WY. RULES AND REGULATIONS 044.0002.54 (1977/1989).

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

Table of Contents

ARTICLE I. GENERAL PROVISIONS

Section 1. Authority

This regulation is promulgated pursuant to the authority granted by Sections [insert applicable sections] of the Insurance Law.

Section 2. Purpose and Scope

A. Purpose. This regulation governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

(1) Requires a licensee to provide notice to individuals about its privacy policies and practices;

(2) Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

(3) Provides methods for individuals to prevent a licensee from disclosing that information.

B. Scope. This regulation applies to:

(1) Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

(2) All nonpublic personal health information.

C. Compliance. A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act (PL 102-106) may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in the other state.

Drafting Note: Subsection C is intended to give licensees some guidance for complying with Title V of the Gramm-Leach-Bliley Act in those states that do not have laws or regulations that meet GLBA's privacy requirements.

Section 3. Rule of Construction

The examples in this regulation, the sample clauses in Appendix A, and the Federal Model Privacy Form in Appendix B of this regulation are not exclusive. Compliance with an example, use of a sample clause, or the Federal Privacy Model Form, to the extent applicable, constitutes compliance with this regulation.

Licensees may rely on use of the Federal Privacy Form in Appendix B, consistent with the attached instructions, as a safe harbor of compliance with the privacy notice content requirements of this regulation.

Use of the Federal Model Privacy Form is not required. Licensees may continue to use other types of privacy notices, including notices that contain the examples in this regulation and/or the sample clauses in Appendix A, provided that such notices accurately describe the Licensee's privacy practices and otherwise meet the notice content requirements of this regulation. However, while Licensees may continue to use privacy notices that contain the examples in this regulation and/or the sample clauses in Appendix A, Licensees may not rely on use of privacy notices with the sample clauses in Appendix A as a safe harbor of compliance with the notice content requirements of this regulation after July 1, 2019.

Drafting Note: Safe harbor of compliance with this regulation for use of sample clauses in Appendix A sunsets on July 1, 2019.

Section 4. Definitions

As used in this regulation, unless the context requires otherwise:

A. "Affiliate" means a company that controls, is controlled by or is under common control with another company.

B. (1) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(2) Examples.

(a) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(i) Presents the information in the notice in clear, concise sentences, paragraphs and sections;

(ii) Uses short explanatory sentences or bullet lists whenever possible;

(iii) Uses definite, concrete, everyday words and active voice whenever possible;

(iv) Avoids multiple negatives;

(v) Avoids legal and highly technical business terminology whenever possible; and

(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(i) Uses a plain-language heading to call attention to the notice;

(ii) Uses a typeface and type size that are easy to read;

(iii) Provides wide margins and ample line spacing;

(iv) Uses boldface or italics for key words; and

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

C. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

D. "Commissioner" means the insurance commissioner of the state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health licensees, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

E. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

F. (1) "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative.

(2) Examples.

(a) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if:

(i) (I) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(II) The individual is a claimant under an insurance policy issued by the licensee;

(III) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(IV) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(ii) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under Sections 15, 16 and 17 of this regulation.

(e) Provided that the licensee provides the initial, annual and revised notices under Section 10 of this regulation to the plan sponsor, group or blanket insurance policyholder or group annuity contractholder, or workers' compensation policyholder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about an individual described in Item (i), (ii) or (iii), other than as permitted under Sections 15, 16 and 17 of this regulation, such an individual is not the consumer of the licensee solely because he or she is:

(i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(ii) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee; or

(iii) A claimant covered by a workers' compensation plan.

Drafting Note: In states where the workers' compensation self-insurance or workers' compensation state fund coverage is outside the commissioner's jurisdiction, regulators may wish to urge the applicable agency or agencies to promulgate a regulation similar to this regulation in order to ensure parity in treatment of workers' compensation plans and to ensure that all workers covered by such plans have privacy protections.

(f) (i) The individuals described in Subparagraph (e)(i) through (iii) of this paragraph are consumers of a licensee if the licensee does not meet all the conditions of Subparagraph (e).

(ii) In no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through (iii) above, be deemed to be customers for purposes of this regulation.

(g) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(h) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

G. "Consumer reporting agency" has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

H. "Control" means:

(1) Ownership, control or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(2) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(3) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

I. "Customer" means a consumer who has a customer relationship with a licensee.

J. (1) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(2) Examples.

(a) A consumer has a continuing relationship with a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(i) The consumer applies for insurance but does not purchase the insurance;

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction;

(iii) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(vi) The customer's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(viii) For the purposes of this regulation, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

K. (1) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial institution does not include:

(a) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 *et seq.*);

(b) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 *et seq.*); or

(c) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

L. (1) "Financial product or service" means a product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

M. "Health care" means:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(2) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

N. "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

O. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(1) The past, present or future physical, mental or behavioral health or condition of an individual;

(2) The provision of health care to an individual; or

(3) Payment for the provision of health care to an individual.

P. (1) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

(2) Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for a insurance product or service.

Q. (1) "Licensee" means all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state, [and health maintenance organizations holding a certificate of authority pursuant to Section [insert section] of this state's Public Health Law].

Drafting Note: Add bracketed language if HMOs are licensed under other than insurance statutes, and cite appropriate state law.

(2) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(a) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(b) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

(3) (a) Subject to Subparagraph (b), "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to Section [insert section] of this state's laws.

(b) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation provided:

(i) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under Section 15 of this regulation, except as permitted by Section 16 or 17 of this regulation; and

(ii) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to nonaffiliates of the brokers or insurers except as permitted by law."

Drafting Note: References to "excess lines broker" and "excess lines insurer" should be changed as necessary to correspond with the applicable terms used in each state.

R. (1) "Nonaffiliated third party" means any person except:

(a) A licensee's affiliate; or

(b) A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

(2) Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

S. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

T. (1) "Nonpublic personal financial information" means:

(a) Personally identifiable financial information; and

(b) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(2) Nonpublic personal financial information does not include:

(a) Health information;

(b) Publicly available information, except as included on a list described in Subsection T(1)(b) of this section; or

(c) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

(3) Examples of lists.

(a) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(b) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

U. "Nonpublic personal health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

V. (1) "Personally identifiable financial information" means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

(2) Examples.

(a) Information included. Personally identifiable financial information includes:

(i) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(ii) Account balance information and payment history;

(iii) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(iv) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(v) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(vi) Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

(vii) Information from a consumer report.

(b) Information not included. Personally identifiable financial information does not include:

(i) Health information;

(ii) A list of names and addresses of customers of an entity that is not a financial institution; and

(iii) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

W. (1) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(a) Federal, state or local government records;

(b) Widely distributed media; or

(c) Disclosures to the general public that are required to be made by federal, state or local law.

(2) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(a) That the information is of the type that is available to the general public; and

(b) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(3) Examples.

(a) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(b) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(c) Reasonable basis.

(i) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(ii) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

ARTICLE II. PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

Section 5. Initial Privacy Notice to Consumers Required

A. Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in Subsection E of this section; and

(2) Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by Sections 16 and 17.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under Subsection A(2) of this section if:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by Sections 16 and 17, and the licensee does not have a customer relationship with the consumer; or

(2) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the licensee establishes a customer relationship.

(1) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(2) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(a) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of Subsection A of this section as follows:

(1) The licensee may provide a revised policy notice, under Section 9, that covers the customer's new insurance product or service; or

(2) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection A of this section.

E. Exceptions to allow subsequent delivery of notice.

(1) A licensee may provide the initial notice required by Subsection A(1) of this section within a reasonable time after the licensee establishes a customer relationship if:

(a) Establishing the customer relationship is not at the customer's election; or

(b) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) Examples of exceptions.

(a) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(c) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to Section 11. If the licensee uses a short-form initial notice for non-customers according to Section 7D, the licensee may deliver its privacy notice according to Section 7D(3).

Section 6. Annual Privacy Notice to Customers Required

A. (1) General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(2) Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

B. Exception to general rule. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 15, 16, or 17 and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section or Section 5 shall not be required to provide an annual disclosure under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

C. (1) Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(2) Examples.

(a) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(b) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

(c) For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(d) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

D. Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to Section 11.

Section 7. Information to be Included in Privacy Notices

A. General rule. The initial, annual and revised privacy notices that a licensee provides under Sections 5, 6 and 9 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects;

(2) The categories of nonpublic personal financial information that the licensee discloses;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 15 (and no other exception in Sections 16 and 17 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(6) An explanation of the consumer's right under Section 12A to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(9) Any disclosure that the licensee makes under Subsection B of this section.

B. Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under Sections 16 and 17, the licensee is not required to list those exceptions in the initial or annual privacy notices required by Sections 5 and 6. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples.

(1) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from a consumer reporting agency.

(2) Categories of nonpublic personal financial information a licensee discloses.

(a) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in Paragraph (1), as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(i) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

(ii) Transaction information, such as information about balances, payment history and parties to the transaction; and

(iii) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(3) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(a) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(4) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in Section 15 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection A(5) of this section if it:

(a) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Subsection A(2) of this section, as applicable; and

(b) States whether the third party is:

(i) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(ii) A financial institution with whom the licensee has a joint marketing agreement.

(5) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under Sections 16 and 17, the licensee may simply state that fact, in addition to the information it shall provide under Subsections A(1), A(8), A(9) and Subsection B of this section.

(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-form initial notice with opt out notice for non-customers.

(1) A licensee may satisfy the initial notice requirements in Sections 5A(2) and 8C for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in Section 8.

(2) A short-form initial notice shall:

(a) Be clear and conspicuous;

(b) State that the licensee's privacy notice is available upon request; and

(c) Explain a reasonable means by which the consumer may obtain that notice.

(3) The licensee shall deliver its short-form initial notice according to Section 10. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to Section 11.

(4) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(a) Provides a toll-free telephone number that the consumer may call to request the notice; or

(b) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future disclosures. The licensee's notice may include:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample Clauses and Federal Model Privacy Form. Sample clauses illustrating some of the notice content required by this section and the Federal Model Privacy Form are included in Appendix A and Appendix B, respectively, of this regulation.

Section 8. Form of Opt Out Notice to Consumers and Opt Out Methods

A. (1) Form of opt out notice. If a licensee is required to provide an opt out notice under Section 12A, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c) A reasonable means by which the consumer may exercise the opt out right.

(2) Examples.

(a) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(i) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in Section 7A(2) and (3), and states that the consumer can opt out of the disclosure of that information; and

(ii) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(b) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(i) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(ii) Includes a reply form together with the opt out notice;

(iii) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(iv) Provides a toll-free telephone number that consumers may call to opt out.

(c) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(i) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(ii) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(d) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

B. Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with Section 5.

C. Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with Section 5, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

D. Joint relationships.

(1) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in Paragraph (5) of this subsection).

(2) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(a) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(b) Permit each joint consumer to opt out separately.

(3) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(4) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(5) Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(a) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(b) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(c) Permit John and Mary to make different opt out directions. If the licensee does so:

(i) It shall permit John and Mary to opt out for each other;

(ii) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(iii) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

E. Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

F. Continuing right to opt out. A consumer may exercise the right to opt out at any time.

G. Duration of consumer's opt out direction.

(1) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(2) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

H. Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to Section 11.

Section 9. Revised Privacy Notices

A. General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under Section 5, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice;

(3) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

B. Examples.

(1) Except as otherwise permitted by Sections 15, 16 and 17, a licensee shall provide a revised notice before it:

(a) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(b) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(c) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(2) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to Section 11.

Section 10. Privacy Notices to Group Policyholders

Unless a licensee is providing privacy notices directly to covered individuals described in Section 4F(2)(e)(i), (ii) or (iii), a licensee shall provide initial, annual and revised notices to the plan sponsor, group or blanket insurance policyholder or group annuity contractholder, or workers' compensation policyholder, in the manner described in Sections 5 through 9 of this regulation, describing the licensee's privacy practices with respect to nonpublic personal information about individuals covered under the policies, contracts or plans.

Section 11. Delivery

A. How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

B. (1) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(2) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(a) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

C. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(1) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(2) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

D. Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

E. Retention or accessibility of notices for customers.

(1) For customers only, a licensee shall provide the initial notice required by Section 5A(1), the annual notice required by Section 6A, and the revised notice required by Section 9 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(2) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

F. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

G. Joint relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of Sections 5A, 6A and 9A, respectively, by providing one notice to those consumers jointly.

ARTICLE III. LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 12. Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties

A. (1) Conditions for disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(a) The licensee has provided to the consumer an initial notice as required under Section 5;

(b) The licensee has provided to the consumer an opt out notice as required in Section 8;

(c) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 15, 16 and 17.

(3) Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(a) By mail. The licensee mails the notices required in Paragraph (1) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(b) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Paragraph (1) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(c) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in Paragraph (1) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

B. Application of opt out to all consumers and all nonpublic personal financial information.

(1) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(2) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

C. Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

Section 13. Limits on Redisclosure and Reuse of Nonpublic Personal Financial Information

A. (1) Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in Sections 16 or 17 of this regulation, the licensee's disclosure and use of that information is limited as follows:

(a) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(b) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(c) The licensee may disclose and use the information pursuant to an exception in Sections 16 or 17 of this regulation, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B. (1) Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in Sections 16 or 17 of this regulation, the licensee may disclose the information only:

(a) To the affiliates of the financial institution from which the licensee received the information;

(b) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(c) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(2) Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in Sections 16 or 17:

(a) The licensee may use that list for its own purposes; and

(b) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in Sections 16 or 17, such as to the licensee's attorneys or accountants.

C. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in Sections 16 or 17 of this regulation, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to the licensee's affiliates;

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) The third party may disclose and use the information pursuant to an exception in Sections 16 or 17 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in Sections 16 or 17 of this regulation, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

Section 14. Limits on Sharing Account Number Information for Marketing Purposes

A. General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(2) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(3) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples.

(1) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(2) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

ARTICLE IV. EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 15. Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing

A. General rule.

(1) The opt out requirements in Sections 8 and 12 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(a) Provides the initial notice in accordance with Section 5; and

(b) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in Sections 16 or 17 in the ordinary course of business to carry out those purposes.

(2) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of Paragraph (1)(b) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in Sections 16 or 17 in the ordinary course of business to carry out that joint marketing.

B. Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under Subsection A of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

C. Definition of "joint agreement." For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

Section 16. Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions

A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(3) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(4) Reinsurance or stop loss or excess loss insurance.

B. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate or acceptable method:

(a) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(b) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(c) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(d) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(e) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(f) In connection with:

(i) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

(ii) The transfer of receivables, accounts or interests therein; or

(iii) The audit of debit, credit or other payment information.

Section 17. Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information

A. Exceptions to opt out requirements. The requirements for initial notice to consumers in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply when a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2) (a) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

(b) To protect against or prevent actual or potential fraud or unauthorized transactions;

(c) For required institutional risk control or for resolving consumer disputes or inquiries;

(d) To persons holding a legal or beneficial interest relating to the consumer; or

(e) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

(5) (a) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

(b) From a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(7) (a) To comply with federal, state or local laws, rules and other applicable legal requirements;

(b) To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities; or

(c) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

B. Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under Section 8F.

Drafting Note: Because the notice requirements of this regulation could be a financial burden on a company in liquidation or receivership and negatively impact the ability of the liquidator or receiver to pay claims, regulators may want to consider adding an additional exception providing that licensees in liquidation or receivership are not subject to the notice provisions of this regulation.

ARTICLE V. RULES FOR HEALTH INFORMATION

Section 18. When Authorization Required for Disclosure of Nonpublic Personal Health Information

A. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

B. Nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the commissioner to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

Section 19. Authorizations

A. A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(1) The identity of the consumer or customer who is the subject of the nonpublic personal health information;

(2) A general description of the types of nonpublic personal health information to be disclosed;

(3) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

Section 20. Authorization Request Delivery

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to Section 11, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to Section 18A.

Section 21. Relationship to Federal Rules

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the U.S. Department of Health and Human Services [insert cite] (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of this Article V.

Drafting Note: The drafters note that the effective date of this regulation is July 1, 2001. The HHS regulation is anticipated to be promulgated in late 2000, thereby becoming effective in late 2002. As of July 1, 2001, if the licensee is in compliance with all requirements of the HHS regulation except its effective date provision, the licensee is not subject to the provisions of this article. If the licensee comes into compliance with the HHS regulation after that date, the licensee is no longer subject to the provisions of this article as of the date the licensee comes into compliance with the HHS regulation.

Section 22. Relationship to State Laws

Nothing in this article shall preempt or supercede existing state law related to medical records, health or insurance information privacy.

ARTICLE VI. ADDITIONAL PROVISIONS

Section 23. Protection of Fair Credit Reporting Act

Nothing in this regulation shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under Section 603 of that Act.

Section 24. Nondiscrimination

A. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

B. A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

Section 25. Violation

Drafting Note: Cite state unfair trade practices act or other applicable state law.

Section 26. Severability

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Section 27. Effective Date

A. Effective date. This regulation is effective November 13, 2000. In order to provide sufficient time for licensees to establish policies and systems to comply with the requirements of this regulation, the commissioner has extended the time for compliance with this regulation until July 1, 2001.

B. (1) Notice requirement for consumers who are the licensee's customers on the compliance date. By July 1, 2001, a licensee shall provide an initial notice, as required by Section 5, to consumers who are the licensee's customers on July 1, 2001.

(2) Example. A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

C. Two-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of Section 15A(1)(b) of this regulation, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.

APPENDIX A – SAMPLE CLAUSES

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1–Categories of information a licensee collects (all institutions)
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(1) to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

Drafting Note: The safe harbor of compliance for use of sample clause A-1 expires on July 1, 2019.

A-2–Categories of information a licensee discloses (institutions that disclose outside of the exceptions)
A licensee may use one of these clauses, as applicable, to meet the requirement of Section 7A(2) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and

- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Drafting Note: The safe harbor of compliance for use of sample clause A-2, Alternative 1 expires on July 1, 2019.

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

Drafting Note: The safe harbor of compliance for use of sample clause A-2, Alternative 2 expires on July 1, 2019.

A-3–Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirements of Sections 7A(2), (3), and (4) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in Sections 16 and 17.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

Drafting Note: The safe harbor of compliance for use of sample clause A-3 expires on July 1, 2019.

A-4–Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(3) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17, as well as when permitted by the exceptions in Sections 16 and 17.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];

- Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and

- Others, such as [provide illustrative examples, such as "non-profit organizations"].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

Drafting Note: The safe harbor of compliance for use of sample clause A-4 expires on July 1, 2019.

A-5–Service provider/joint marketing exception
A licensee may use one of these clauses, as applicable, to meet the requirements of Section 7A(5) related to the exception for service providers and joint marketers in Section 15. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and

- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Drafting Note: The safe harbor of compliance for use of sample clause A-5, Alternative 1 expires on July 1, 2019.

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

Drafting Note: The safe harbor of compliance for use of sample clause A-5, Alternative 2 expires on July 1, 2019.

A-6–Explanation of opt out right (institutions that disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(6) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)].

Drafting Note: The safe harbor of compliance for use of sample clause A-6 expires on July 1, 2019.

A-7–Confidentiality and security (all institutions)
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(8) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Drafting Note: The safe harbor of compliance for use of sample clause A-7 expires on July 1, 2019.

APPENDIX B – FEDERAL MODEL PRIVACY FORM

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the Federal Model Privacy Form, if the Form is accurate for each institution that uses the Form. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A. General Instructions

1. How the Model Privacy Form is used.

   (a) The Model Form may be used, at the option of a "licensee"), including a group of licensees or other financial institutions that use a common privacy notice, to meet the content requirements of the privacy notice and opt-out notice set forth in [insert citation for sections of statute or regulation sections that parallel Sections 7 and 8 of the *NAIC Privacy of Consumer Financial and Health Information Regulation*]

   (b) The Model Form is a standardized form, including page layout, content, format, style, pagination, and shading. Licensees seeking to obtain the safe harbor through use of the Model Form may modify it only as described in these Instructions.

   (c) Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act (FCRA), codified at 15 U.S.C. §§ 1681-1681x, such as a requirement to permit a consumer to opt out of disclosures to affiliates, or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

   (d) The word "customer" may be replaced by the word "member," whenever it appears in the Model Form, as appropriate.

2. The Contents of the Model Privacy Form

   The Model Form consists of two pages, which may be printed on both sides of a single sheet of paper or may appear on two separate pages. Where a licensee provides a long list of licensees or financial institutions at the end of the Model Form in accordance with Instruction B3(a)(i), or provides additional information in accordance with Instruction B3(c) and such list or additional information exceeds the space available on Page Two of the Model Form, such list or additional information may extend to a third page.

   (a) Page One. The first page consists of the following components:

      (1) Date last revised (upper right-hand corner)
      (2) Title
      (3) Key frame (Why? What? How?)
      (4) Disclosure table ("Reasons we can share your personal information")
      (5) "To limit our sharing" box, as needed, for the licensee's opt-out information
      (6) "Questions" box, for customer service contact information
      (7) Mail-in opt-out form, as needed

   (b) Page Two. The second page consists of the following components:

      (1) Heading (Page 2)
      (2) Frequently Asked Questions ("Who we are" and "What we do")
      (3) Definitions
      (4) "Other important information" box, as needed

3. The format of the Model Privacy Form.

The format of the Model Form may be modified only as described below.

(a) Easily readable type font. Licensees that use the Model Form must use an easily readable type font. While a number of factors together produce easily readable font, licensees are required to use a minimum of 10- point font (unless otherwise expressly permitted in these Instructions) and sufficient spacing between lines.

(b) Logo. A licensee may include a corporate logo on any page of the notice, so long as it does not interfere with the readability of the Model Form or the space constraints of each page.

(c) Page size and orientation. Each page of the Model Form must be printed in portrait orientation, the size of which must be sufficient to meet the layout and minimum font size requirements, with sufficient white space on the top, bottom, and sides of the content.

(d) Color. The Model Form must be printed on white or light color paper (such as cream) with black or other contrasting ink color. Spot color may be used to achieve visual interest, so long as the color contrast is distinctive and the color does not detract from the readability of the Model Form. Logos may also be printed in color.

(e) Languages. The Model Form may be translated into languages other than English.

B. Information Required in the Model Privacy Form

The information in the Model Form may be modified only as described below:

1. Name of licensee or group of affiliated licensees or institutions providing the notice

Insert the name of the licensee providing the notice, or a common identity of the affiliated licensees or financial institutions jointly providing the notice on the form, wherever [name of licensee] appears.

2. Page One

(a) Last revised date. The licensee must insert in the upper right-hand corner the date on which the notice was last revised. The information shall appear in minimum 8-point font as "rev. [month/year]" using either the name or number of the month, such as "rev. July 2016" or "rev. 7/16."

(b) General instructions for the "What?" box

(i) The bulleted list identifies the types of personal information that the licensee collects and shares. All licensees must use the term "Social Security Number" in the first bullet.

(ii) A licensee must use five (5) of the following terms, to complete the bulleted list: income; account balances; payment history; transaction history; transaction or loss history; credit history; credit scores; assets; investment experience; credit-based insurance scores; insurance claim history; medical information; overdraft history; purchase history; account transactions; risk tolerance; medical-related debts; credit card or other debt; mortgage rates and payments; retirement assets; checking account information; employment information; wire transfer instructions.

(c) General instructions for the disclosure table. The left column lists reasons for sharing or using personal information. Each reason correlates to a specific legal provision described in Paragraph 2(d) of this Instruction. In the middle column, each licensee must provide a "Yes" or "No" response that accurately reflects its information-sharing policies and practices with respect to the reason listed on the left. In the right column, each licensee must provide in each box one of the following three (3) responses, as applicable, that reflects whether a consumer can limit such sharing:

"Yes," if it is required to or voluntarily provides an opt-out; "No," if it does not provide an opt-out; or

"We don't share," if it answers "No" in the middle column.

Only the sixth row ("For our affiliates to market to you") may be omitted at the option of the licensee. See Paragraph 2(d)(6) of this instruction..

(d) Specific disclosures and corresponding legal provisions

(i) For our everyday business purposes. This reason incorporates sharing information under [insert citation for sections of statute or regulation sections that parallel Sections 16 and 17 of NAIC model *Privacy of Consumer Financial and Health Regulation*] and with service providers pursuant to [insert citation for section of statute or regulation that parallels Section 15 of *NAIC Privacy of Consumer Financial and Health Regulation*] other than the disclosures described in Paragraphs (2)(d)(ii) or (2)(d)(iii) of this instruction.

(ii) For our marketing purposes. This reason incorporates sharing information with service providers by a licensee for its own marketing pursuant to [insert citation for section of statute or regulation that parallels Section 15 of *NAIC Privacy of Consumer Financial and Health Regulation*]. A licensee that shares for this reason may choose to provide an opt-out.

(iii) For joint marketing with other financial companies. This reason incorporates sharing information under joint marketing agreements between 2 or more licensees or financial institutions and with any service provider used in conjunction with such agreement pursuant to [insert citation for section of statute or regulation that parallels Section 15 of *NAIC Privacy of Consumer Financial and Health Regulation*]. A licensee that shares for this reason may choose to provide an opt-out.

(iv) For our affiliates' everyday business purposes – information about transactions and experiences. This reason incorporates sharing information specified in Sections 603(d)(2)(A)(i) and (ii) of the FCRA. A licensee that shares information for this reason may choose to provide an opt-out.

(v) For our affiliates' everyday business purposes – information about creditworthiness. This reason incorporates sharing information pursuant to Section 603(d)(2)(A)(iii) of the FCRA. A licensee that shares information for this reason must provide an opt-out.

(vi) For our affiliates to market to you. This reason incorporates sharing information specified in Section 624 of the FCRA. This reason may be omitted from the disclosure table when: the licensee does not have affiliates (or does not disclose personal information to its affiliates); the licensee's affiliates do not use personal information in a manner that requires an opt-out; or the licensee provides the affiliate marketing notice separately. Licensees that include this reason must provide an opt-out of indefinite duration. A licensee that is required to provide an affiliate marketing opt-out, but does not include that opt-out in the Model Form under this part, must comply with Section 624 of the FCRA and [insert citation for statute or regulation that parallels *NAIC Privacy of Consumer Financial and Health Information Regulation*], with respect to the initial notice and opt-out and any subsequent renewal notice and opt-out. A licensee not required to provide an opt-out under this subparagraph may elect to include this reason in the Model Form.

(vii) For nonaffiliates to market to you. This reason incorporates sharing described in [insert citation for sections of statute or regulation sections that parallel Sections 8 and 12(A) of *NAIC Privacy of Consumer Financial and Health Information Regulation*]. A licensee that shares personal information for this reason must provide an opt-out.

(e) To limit our sharing. A licensee must include this section of the Model Form only if it provides an opt-out. The word "choice" may be written in either the singular or plural, as appropriate. Licensees must select one or more of the applicable opt-out methods described: telephone, such as by a toll-free number; a web site; or use of a mail-in opt-out form. Licensees may include the word "toll-free" before telephone, as appropriate. A licensee that allows consumers to opt out online must provide either a specific web address that takes consumers directly to the opt-out page or a general web address that provides a clear and conspicuous direct link to the opt-out page. The opt-out choices made available to the consumer who contacts the licensee through these methods must correspond accurately to the "Yes" responses in the third column of the disclosure table. In the part entitled "Please note," licensees may insert a number that is 30 days or greater in the space marked "[30]." Instructions on voluntary or state privacy law opt-out information are in Paragraph 2(g)(v) of these Instructions.

(f) Questions box. Customer service contact information must be inserted as appropriate where [phone number] or [web site] appear. Licensees may elect to provide either a phone number, such as a toll-free number, or a web address, or both. Licensees may include the words "toll-free" before the telephone number, as appropriate.

(g) Mail-in opt-out form. Licensees must include this mail-in form only if they state in the "To limit our sharing" box that consumers can opt out by mail. The mail-in form must provide opt-out options that correspond accurately to the "Yes" responses in the third column of the disclosure table. Licensees that require consumers to provide only name and address may omit the section identified as "[account #]." Licensees that require additional or different information, such as a random opt-out number or a truncated account number to implement an opt-out election should modify the "[account #]" reference accordingly. This includes licensees that require customers with multiple accounts to identify each account to which the opt-out should apply. A licensee must enter its opt-out mailing address in the far right of this form (see version 3); or below the form (see version 4). The reverse side of the mail-in opt-out form must not include any content of the Model Form.

(i) Joint accountholder. Only licensees that provide their joint accountholders the choice to opt out for only one accountholder, in accordance with Paragraph 3(a)(5) of these Instructions, must include in the far left column of the mail-in form the following statement:

If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below.

□ Apply my choice(s) only to me.

The word "choice" may be written in either the singular or plural, as appropriate. Licensees that provide insurance products or services, provide this option, and elect to use the Model Form may substitute the word "policy" for "account" in this statement. Licensees that do not provide this option may eliminate this left column from the mail-in form.

(ii) FCRA Section 603(d)(2)(A)(iii) opt-out. If the licensee shares personal information pursuant to Section 603(d)(2)(A)(iii) of the FCRA, it must include in the mail-in opt-out form the following statement:

□ Do not share information about my creditworthiness with your affiliates for their everyday business purposes.

(iii) FCRA Section 624 opt-out. If the licensee uses Section 624 of the FCRA, in accord with paragraph 2(d)(6) of these Instructions, it must include in the mail-in opt-out form the following statement:

□ Do not allow your affiliates to use my personal information to market to me.

(iv) Nonaffiliate opt-out. If the licensee shares personal information pursuant to [insert citation for section of statute or regulation that parallels Section 12(A) of *NAIC Privacy of Consumer Financial and Health Information Regulation*], it must include in the mail-in opt-out form the following statement:

□ Do not share my personal information with nonaffiliates to market their products and services to me.

(v) Additional opt-outs. Licensees that use the disclosure table to provide opt-out options beyond those required by Federal law must provide those opt-outs in this section of the Model Form. A licensee that chooses to offer an opt-out for its own marketing in the mail-in opt-out form must include one of the two following statements:

□ Do not share my personal information to market to me. or

□ Do not use my personal information to market to me.

A licensee that chooses to offer an opt-out for joint marketing must include the following statement:

□ Do not share my personal information with other financial institutions to jointly market to me.

(h) Barcodes. A licensee may elect to include a barcode and/or "tagline" (an internal identifier) in 6-point type at the bottom of page one, as needed for information internal to the licensee, so long as these do not interfere with the clarity or text of the form.

3. Page Two

(a) General Instructions for the Questions. Certain Questions on the Model Form may be customized as follows:

(i) "Who is providing this notice?" This question may be omitted where only one licensee provides the Model Form and that licensee is clearly identified in the title on Page One. Two or more licensees or financial institutions that jointly provide the Model Form must use this question to identify themselves as required by [insert citation for section of statute or regulation that parallels Section 11(F) of NAIC model *Privacy of Consumer Financial and Health Information Regulation*]. Where the list of licensees or financial institutions exceeds four (4) lines, the licensee must describe in the response to this question the general types of licensees or financial institutions jointly providing the notice and must separately identify those licensees or financial institutions, in minimum 8-point font, directly following the "Other important information" box, or, if that box is not included in the licensee's form, directly following the "Definitions." The list may appear in a multi- column format.

(ii) "How does [name of licensee] protect my personal information?" The licensee may only provide additional information pertaining to its safeguards practices following the designated response to this question. Such information may include information about the licensee's use of cookies or other measures it uses to safeguard personal information. Licensees are limited to a maximum of 30 additional words.

(iii) "How does [name of licensee] collect my personal information?" Licensees must use five (5) of the following terms to complete the bulleted list for this question: open an account; deposit money; pay your bills; apply for a loan; use your credit or debit card; seek financial or tax advice; apply for insurance; pay insurance premiums; file an insurance claim; seek advice about your investments; buy securities from us; sell securities to us; direct us to buy securities; direct us to sell your securities; make deposits or withdrawals from your account; enter into an investment advisory contract; give us your income information; provide employment information; give us your employment history; tell us about your investment or retirement portfolio; tell us about your investment or retirement earnings; apply for financing; apply for a lease; provide account information; give us your contact information; pay us by check; give us your wage statements; provide your mortgage information; make a wire transfer; tell us who receives the money; tell us where to send the money; show your government-issued ID; show your driver's license; order a commodity futures or option trade.

Licensees that collect personal information from their affiliates and/or credit bureaus must include the following statement after the bulleted list: "We also collect your personal information from others, such as credit bureaus, affiliates, or other companies." Licensees that do not collect personal information from their affiliates or credit bureaus but do collect information from other companies must include the following statement instead: "We also collect your personal information from other companies." Only licensees that do not collect any personal information from affiliates, credit bureaus, or other companies can omit both statements.

(iv) "Why can't I limit all sharing?" Licensees that describe state privacy law provisions in the "Other important information" box must use the bracketed sentence: "See below for more on your rights under state law." Other licensees must omit this sentence.

(v) "What happens when I limit sharing for an account I hold jointly with someone else?" Only licensees that provide opt-out options must use this question. Other licensees must omit this question. Licensees must choose one of the following two statements to respond to this question: "Your choices will apply to everyone on your account." or "Your choices will apply to everyone on your account—unless you tell us otherwise." Licensees may substitute the word "policy" for "account" in these statements.

(b) General Instructions for the Definitions. The licensee must customize the space below the responses to the three definitions in this section. This specific information must be in italicized lettering to set off the information from the standardized definitions.

(i) Affiliates. As required by [insert citation for section of statute or regulation that parallels Section 7(A)(3) of *NAIC Privacy of Consumer Financial and Health Information Regulation*], where [affiliate information] appears, the licensee must:

(a) If it has no affiliates, state: "[name of licensee] has no affiliates";

(b) If it has affiliates but does not share personal information with them, state: "[name of licensee] does not share with our affiliates"; or

(c) If it shares with its affiliates, state, as applicable: "Our affiliates include companies with a [common corporate identity of licensee] name; financial companies such as [insert illustrative list of companies]; nonfinancial companies, such as [insert illustrative list of companies]; and others, such as [insert illustrative list]."

(ii) Nonaffiliates. As required by [insert citation for section of statute or regulation that parallels Section 7(C)(3) of *NAIC Privacy of Consumer Financial and Health Information Regulation*], where [nonaffiliate information] appears, the licensee must:

(a) If it does not share with nonaffiliated third parties, state: "[name of licensee] does not share with nonaffiliates so they can market to you"; or

(b) If it shares with nonaffiliated third parties, state, as applicable: "Nonaffiliates we share with can include [list categories of companies such as mortgage companies, insurance companies, direct marketing companies, and nonprofit organizations]."

(iii) Joint Marketing. As required by [insert citation for section of statute or regulation that parallels Section 15 of *NAIC Privacy of Consumer Financial and Health Information Regulation*], where [joint marketing] appears, the licensee must:

(a) If it does not engage in joint marketing, state: "[name of licensee] doesn't jointly market"; or

(b) If it shares personal information for joint marketing, state, as applicable: "Our joint marketing partners include [list categories of companies such as credit card companies]."

(c) General instructions for the "Other important information" box. This box is optional. The space provided for information in this box is not limited, and an additional page may be used if necessary. Only the following types of information can appear in this box:

(i) State and/or international privacy law information; and/or

(ii) A form by which the consumer may acknowledge receipt of the notice.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2000 Proc. 3rd Quarter 7, 10, 14-36, 904 (adopted).
2002 Proc. 3rd Quarter12, 13, 71, 72-73 (amended).
2017 Spring National Meeting (amended).

Version 1:
Model Form with No Opt-Out

Rev. [insert date]

FACTS	WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ■ Social Security number and [income] ■ [account balances] and [payment history] ■ [credit history] and [credit scores] When you are *no longer* our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does [name of licensee] share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes— to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes— information about your transactions and experiences		
For our affiliates' everyday business purposes— information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

Questions?	Call [phone number] or go to [web site]

Page 2

Who we are	
Who is providing this notice?	[insert]
What we do	
How does [name of licensee] protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does [name of licensee] collect my personal information?	We collect your personal information, for example, when you ■ [open an account] or [deposit money] ■ [pay your bills] or [apply for a loan] ■ [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes—information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ *[affiliate information]*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *[nonaffiliate information]*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ *[joint marketing information]*
Other important information	
[insert other important information]	

Version 2: Model Form with Opt-Out by Telephone and/or Online

Rev. [insert date]

FACTS	**WHAT DOES [NAME OF LICENSEE] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ■ Social Security number and [income] ■ [account balances] and [payment history] ■ [credit history] and [credit scores]
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does [name of licensee] share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes— to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes— information about your transactions and experiences		
For our affiliates' everyday business purposes— information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

To limit our sharing	■ Call [phone number] —our menu will prompt you through your choice(s) **or** ■ Visit us online: [web site] **Please note:** If you are a *new* customer, we can begin sharing your information [30] days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call [phone number] or go to [web site]

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Who we are	
Who is providing this notice?	[insert]
What we do	
How does [name of licensee] protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does [name of licensee] collect my personal information?	We collect your personal information, for example, when you ■ [open an account] or [deposit money] ■ [pay your bills] or [apply for a loan] ■ [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes—information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
What happens when I limit sharing for an account I hold jointly with someone else?	[Your choices will apply to everyone on your account.] OR [Your choices will apply to everyone on your account - unless you tell us otherwise.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ *[affiliate information]*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *[nonaffiliate information]*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ *[joint marketing information]*
Other important information	
[insert other important information]	

Rev. [insert date

Version 3: Model Form with Mail-in Opt-Out Form

FACTS	WHAT DOES [NAME OF LICENSEE] DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ■ Social Security number and [income] ■ [account balances] and [payment history] ■ [credit history] and [credit scores]
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does [name of licensee] share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes— to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes— information about your transactions and experiences		
For our affiliates' everyday business purposes— information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

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To limit our sharing	■ Call [phone number] —our menu will prompt you through your choice(s) ■ Visit us online: [web site] or ■ Mail the form below **Please note:** If you are a *new* customer, we can begin sharing your information [30] days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call [phone number] or go to [web site]

Mail-in Form

Leave Blank OR [If you have a joint account, your choice(s) will apply to everyone on your account unless your mark below. ☐ Apply my choices only to me]	Mark any/all you want to limit: ☐ Do not share information about my creditworthiness with your affiliates for their everyday business purposes. ☐ Do not allow your affiliates to use my personal information to market to me. ☐ Do not share my personal information with nonaffiliates to market their products and services to me.	
	Name	
	Address	
	City, State, Zip	
	[Account #]	
Mail To:	[Name of Licensee] [Address] [City], [ST] [ZIP]	

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Who we are	
Who is providing this notice?	[insert]
What we do	
How does [name of licensee] protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does [name of licensee] collect my personal information?	We collect your personal information, for example, when you ■ [open an account] or [deposit money] ■ pay your bills] or [apply for a loan] ■ [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes—information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
What happens when I limit sharing for an account I hold jointly with someone else?	[Your choices will apply to everyone on your account.] OR [Your choices will apply to everyone on your account - unless you tell us otherwise.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ *[affiliate information]*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *[nonaffiliate information]*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ *[joint marketing information]*
Other important information	
[insert other important information]	

Version 4: Optional Mail-in Form

Mail-in Form	
Leave Blank OR [If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below. ☐ Apply my choices only to me]	Mark any/all you want to limit: ☐ Do not share information about my creditworthiness with your affiliates for their everyday business purposes. ☐ Do not allow your affiliates to use my personal information to market to me. ☐ Do not share my personal information with nonaffiliates to market their products and services to me. **Name** **Address** **City, State, Zip** **[Account #]**
Mail To:	[Name of Licensee], [Address 1], [Address 2], [City], [ST] [ZIP]

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-122 (2000/2016).	
Alaska		ALASKA ADMIN. CODE tit. 3, §§ 26.605 to 26.749 (2005/2011).	
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-2101 to 20-2122 (1981/2019).
Arkansas		054.00 ARK. CODE R. §§ 74-1 to 74-26 (2002).	
California		CAL. CODE REGS. tit. 10, §§ 2689.1 to 2689.24 (2002).	CAL. FIN. CODE §§ 4050 to 4060 (2003/2015); CAL. CIV. CODE § 56.30 (2010/2014).
Colorado	3 COLO. CODE REGS. § 702-6:6-4-1 (2000/2018).		
Connecticut		CONN. AGENCIES REGS. §§ 38a-8-105 to 38a-8-123 (2002/2018).	
Delaware	18 DEL. CODE REGS. § 904 (2001/2019).		DEL. CODE ANN. tit. 16, § 1212 (2002/2018).
District of Columbia		D.C. MUN. REGS. tit. 26, §§ 3600.1 to 3699 (2000/2003).	

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida		FLA. ADMIN. CODE ANN. r. 69O-128.001 to 69O-128.024 (2001).	
Georgia			GA. COMP. R. & REGS. 120-2-87 (2001) (requires compliance with GLBA).
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. §§ 431:3A-101 to 431:3A-504 (2001/2019).	
Idaho		IDAHO ADMIN. CODE 18.01.48 (2017).	
Illinois		ILL. ADMIN. CODE tit. 50, §§ 4002.10 to 4002.240 (2001/2017).	
Indiana		760 IND. ADMIN. CODE 1-67-1 to 1-67-20 (2007/2019).	
Iowa		IOWA ADMIN. CODE §§ 191-90.1 to 191-90.26 (2001/2016).	
Kansas		KAN. ADMIN. REGS. § 40-1-46 (2001/2002).	
Kentucky	806 KY. ADMIN. REGS. 3:210 to 3:230 (2001/2017).		
Louisiana		LA. ADMIN. CODE tit. 37, §§ XIII.9901 to XIII.9955 (Regulation 76) (2001/2017).	LA. REV. STAT. ANN. § 22:1079 (2003/2009).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2220 (2001) (authority to adopt regulations); BULLETIN 308 (2001).
Maryland		MD. CODE REGS. 31.16.08.01 to 31.16.08.24 (2002/2017).	
Massachusetts			MASS. GEN. LAWS ch. 175I, §§ 1 to 22 (1991/1996).

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.501 to 500.547 (2001).	BULLETIN 2001-06-OFIS (2001).
Minnesota			MINN. STAT. §§ 72A.49 to 72A.505 (1989/2014).
Mississippi		19 MISS. CODE R. §§ 28.01 to 28.27 (2012/2018).	
Missouri		MO. CODE REGS. ANN. tit. 20, § 100-6.100 (2002/2019).	
Montana			MONT. ADMIN. R. 6.6.6901 to 6.6.6904 (2002).
Nebraska		NEB. REV. STAT. § 44-901 to 44-925 (2001/2019).	
Nevada		NEV. ADMIN. CODE §§ 679B.800 to 679B.878 (2002/2018).	
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 3001 to 3007 (2001/2019).		
New Jersey			BULLETIN 2000-15 (2000); BULLETIN 2001-10 (2001).
New Mexico		N.M. CODE R. §§ 13.1.3.1 to 13.1.3.28 (2002).	
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 420.0 to 420.25 (Regulation 169) (2001/2017).	
North Carolina			N.C. GEN. STAT. §§ 58-39-1 to 59-39-125 (1981/2019).
North Dakota		N.D. ADMIN. CODE 45-14-01-01 to 45-14-01-25 (2001/2004).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3904.1 to 3904.22 (1994/1997).

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma		OKLA. ADMIN. CODE §§ 365:35-1-1 to 365:35-1-54 (2002).	
Oregon			OR. ADMIN. R. 836-080-0501 to 836-080-0551 (2002/2006); 836-080-0600 to 836-080-0700 (2005).
Pennsylvania		31 PA. CODE §§ 146a.1 to 146a.44 (2001/2019); §§ 146b.1 to 146b.24 (2002).	
Puerto Rico		P.R. REGS. OCS § 6538 (Rule 75) (2003).	RULING D-203-2016 (2016).
Rhode Island	230-20-60 R.I. CODE R. §§ 7.1 to 7.26 (2001/2018).		R.I. GEN. LAWS §§ 5-37.3-1 to 5-37.3-11 (1978/2019).
South Carolina	S.C. CODE ANN. REGS. 69-58 (2001/2017).		
South Dakota		S.D. ADMIN. R. 20:06:45 (2001/2004).	
Tennessee		TENN. COMP. R. & REGS. 0780-1-72 (2001).	
Texas	BULLETIN B-0030-01 (2001).	28 TEX. ADMIN. CODE §§ 22.1 to 22.27 (2001/2017); §§ 22.51 to 22.67 (2002).	
Utah	UTAH ADMIN. CODE r. 590-206-1 to 590-206-26 (2000/2017).		
Vermont	4-2 VT. CODE R. 10:1 to 10:26 (2018).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-600 to 38.2-620 (1986/2017).

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	WASH. ADMIN. CODE 284-04-120 to 284-04-625 (2002/2018).		
West Virginia		W. VA. CODE R. §§ 114-57-1 to 144-57-22 (2001/2002).	
Wisconsin		WIS. ADMIN. CODE INS. §§ 25.01 to 25.95 (2001/2018).	
Wyoming		44-54 WYO. CODE R. §§ 1 to 26 (2001).	

PROJECT HISTORY - 2017

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION REGULATION (#672)

1. Description of the Project, Issues Addressed, etc.

This project was to: 1) review the *Privacy of Consumer Financial and Health Information Regulation* (#672) to determine what, if any, changes should be made to the model regulation to be more consistent with the amendments to Regulation P (Privacy of Consumer Financial Information), which create an alternative electronic delivery option of privacy notices by financial institutions to consumers; and 2) review the sample privacy notices of Model #672, which provide a safe harbor of compliance with state privacy notice requirements, to determine what, if any, changes should be made to the sample privacy notices to be more consistent with the privacy model notice form issued by federal regulatory agencies for use by financial institutions as a safe harbor of compliance with the privacy notification requirements of the federal Gramm-Leach-Bliley Act (GLBA).

2. Name of Group Responsible for Drafting the Model and States Participating

The Privacy Disclosures (D) Working Group was responsible for reviewing all pertinent documents and determining if any changes to Model #672 were needed. The states participating were Washington (chair), Colorado (vice chair), California, Connecticut, Maine, Maryland, Massachusetts, Missouri, Ohio, Oklahoma, Pennsylvania, Vermont, Virginia and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

When this Working Group was created in 2015, this project was authorized by the following charges: "Review the *Privacy of Consumer Financial and Health Information Regulation* (#672) to determine what, if any, changes should be made to the model regulation to be more consistent with the amendments to Regulation P (Privacy of Consumer Financial Information), which create an alternative electronic delivery option of privacy notices by financial institutions to consumers, and to review the sample privacy notices of the *Privacy of Consumer Financial and Health Information Regulation* (#672), which provide a safe harbor of compliance with state privacy notice requirements, to determine what, if any, changes should be made to the sample privacy notices to be more consistent with the privacy model notice form issued by federal regulatory agencies for use by financial institutions as a safe harbor of compliance with the privacy notification requirements of the federal Gramm-Leach-Bliley Act."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

After soliciting input from regulators, industry and consumer subject matter experts, NAIC staff worked with the Working Group chair to draft proposed revisions to Model #672.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

Background
The issue of privacy disclosures and the development of disclosures had been discussed by various working groups at the NAIC since 2004. The following process describes the discussion, which has occurred since 2015 when the Privacy Disclosures (D) Working Group was given its charges.

August 2015 (NAIC 2015 Summer National Meeting)
The Working Group chair provided a briefing on past activities. The Working Group discussed the electronic delivery of privacy notices and the sample privacy notices in Model #672.

November 2015 (NAIC 2015 Fall National Meeting)
Brenda J. Cude (University of Georgia) and Sonja Larkin-Thorne (Consumer Advocate) gave a presentation and recommended: 1) the NAIC GLBA Notices Bulletin, adopted by the NAIC in 2010, be archived; 2) the sample privacy notices in Model #672 be sunset and replaced with the federal model privacy form; and 3) establish electronic delivery of privacy notices as the default delivery method when no delivery method is selected by a consumer. Industry comments on the consumer recommendations were made by Robbie Meyer (American Council of Life Insurers—ACLI).

April 2016 (NAIC 2016 Spring National Meeting)
Following a 30-day exposure period of proposed revisions to Model #672, the Working Group discussed comments received from industry, insurance regulators and consumer representatives. In response to the federal Fixing America's Surface Transportation Act (FAST Act), which was enacted into law on Dec. 4, 2015, the proposed revisions to Model #672 included amendments to Section 6 to eliminate the requirement for financial institutions to provide annual privacy notices if certain conditions are met. This was done to be consistent with the FAST Act, which included an amendment to the GLBA to eliminate the requirements for financial institutions to provide annual privacy notices if certain conditions were met.

The Working Group adopted revisions to Section 6 of Model #672 at this meeting. At the same time, the Working Group adopted an NAIC Model Bulletin to address the FAST Act amendments to the GLBA annual privacy notice requirements. This bulletin was adopted for potential issuance by a state to clarify that a "licensee" subject to the GLBA annual privacy notice requirements is no longer required to provide an annual privacy notice if certain conditions are met.

The Market Regulation and Consumer Affairs (D) Committee adopted the bulletin at this national meeting. The Market Regulation and Consumer (D) Committee did not adopt the revisions to Section 6 of Model #672 since the Working Group was continuing to make further revisions to the model.

August 2016 (Open Conference Call)
The Working Group discussed the process for the NAIC Executive (EX) Committee and Plenary to adopt the NAIC GLBA Privacy Notices Bulletin during the NAIC Summer National Meeting. The Working Group decided to continue meeting in a series of conference calls going forward rather than meeting at national meetings.

September and October 2016 (Open Conference Calls)
The Working Group discussed revisions to Model #672, which would replace the sample privacy notices in Model #672 with the federal model privacy form.

November 2016 (Open Conference Call)
After a 30-day exposure period, the Working Group had an extended period of negotiating and wordsmithing between regulators, industry and consumer representatives during the November call.

The Working Group adopted revisions to replace the sample privacy notices, which provide a safe harbor of compliance with the privacy notice content requirements, with the Federal Model Privacy Form. The federal model privacy form was issued by federal regulatory agencies for use by financial institutions, such as banks and security investment companies, as a safe harbor of compliance with the privacy notification requirements of GLBA. As part of this adoption, the Working Group added Appendix B, which provides instructions on the use of the federal model privacy form.

December 2016 (NAIC 2016 Fall National Meeting)
During the 2016 Fall National Meeting, the Market Regulation and Consumer Affairs (D) Committee adopted the revisions to Model 672.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The revisions accomplish the following:

- Eliminate the requirement for financial institutions to provide annual privacy notices if certain conditions are met.
- Sunset the safe harbor of compliance with the privacy notice content requirements for the existing sample privacy notice clauses 18 months from Jan. 1, 2018 (by July 1, 2019).
- Create a new safe harbor of compliance with the privacy notice content requirements by replacing the existing sample privacy notice clauses with the federal model privacy form.
- Allow additional variations of the federal model privacy form, but without an explicit safe harbor of compliance.

Items of some controversy were whether to sunset the use of the sample clauses in the model as a safe harbor; whether to require and sunset as a safe harbor the use of the federal model privacy form; and the amount of transition time for the revisions to the model to become effective. Also of some controversy was the lack of uniformity, specifically the different versions of the model in effect in states.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

PROJECT HISTORY - 2002

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION MODEL REGULATION (#672)

1. Project Description

The amendment to the Privacy of Consumer Financial and Health Information Model Regulation was drafted to ensure that the original intent of the model regulation with respect to the treatment of group policies was implemented by licensees. The amendment clarifies that licensees are required to provide privacy notices to group policyholders, including holders of group life, health and workers compensation plans, if they choose not to provide notices to individuals covered under such policies. Licensees are required to provide notices to individuals covered under such policies only if the licensee chooses to disclose nonpublic personal financial information outside the model regulation's legal, business and joint marketing exceptions.

2. Group Responsible for Drafting Model and States Participating

The Privacy Issues Working Group developed the model. The members of that working group are New York, Co-Chair, Florida, Co-Chair, Kansas, Vice Chair, California, Delaware, District of Columbia, Kentucky, Maine, Minnesota, Missouri, Montana, Ohio, Pennsylvania, South Carolina, Texas, Virginia, West Virginia, Wisconsin, and Wyoming.

3. General Description of Drafting Process

The Privacy Issues Working Group decided to amend the Privacy of Consumer Financial and Health Information Model Regulation in March 2002 after several meetings of the Privacy Working Group at which certain interested parties disagreed with the treatment of group policies under the model regulation. Prior to that, working group members had drafted an analysis that explained the treatment of group policyholders. The intent was to include the analysis in the privacy Q&A on the NAIC website. Although the working group agreed with the content of the analysis, working group members decided to amend the model in order to avoid any further misinterpretation of the group policyholder requirement and ensure the original intent of the model regulation with respect to the treatment of group policyholders was implemented by licensees.

A draft amendment was distributed to interested parties for comment in June 2002. The working group received and reviewed numerous comments from interested parties. The amendment was revised and a second draft was distributed publicly in August 2002. The working group received additional comments in writing and orally at the Privacy Issues Working Group meeting in New Orleans on September 10, 2002. The amendment was adopted by the working group at their meeting on September 10, 2002.

4. Significant Issues Raised

As stated above, the amendment ensures that the original intent of the treatment of group policyholders under the model privacy regulation is implemented. This issue was the subject of much discussion during the initial drafting of the model regulation and the language in the model regulation was the result of a compromise between the drafters and interested parties. The major trade associations supported final adoption of the model regulation, and, according to NAIC records, no objections to this compromise were raised.

The amendment does not change the compromise or the intent of the regulation. It merely ensures that the model regulation is being interpreted correctly. Indeed, most of the states are interpreting the current regulation in this manner.

The only interested parties that raised substantive objections to the amendment were property and casualty trade groups, most notably the American Insurance Association (AIA). During the debate on the amendment, AIA made no assertions about the language as it applies to group health or life policies, but objected to the requirement that insurers providing workers compensation coverage deliver notices to employers. Their objections were based on two arguments:

(i) they interpreted the model language to require licensees to treat individuals covered under workers compensation policies as consumers ONLY if the licensee discloses information outside the exceptions in sections 14, 15 and 16 of the model regulation; therefore, under their interpretation, if the licensee was not disclosing information outside of the exemptions in sections 14, 15 and 16, neither the group policyholder nor the individuals covered under the policy would receive any privacy notice; and

(ii) workers compensation should not be covered under the model regulation because it is a commercial line.

The working group responded as follows:

(i) AIA's interpretation of the treatment of group policyholders is incorrect. The original intent of the model regulation was to require that licensees send notices to group policyholders if licensees chose not to provide notices to individuals covered by such policies. Individuals would receive notices only if a licensee wished to disclose an individual's nonpublic personal financial information outside the legal, business, and joint marketing exceptions. Under AIA's interpretation, group policyholders would never receive notices and individuals would only receive notices if information was disclosed outside the exceptions. It should be noted that both the life and health trade associations agreed with the working group's interpretation of the treatment of group policyholders under the model regulation.

(ii) When the model privacy regulation was drafted, the decision was made to include group policies – including workers compensation – because the benefits of such policies accrue to individuals for personal, family or household use. Although technically commercial policies, the working group believed that there was no reason to treat nonpublic personal information about individuals covered under such policies different from other insurance policyholders. In addition, GLBA explicitly permits the states to enact rules that are more protective of consumer privacy than the GLBA standards, thus enabling the states to protect information covered under commercial policies.

In addition to the substantive issue described above, interested parties also expressed concern that opening the model to any amendment could cause problems maintaining uniformity across the states because amending the model might encourage individual states to make other changes in their privacy rules that would differ from state to state. However, as noted above, most states are interpreting the regulation in this manner. To address this concern, it was decided that a drafting note or cover letter would be included advising that if a state currently interprets its regulation in accordance with the original intent, it need not amend its regulation.

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

Table of Contents

Section 1. Preamble

A. This regulation establishes standards for developing and implementing administrative, technical and physical safeguards to protect the security, confidentiality and integrity of customer information, pursuant to Sections 501, 505(b), and 507 of the Gramm-Leach-Bliley Act, codified at 15 U.S.C. 6801, 6805(b) and 6807.

B. Section 501(a) provides that it is the policy of the Congress that each financial institution has an affirmative and continuing obligation to respect the privacy of its customers and to protect the security and confidentiality of those customers' nonpublic personal information. Section 501(b) requires the state insurance regulatory authorities to establish appropriate standards relating to administrative, technical and physical safeguards: (1) to ensure the security and confidentiality of customer records and information; (2) to protect against any anticipated threats or hazards to the security or integrity of such records; and (3) to protect against unauthorized access to or use of records or information that could result in substantial harm or inconvenience to a customer.

C. Section 505(b)(2) calls on state insurance regulatory authorities to implement the standards prescribed under Section 501(b) by regulation with respect to persons engaged in providing insurance.

D. Section 507 provides, among other things, that a state regulation may afford persons greater privacy protections than those provided by subtitle A of Title V of the Gramm-Leach-Bliley Act. This regulation requires that the safeguards established pursuant to this regulation shall apply to nonpublic personal information, including nonpublic personal financial information and nonpublic personal health information.

Section 2. Definitions

For purposes of this regulation, the following definitions apply:

A. "Customer" means a customer of the licensee as the term customer is defined in [cite applicable section of state regulation that corresponds with the NAIC Privacy of Consumer Financial and Health Information Model Regulation].

B. "Customer information" means nonpublic personal information as defined in Section [cite applicable section of state regulation that corresponds with Section 4S of the NAIC Privacy of Consumer Financial and Health Information Model Regulation] about a customer, whether in paper, electronic or other form, that is maintained by or on behalf of the licensee.

C. "Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect or dispose of customer information.

D. "Licensee" means a licensee as that term is defined in Section [cite applicable section of state regulation that corresponds with Section 4Q of the NAIC Privacy of Consumer Financial and Health Information Model Regulation], except that "licensee" shall not include: a purchasing group; or an unauthorized insurer in regard to the excess line business conducted pursuant to [cite applicable regulation or section of state insurance law].

Drafting Note: Service contract providers and extended warranty providers are "licensees" under the insurance laws of many states. Regulators should consider whether they wish to subject these entities to the requirements of this regulation.

E. "Service provider" means a person that maintains, processes or otherwise is permitted access to customer information through its provision of services directly to the licensee.

Section 3. Information Security Program

Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

Section 4. Objectives of Information Security Program

A licensee's information security program shall be designed to:

A. Ensure the security and confidentiality of customer information;

B. Protect against any anticipated threats or hazards to the security or integrity of the information; and

C. Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

Section 5. Examples of Methods of Development and Implementation

The actions and procedures described in Sections 6 through 9 of this regulation are examples of methods of implementation of the requirements of Sections 3 and 4 of this regulation. These examples are non-exclusive illustrations of actions and procedures that licensees may follow to implement Sections 3 and 4 of this regulation.

Section 6. Assess Risk

The licensee:

A. Identifies reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration or destruction of customer information or customer information systems;

B. Assesses the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and

C. Assesses the sufficiency of policies, procedures, customer information systems and other safeguards in place to control risks.

Section 7. Manage and Control Risk

The licensee:

A. Designs its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;

B. Trains staff, as appropriate, to implement the licensee's information security program; and

C. Regularly tests or otherwise regularly monitors the key controls, systems and procedures of the information security program. The frequency and nature of these tests or other monitoring practices are determined by the licensee's risk assessment.

Section 8. Oversee Service Provider Arrangements

The licensee:

A. Exercises appropriate due diligence in selecting its service providers; and

B. Requires its service providers to implement appropriate measures designed to meet the objectives of this regulation, and, where indicated by the licensee's risk assessment, takes appropriate steps to confirm that its service providers have satisfied these obligations.

Section 9. Adjust the Program

The licensee monitors, evaluates and adjusts, as appropriate, the information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to customer information systems.

Section 10. Determined Violation

Drafting Note: Cite Unfair Trade Practices Act or other applicable state law.

Section 11. Effective Date

Each licensee shall establish and implement an information security program, including appropriate policies and systems pursuant to this regulation by [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2002 Proc. 1st Quarter 99, 101-103 (model adopted later is printed here).
2002 Proc. 2nd Quarter 7-8 (adopted).

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-126 (2003).		
Alaska	ALASKA ADMIN. CODE tit. 3, § 26.705 (2005).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE §§ 20-6-2101 to 20-6-2104 (2004).		
Arkansas	054.00.77 ARK. CODE R. § 1-13 (2003).		BULLETIN 1-2006 (2006).
California	CAL. CODE REGS. tit. 10, §§ 2689.12 to 2689.20 (2003).		
Colorado	3 COLO. CODE REGS. § 702-6:6-4-2 (2003).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-8-124 to 38a-8-126 (2004).		
Delaware	18 DEL. CODE REGS. § 905 (2002/2003).		
District of Columbia	D.C. MUN. REGS. tit 26, §§ 3613 to 3620.1 (2003).		

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69O-128.030 to 69O-128.035 (2002).		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. § 28-51-105 (2006/2014).
Illinois	ILL. ADMIN. CODE tit. 50, §§ 4003.10 to 4003.110 (2003).		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-90.37 to 191-90.40 (2002)		
Kansas	NO CURRENT ACTIVITY		
Kentucky	806 KY. ADMIN. REGS. 3:230 (2004).		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. CODE R. § 980 (2004).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts			201 MASS. CODE REGS. 17.00 to 17.05 (2008/2009).
Michigan	MICH. ADMIN. CODE r. 500.551 to 500.560 (2004).		
Minnesota	MINN. STAT. §§ 60A.98 to 60A.982 (2005/2014).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 100-6.110 (2003).		
Montana	MONT. ADMIN. R. 6.6.7001 to 6.6.7019 (2005).		

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	210 NEB. ADMIN. CODE § 77 (2003).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 3701.01 to 3711.01 (2004).		
New Jersey	N.J. ADMIN. CODE §§ 11:1-44.1 to 11:1-44.11 (2004).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 421.0 to 421.10 (Regulation 173) (2002).		
North Carolina	N.C. GEN. STAT. §§ 58-39-130 to 58-39-165 (2003).		
North Dakota	N.D. ADMIN. CODE 45-14-02-01 to 45-14-02-03 (2004).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. ADMIN. CODE §§ 365:35-3-1 to 365:35-3-11 (2005).		
Oregon	OR. ADMIN. R. 836-081-0101 to 836-081-0126 (2003).		
Pennsylvania	31 PA. CODE §§ 146c.1 to 146c.11 (2005).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230-20 R.I. CODE R. §§ 8.1 to 8.12 (2005).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. ADMIN. R. §§ 20:06:45:20 to 20:06:45:26 (2003).		

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE r. 590-216-1 to 590-216-8 (2002/2012).		
Vermont	VT. CODE R. IH-2002-3 (2003).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-613.2 (2003) (portions of model).		ADMINISTRATIVE LETTER 2003-4 (2003).
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE §§ 114-62-1 to 114-62-6 (2002).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	044-55 WYO. CODE R. § 1-12 (2003).		

UNIFORM FRATERNAL CODE

Table of Contents

Section 1. Fraternal Benefit Societies Defined

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of Section 42B of this Article whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which makes provision for the payment of benefits in accordance with this Article, is hereby declared to be a fraternal benefit society.

When used in this Article the word "society," unless otherwise indicated, shall mean fraternal benefit society.

Section 2. Lodge System Defined

A society having a supreme legislative or governing body and subordinate lodges or branches by whatever name known, into which members are elected, initiated or admitted in accordance with its constitution, laws ritual and rules, which subordinate lodges or branches shall be required by the laws of the society to hold regular meetings at least once in each month, shall be deemed to be operating on the lodge system.

Section 3. Representative Form of Government Defined

A society shall be deemed to have a representative form of government when:

A. It provides in its constitution or laws for a supreme legislative or governing body, composed of representatives elected either by the members or by delegates elected directly or indirectly by the members, together with such other members of such body as may be prescribed by the society's constitution and laws;

B. The representatives elected constitute a majority in number and have not less than two-thirds of the votes nor less than the votes required to amend its constitution and laws;

C. The meetings of the supreme legislative or governing body and the election of officers, representatives or delegates are held as often as once in four (4) calendar years;

D. Each insured member shall be eligible for election to act or serve as a delegate to such meeting;

E. The society has a board of directors charged with the responsibility for managing its affairs in the interim between meetings of its supreme legislative or governing body, subject to control by such body and having powers and duties delegated to it in the constitution or laws of the society;

F. Such board of directors is elected by the supreme legislative or governing body, except in case of filling a vacancy in the interim between meetings of such body;

G. The officers are elected either by the supreme legislative or governing body or by the board of directors; and

H. The members, officers, representatives or delegates shall not vote by proxy.

Section 4. Organization

The organization of a society shall be governed as follows:

A. Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds or articles of incorporation, in which shall be stated:

(1) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(2) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this Article, provided that any lawful, social, intellectual, educational, charitable, benevolent, moral, fraternal or religious advantages may be set forth among the purposes of the society; and

(3) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme legislative or governing body, which election shall be held not later than one year from the date of the issuance of the permanent certificate.

B. Such articles of incorporation, duly certified copies of the constitution, laws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commissioner of Insurance, who may require such further information as he deems necessary. The bond with sureties approved by the Commissioner of Insurance shall be in such amount, not less than $5,000 nor more than $25,000, as required by the Commissioner of Insurance. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this Article and all provisions of the law have been complied with, the Commissioner of Insurance shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commissioner of Insurance upon cause shown unless the 500 applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

D. Upon receipt of a preliminary certificate from the Commissioner of Insurance, the society may solicit members for the purpose of completing its organization, shallcollect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates as provided by its constitution and laws, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any death or disability benefit to any person until:

(1) Actual bona fide applications for death benefits have been secured aggregating at least $500,000 on not less than 500 lives;

(2) All such applicants for death benefits shall have furnished evidence of insurability satisfactory to the society;

(3) Certificates of examinations or acceptable declarations of insurability have been duly filed and approved by the chief medical examiner of the society;

(4) Ten (10) subordinate lodges or branches have been established into which the 500 applicants have been admitted;

(5) There has been submitted to the Commissioner of Insurance, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate branch of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(6) It shall have been shown to the Commissioner of Insurance, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least $2,500 dollars, all of which shall be credited to the fund or funds from which benefits are to be paid and no part of which may be used for expenses. Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, as herein provided, such premiums shall be returned to said applicants.

E. The Commissioner of Insurance may make such examination and require such further information as he deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, he shall issue to the society a certificate to that effect and that the society is authorized to transact business pursuant to the provisions of this Article. The certificate shall be prima facie evidence of the existence of the society at the date of such certificate. The Commissioner of Insurance shall cause a record of such certificate to be made. A certified copy of such record may be given in evidence with like effect as the original certificate.

F. Every society shall have the power to adopt a constitution and laws for the government of the society, the admission of its members, the management of its affairs and the fixing and readjusting of the rates of its members from time to time. It shall have the power to change, alter, add to or amend such constitution and laws and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

Section 5. Corporate Powers Retained

Any incorporated society authorized to transact business in this state at the time this Article becomes effective may thereafter exercise all the rights, powers and privileges prescribed in this Article and in its charter or articles of incorporation as far as consistent with this Article. A domestic society shall not be required to reincorporate.

Section 6. Existing Voluntary Associations--May Incorporate

After one year from the effective date of this Article, no unincorporated or voluntary association shall be permitted to transact business in this state as a fraternal benefit society.

Any domestic voluntary association now authorized to transact business in this state may incorporate and shall receive from the Commissioner of Insurance a permanent certificate of incorporation as a fraternal benefit society when:

A. It shall have completed its conversion to an incorporated society not later than one year from the effective date of this Article;

B. It has filed its articles of incorporation and has satisfied the other requirements described in Section 4; and

C. The Commissioner of Insurance shall have made such examination and procured whatever additional information he shall deem advisable.

Every voluntary association so incorporated shall incur the obligations and enjoy the benefits thereof the same as though originally incorporated, and such corporation shall be deemed a continuation of the original voluntary association. The officers thereof shall serve through their respective terms as provided in its original articles of association, but their successors shall be elected and serve as provided in its articles of incorporation. Incorporation of a voluntary association shall not affect existing suits, claims or contracts.

Section 7. Location of Office--Place of Meeting

The principal office of any domestic society shall be located in this state. The meetings of its supreme legislative or governing body may be held in any state, district, province or territory wherein such society has at least five (5) subordinate branches and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state.

Section 8. Consolidations and Mergers

A domestic society may consolidate or merge with any other society by complying with the provisions of this section.

It shall file with the Commissioner of Insurance:

A. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

B. A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the Commissioner of Insurance but not earlier than December thirty-first, next preceding the date of the contract;

C. A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme legislative or governing body of each society; and

D. Evidence that at least sixty (60) days prior to the action of the supreme legislative or governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official organ of each society.

If the Commissioner of Insurance finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, he shall approve the contract and issue his certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the Commissioner of Insurance of this state or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the Commissioner of Insurance of such state or territory and a certificate of such approval filed with the Commissioner of Insurance of this state.

Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished to the addressees.

Section 9. Conversion of Fraternal Benefit Society into Mutual Life Insurance Company

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of [insert section numbers of sections dealing with financial requirements of mutual life insurance companies] if such plan of conversion has been approved by the Commissioner of Insurance. Such plan shall be prepared in writing setting forth in full the terms and conditions thereof. The board of directors shall submit such plan to the supreme legislative or governing body of such society at any regular or special meeting thereof, by giving a full, true and complete

copy of such plan with the notice of such meeting. Such notice shall be given as provided in the laws of the society for the convocation of a regular or special meeting of such body, as the case may be. The affirmative vote of two-thirds of all members of such body shall be necessary for the approval of such agreement. No such conversion shall take effect unless and until approved by the Commissioner of Insurance who may give such approval if he finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

Section 10. Qualifications for Membership

A society may admit to benefit membership any person not less than fifteen (15) years of age, nearest birthday, who has furnished evidence of insurability acceptable to the society. Any such member who shall apply for additional benefits more than six (6) months after becoming a benefit member shall furnish additional evidence of insurability acceptable to the society unless such additional benefits are issued pursuant to an existing contract under the terms of which such member is entitled to purchase such additional benefits without furnishing evidence of insurability.

Any person admitted prior to attaining the full age of twenty-one (21) years shall be bound by the terms of the application and certificate and by all the laws and rules of the society and shall be entitled to all the rights and privileges of membership therein to the same extent as though the age of majority had been attained at the time of application. A society may also admit general or social members who shall have no voice or vote in the management of its insurance affairs.

Section 11. Articles of Incorporation, Constitution and Laws - Amendments

A domestic society may amend its articles of incorporation, constitution or laws in accordance with the provisions thereof by action of its supreme legislative or governing body at any regular or special meeting thereof or, if its articles of incorporation, constitution or laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its articles of incorporation, constitution or laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges or branches. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of submission thereof, a majority of all of the voting members of the society shall have signified their consent to such amendment by one of the methods herein specified.

No amendment to the articles of incorporation, constitution or laws of any domestic society shall take effect unless approved by the Commissioner of Insurance who shall approve such amendment if he finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the Commissioner of Insurance shall disapprove any such amendment within sixty (60) days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the Commissioner of Insurance shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case he disapproves such amendment, the reasons therefor shall be stated in such written notice.

Within ninety (90) days from the approval thereof by the Commissioner of Insurance, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official organ of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

Every foreign or alien society authorized to do business in this state shall file with the Commissioner of Insurance a duly certified copy of all amendments of, or additions to, its articles of incorporation, constitution or laws within ninety (90) days after the enactment of same.

Printed copies of the constitution or laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

Section 12. Institutions

It shall be lawful for a society to create, maintain and operate charitable, benevolent or educational institutions for the benefit of its members and their families and dependents and for the benefit of children insured by the society. For such purpose it may own, hold or lease personal property or real property located within or without this state, with necessary buildings thereon. Such property shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

Maintenance, treatment and proper attendance in any such institution may be furnished free or a reasonable charge may be made therefor, but no such institution shall be operated for profit. The society shall maintain a separate accounting of any income and disbursements under this section and report them in its annual statement. No society shall own or operate funeral homes or undertaking establishments.

Section 13. No Personal Liability

The officers and members of the supreme, grand or any subordinate body of a society shall not be personally liable for payment of any benefits provided by a society.

Section 14. Benefits

A. A society authorized to do business in this state may provide for the payment of:

(1) Death benefits in any form;

(2) Endowment benefits;

(3) Annuity benefits;

(4) Temporary or permanent disability benefits as a result of disease or accident;

(5) Hospital, medical or nursing benefits due to sickness or bodily infirmity or accident; and

(6) Monument or tombstone benefits to the memory of deceased members not exceeding in any case the sum of $300.

B. Such benefits may be provided on the lives of members or, upon application of a member, on the lives of the member's family, including the member, the member's spouse and minor children, in the same or separate certificates.

Section 15. Benefits on Lives of Children

A society may provide for benefits on the lives of children under the minimum age for adult membership but not greater than twenty-one (21) years of age at time of application therefor, upon the application of some adult person, as its laws or rules may provide, which benefits shall be in accordance with the provisions of Section 14A of this Article. A society may, at its option, organize and operate branches for such children. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice in the management of the society.

A society shall have power to provide for the designation and changing of designation of beneficiaries in the certificates providing for such benefits and to provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith.

Section 16. Nonforfeiture Benefits, Cash Surrender Values, Certificate Loans and Other Options

A society may grant paid-up nonforfeiture benefits, cash surrender values, certificate loans and such other options as its laws may permit. As to certificates issued on and after the effective date of this Article, a society shall grant at least one paid-up nonforfeiture benefit, except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term

insurance contracts or contracts of term insurance of uniform amount of fifteen (15) years or less expiring before age sixty-six (66).

In the case of certificates other than those for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the excess, if any, of (a) over (b) as follows:

A. The reserve under the certificate determined on the basis specified in the certificate; and

B. The sum of any indebtedness to the society on the certificate, including interest due and accrued, and a surrender charge equal to two and one-half per cent (2-1/2%) of the face amount of the certificate, which, in the case of insurance on the lives of children, shall be the ultimate face amount of the certificate, if death benefits provided therein are graded.

However, in the case of certificates issued on a substandard basis or in the case of certificates, the reserves for which are computed upon the American Men Ultimate Table of Mortality, the term of any extended insurance benefit granted including accompanying pure endowment, if any, may be computed upon the rates of mortality not greater than 130 per cent of those shown by the mortality table specified in the certificate for the computation of the reserve.

In the case of certificates for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the provisions of the laws of this state applicable to life insurance companies issuing policies containing like insurance benefits based upon such tables.

Section 17. Beneficiaries

The member shall have the right at all times to change the beneficiary or beneficiaries in accordance with the constitution, laws or rules of the society. Every society by its constitution, laws or rules may limit the scope of beneficiaries and shall provide that no beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the insurance contract.

A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of $500.

If, at the death of any member, there is no lawful beneficiary to whom the insurance benefits shall be payable, the amount of such benefits, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased member.

Section 18. Benefits Not Attachable

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

Section 19. The Contract

Every society authorized to do business in this state shall issue to each benefit member a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the charter or articles of incorporation, the constitution and laws of the society, the application for membership, and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the agreement, as of the date of issuance, between the society and the member, and the certificate shall so state. A copy of the application for membership and of the declaration of insurability, if any, shall be endorsed upon or attached to the certificate.

All statements purporting to be made by the member shall be representations and not warranties. Any waiver of this provision shall be void.

Any changes, additions or amendments to the charter or articles of incorporation, constitution or laws duly made or enacted subsequent to the issuance of the certificate, shall bind the member and the beneficiaries, and shall govern and control the agreement in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for membership, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the member as of the date of issuance.

Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

A society shall provide in its constitution or laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the member to the society the amount of the member's equitable proportion of such deficiency as ascertained by its board, and that if the payment be not made it shall stand as an indebtedness against the certificate and draw interest not to exceed five per cent (5%) per annum compounded annually.

Section 20. Life Benefit Certificate Provisions, Standard and Prohibited

After one year from the effective date of this Article, no life benefit certificate shall be delivered or issued for delivery in this state unless a copy of the form shall have been file with theCommissioner of Insurance. (If approval of certificate forms is desired, insert: "and approved by him as conforming to the requirements of this section and not inconsistent with any other provisions of law applicable thereto. A certificate shall be deemed approved unless disapproved by the Commissioner of Insurance within sixty (60) days from the date of such filing.")

A. The certificate shall contain in substance the following standard provisions or, in lieu thereof, provisions which are more favorable to the member:

(1) Title on the face and filing page of the certificate clearly and correctly describing its form;

(2) A provision stating the amount of rates, premiums or other required contributions, by whatever name known, which are payable by the insured under the certificate;

(3) A provision that the member is entitled to a grace period of not less than a full month (or thirty (30) days at the option of the society) in which the payment of any premium after the first, may be made. During such grace period the certificate shall continue in full force, but in case the certificate becomes a claim during the grace period before the overdue payment is made, the amount of such overdue payment or payments may be deducted in any settlement under the certificate;

(4) A provision that the member shall be entitled to have the certificate reinstated at any time within three (3) years from the due date of the premium in default, unless the certificate has been completely terminated through the application of a nonforfeiture benefit, cash surrender value or certificate loan, upon the production of evidence of insurability satisfactory to the society and the payment of all overdue premiums and any other indebtedness to the society upon the certificate, together with interest on such premiums and such indebtedness, if any, at a rate not exceeding six per cent (6%) per annum compounded annually;

(5) Except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts, or contracts of term insurance of uniform amount of fifteen (15) years or less expiring before age sixty-six (66), a provision that, in the event of default in payment of any premium after three (3) full years' premiums have been paid or after premiums for a lesser period have been paid if the contract so provides, the society will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on the plan stipulated in the certificate, effective as of such due date, of such value as specified in this

Article. The certificate may provide, if the society's laws so specify or if the member shall so elect prior to the expiration of the grace period of any overdue premium, that default shall not occur so long as premiums can be paid under the provisions of an arrangement for automatic premium loan as may be set forth in the certificate;

(6) A provision that one paid-up nonforfeiture benefit as specified in the certificate shall become effective automatically unless the member elects another available paid-up nonforfeiture benefit, not later than sixty (60) days after the due date of the premium in default;

(7) A statement of the mortality table and rate of interest used in determining all paid-up nonforfeiture benefits and cash surrender options available under the certificate, and a brief general statement of the method used in calculating such benefits;

(8) A table showing in figures the value of every paid-up nonforfeiture benefit and cash surrender option available under the certificate for each certificate anniversary either during the first twenty (20) certificate years or during the term of the certificate whichever is shorter;

(9) A provision that the certificate shall be incontestable after it has been in force during the lifetime of the member for a period of two (2) years from its date of issue except for nonpayment of premiums, violation of the provisions of the certificate relating to military, aviation, or naval service and violation of the provisions relating to suspension or expulsion as substantially set forth in the certificate. At the option of the society, supplemental provisions relating to benefits in the event of temporary or permanent disability or hospitalization and provisions which grant additional insurance specifically against death by accident or accidental means, may also be excepted. The certificate shall be incontestable on the ground of suicide after it has been in force during the lifetime of the member for a period of two (2) years from date of issue. The certificate may provide, as to statements made to procure reinstatement, that the society shall have the right to contest a reinstated certificate within a period of two (2) years from date of reinstatement with the same exceptions as herein provided;

(10) A provision that in case the age or sex of the member or of any other person is considered in determining the premium and it is found at any time before final settlement under the certificate that the age or sex has been misstated, and the discrepancy and premium involved have not been adjusted, the amount payable shall be such as the premium would have purchased at the correct age and sex; but if the correct age or sex was not an insurable age or sex under the society's charter or laws, only the premiums paid to the society, less any payments previously made to the member, shall be returned or, at the option of the society, the amount payable under the certificate shall be such as the premium would have purchased at the correct age and sex according to the society's promulgated rates and any extension thereof based on actuarial principals;

(11) A provision or provisions which recite fully, or which set forth the substance of, all sections of the charter, constitution, laws, rules or regulations of the society, in force at the time of issuance of the certificate, the violation of which will result in the termination of, or in the reduction of, the benefit or benefits payable under the certificate; and

(12) If the constitution or laws of the society provide for expulsion or suspension of a member, any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentations in such member's application for membership shall have the privilege of maintaining his insurance in force by continuing payment of the required premium.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance or because the certificate is an annuity certificate may, to the extent inapplicable, be omitted from the certificate.

B. After one year from the effective date of this Article, no life benefit certificate shall be delivered or issued for delivery in this state containing in substance any of the following provisions:

(1) Any provision limiting the time within which any action at law or in equity may be commenced to less than two (2) years after the cause of action shall accrue;

(2) Any provision by which the certificate shall purport to be issued or to take effect more than six (6) months before the original application for the certificate was made, except in case of transfer from one form of certificate to another in connection with which the member is to receive credit for any reserve accumulation under the form of certificate from which the transfer is made; or

(3) Any provision for forfeiture of the certificate for failure to repay any loan thereon or to pay interest on such loan while the total indebtedness, including interest, is less than the loan value of the certificate.

C. The word "premiums" as used in this Article means premiums, rates or other required contributions by whatever name known.

Section 21. Accident and Health Insurance and Total and Permanent Disability Insurance Certificates

No domestic, foreign or alien society authorized to do business in this state shall issue or deliver in this state any certificate or other evidence of any contract of accident insurance or health insurance or of any total and permanent disability insurance contract unless and until the form thereof, together with the form of application and all riders or endorsements for use in connection therewith, shall have been filed with the Commissioner of Insurance. [If approval of certificate forms is desired, delete the period and insert "and approved by him as conforming to reasonable rules and regulations from time to time made by him and as not inconsistent with any other provisions of law applicable thereto. The Commissioner of Insurance shall, within a reasonable time after the filing of any such form, notify the society filing the same either of his approval or of his disapproval of such form. The Commissioner of Insurance may approve any such form which in his opinion contains provisions on any one or more of the several requirements made by him which are more favorable to the members than the one or ones so required."] The Commissioner of Insurance shall have power, from time to time, to make, alter and supersede reasonable regulations prescribing the required, optional and prohibited provisions in such contracts, and such regulations shall conform, as far as practicable, to the provisions of [insert section numbers of sections dealing with uniform health and accident policy provisions and disability policy provisions]. Where the Commissioner of Insurance deems inapplicable, either in part or in their entirety, the provisions of the foregoing sections, he may prescribe the portions or summary thereof of the contract to be printed on the certificate issued to the member. [If approval of certificate forms is desired, insert "Any filing made hereunder shall be deemed approved unless disapproved within ninety (90) days from the date of such filing."]

Section 22. Waiver

The constitution and laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws and constitution of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Section 23. Reinsurance

A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the Commissioner of Insurance, but no such society may reinsure substantially all of its insurance in force without the written permission of the Commissioner of Insurance. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this Article, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

Section 24. Annual License

Societies which are now authorized to transact business in this state may continue such business until the first day of [insert date] next succeeding the effective date of this Article. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the first day of the succeeding [insert date]. However, a license so issued shall continue in full force and effect until the new license be issued or specifically refused. For each such

license or renewal the society shall pay the Commissioner of Insurance $[insert amount]. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this Article.

Section 25. Foreign or Alien Society--Admission

No foreign or alien society shall transact business in this state without a license issued by the Commissioner of Insurance. Any such society may be licensed to transact business in this state upon filing with the Commissioner of Insurance:

A. A duly certified copy of its charter or articles of incorporation;

B. A copy of its constitution and laws, certified by its secretary or corresponding officer;

C. A power of attorney to the Commissioner of Insurance as prescribed in Section 29;

D. A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the Commissioner of Insurance, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Commissioner of Insurance of this state;

E. A certificate from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

F. Copies of its certificate forms; and

G. Such other information as he may deem necessary;

and upon a showing that its assets are invested in accordance with the provisions of this Article.

Any foreign or alien society desiring admission to this state shall have the qualifications required of domestic societies organized under this Article.

Section 26. Injunction, Liquidation, Receivership of Domestic Society

When the Commissioner of Insurance upon investigation finds that a domestic society:

A. Has exceeded its powers;

B. Has failed to comply with any provision of this Article;

C. Is not fulfilling its contracts in good faith;

D. Has a membership of less than 400 after an existence of one year or more; or

E. Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;

he shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. He shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the Commissioner's request for correction, and if the society fails to comply, the Commissioner shall notify the society of his findings of non-compliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the Commissioner of Insurance may present the facts relating thereto to the Attorney General who

shall, if he deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order.

No society so enjoined shall have the authority to do business until:

A. The Commissioner of Insurance finds that the violation complained of has been corrected;

B. The costs of such action shall have been paid by the society if the court finds that the society was in default as charged;

C. The court has dissolved its injunction; and

D. The Commissioner of Insurance has reinstated the certificate of authority.

If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

No action under this section shall be recognized in any court of this state unless brought by the Attorney General upon request of the Commissioner of Insurance. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the Commissioner of Insurance as such receiver.

The provisions of this section relating to hearing by the Commissioner of Insurance, action by the Attorney General at the request of the Commissioner of Insurance, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

Section 27. Suspension, Revocation or Refusal of License of Foreign or Alien Society

When the Commissioner of Insurance upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

A. Has exceeded its powers;

B. Has failed to comply with any of the provisions of this Article;

C. Is not fulfilling its contracts in good faith; or

D. Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public; he shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. He shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the Commissioner's request for correction, and if the society fails to comply, the Commissioner shall notify the society of his findings of non-compliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, he may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to him that such suspension or refusal should be withdrawn or he may revoke the authority of the society to do business in this state.

Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

Section 28. Licensing of Agents

Agents of societies shall be licensed in accordance with the provisions of this section.

A. Insurance Agent Defined. The term "insurance agent" as used in this section means any authorized or acknowledged agent of a society who acts as such in the solicitation, negotiation or procurement or making of a life insurance, accident and health insurance or annuity contract, except that the term "insurance agent" shall not include:

(1) Any regular salaried officer or employee of a licensed society who devotes substantially all of his services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained; or

(2) Any agent or representative of a society who devotes, or intends to devote, less than fifty per cent (50%) of his time to the solicitation and procurement of insurance contracts for such society. Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of $50,000, or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than twenty-five (25) individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting, or intending to devote, fifty per cent (50%) of his time to the solicitation or procurement of insurance contracts for such society.

B. License Required. Any person who in this state acts as insurance agent for a society without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this section shall, except as provided in Subsection A, by guilty of a misdemeanor.

C. Payment of Commissions Forbidden. No society doing business in this state shall pay any commission or other compensation to any person for any services in obtaining in this state any new contract of life, accident or health insurance, or any new annuity contract, except to a licensed insurance agent of such society and except an agent exempted under Subsection A(2) of this section.

D. Prerequisites, Issuance and Renewal of Insurance Agents' Licenses.

(1) The Commissioner of Insurance may issue a license to any person who has paid an annual license fee of $[insert amount] and who has complied with the requirements of this section, authorizing such licensee to act as an insurance agent on behalf of any society named in such license which is authorized to do business in this state.

(2) Before any insurance agent's license shall be issued there shall be on file in the office of the Commissioner of Insurance the following documents:

(a) A written application by the prospective licensee in such form or forms and supplements thereto, and containing such information as the Commissioner of Insurance may prescribe; and

(b) a certificate by the society which is to be named in such license, stating that such society has satisfied itself that the named applicant is trustworthy and competent to act as such insurance agent and that the society will appoint such applicant to act as its agent if the license applied for is issued by the Commissioner of Insurance. Such certificates shall be executed and acknowledged by an officer or managing agent of such society.

(3) No written or other examination shall be required of any individual seeking to be named as a licensee to represent a fraternal benefit society as its agent.

(4) The Commissioner of Insurance may refuse to issue or renew any insurance agent's license if in his judgment the proposed licensee is not trustworthy and competent to act as such agent, or has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance or renewal, as the case may be, of such license.

(5) Every license issued pursuant to this section, and every renewal thereof, shall expire on December 31 of the even-numbered calendar year following the calendar year in which such license or renewal license was issued.

(6) If the application for a renewal license shall have been filed with the Commissioner of Insurance on or before December 31 of the year in which the existing license is to expire, such applicant named in such existing license may continue to act as insurance agent under such existing license, unless same shall be revoked or suspended, until the issuance by the Commissioner of Insurance of the renewal license or until the expiration of five (5) days after he shall have refused to renew such license and shall have served written notice of such refusal on the applicant. If the applicant shall, within thirty (30) days after such notice is given, notify the Commissioner of Insurance in writing of his request for a hearing on such refusal, the Commissioner of Insurance shall, within a reasonable time after receipt of such notice, grant such hearing, and he may, in his discretion, reinstate such license.

(7) Any such renewal license of an insurance agent may be issued upon the application of the society named in the existing license. Such application shall be in the form or forms prescribed by the Commissioner of Insurance and shall contain such information as he may require. Such application shall contain a certificate executed by the president, or by a vice president, a secretary, an assistant secretary, or corresponding officer by whatever name known, or by an employee expressly designated and authorized to execute such certificate of a domestic or foreign society or by the United States manager of an alien society, stating that the addresses therein given of the agents of such society for whom renewal licenses are requested therein have been verified in each instance immediately preceding the preparation of the application. Notwithstanding the filing of such application, the Commissioner of Insurance may, after reasonable notice to any such society, require that any or all agents of such society to be named as licensees in renewal licenses shall execute and file separate applications for the renewal of such licenses, as hereinbefore specified, and he may also require that each such application shall be accompanied by the certificate specified in Subsection D(2)(b) of this section.

E. Notice of Termination of Appointment of Insurance Agent. Every society doing business in this state shall, upon the termination of the appointment of any insurance agent licensed to represent it in this state, forthwith file with the Commissioner of Insurance a statement, in such form as he may prescribe, of the facts relative to such termination and the cause thereof. Every statement made pursuant to this section shall be deemed a privileged communication.

F. Revocation or Suspension of Insurance Agent's License.

(1) The Commissioner of Insurance may revoke, or may suspend for such period as he may determine, any insurance agent's license if, after notice and hearing as specified in this section, he determines that the licensee has:

(a) Violated any provision of, or any obligation imposed by, this section, or has violated any law in the course of his dealings as agent;

(b) Made a material misstatement in the application for such license;

(c) Been guilty of fraudulent or dishonest practices;

(d) Demonstrated his incompetency or untrustworthiness to act as an insurance agent; or

(e) Been guilty of rebating as defined by the laws of this state applicable to life insurance companies.

(2) The revocation or suspension of any insurance agent's license shall terminate forthwith the license of such agent. No individual whose license has been revoked shall be entitled to obtain any insurance agent's license under the provisions of this section for a period of one year after such revocation or, if such revocation be judicially reviewed, for one year after the final determination thereof affirming the action of the Commissioner of Insurance in revoking such license.

Section 29. Service of Process

Every society authorized to do business in this state shall appoint in writing the Commissioner of Insurance and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by said Commissioner of Insurance, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

Service shall only be made upon the Commissioner of Insurance, or if absent, upon the person in charge of his office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the Commissioner of Insurance, he shall forthwith forward one of the duplicate copies by registered mail, prepaid, direct to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the Commissioner of Insurance, the plaintiff or complainant in the action shall pay to the Commissioner of Insurance a fee of $2.00.

Section 30. Injunction

No application or petition for injunction against any domestic, foreign or alien society, or branch thereof, shall be recognized in any court of this state unless made by the Attorney General upon request of the Commissioner of Insurance.

Section 31. Review

All decisions and findings of the Commissioner of Insurance made under the provisions of this Article shall be subject to review by proper proceedings in any court of competent jurisdiction in this state.

Section 32. Funds

All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment or surrender of any part thereof, except as provided in the contract.

A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

Every society, the admitted assets of which are less than the sum of its accrued liabilities and reserves under all of its certificates when valued according to standards required for certificates issued after one year from the effective date of this Article, shall, in every provision of the laws of the society for payments by members of such society, in whatever form made, distinctly state the purpose of the same and the proportion thereof which may be used for expenses, and no part of the money collected for mortuary or disability purposes or the net accretions thereto shall be used for expenses.

Section 33. Investments

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurance companies and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

Section 34. Reports and Valuations

Reports shall be filed and synopses of annual statements shall be published in accordance with the provisions of this section.

A. Every society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the Commissioner of Insurance, file with the Commissioner of Insurance a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay a fee of $[insert amount] for filing same. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the Commissioner of Insurance.

B. A synopsis of its annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society not later than June 1 of each year, or, in lieu thereof, such synopsis may be published in the society's official publication.

C. As a part of the annual statement herein required, each society shall, on or before the first day of March, file with the Commissioner of Insurance a valuation of its certificates in force on December 31 last preceding, provided the Commissioner ofInsurance may, in his discretion for cause shown, extend the time for filing such valuation for not more than two (2) calendar months. Such report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of such society in force and the present midyear value of the future net premiums as the same are in practice actually collected, not including therein any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates. At the option of any society, in lieu of the above, the valuation may show the net tabular value. Such net tabular value as to certificates issued prior to one year after the effective date of this Article shall be determined in accordance with the provisions of law applicable prior to the effective date of this Article and as to certificates issued on or after one year from the effective date of this Article shall not be less than the reserves determined according to the Commissioners' Reserve Valuation method as hereinafter defined. If the premium charged is less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in such premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted in the event that the midyear or tabular values are not appropriate.

D. Reserves according to the Commissioners' Reserve Valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such certificates, over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the certificate, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the certificate and the excess of (1) over (2), as follows:

(1) A net level premium equal to the present value, at the date of issue, of such benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such certificate on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen (19) year premium whole life plan for insurance of the same

amount at an age one year higher than the age at issue of such certificate; and (2)A net one-year term premium for such benefits provided for in the first certificate year.

Reserves according to the Commissioners' Reserve Valuation method for (1) life insurance benefits for varying amounts of benefits or requiring the payment of varying premiums, (2) annuity and pure endowment benefits, (3) disability and accidental death benefits in all certificates and contracts, and (4) all other benefits except life insurance and endowment benefits, shall be calculated by a method consistent with the principles of this subsection.

E. The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in the following subsection.

F. Such valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the Department of Insurance of the state of domicile of the society.

The minimum standards of valuation for certificates issued prior to one year from the effective date of this Article shall be those provided by the law applicable immediately prior to the effective date of this Article but not lower than the standards used in the calculating of rates for such certificates.

The minimum standard of valuation for certificates issued after one year from the effective date of this Article shall be three and one-half per cent (3 1/2%) interest and the following tables:

(1) For certificates of life insurance: American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or with the consent of the Commissioner of Insurance, the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Mortality Table or the Commissioners 1958 Standard Ordinary Mortality Table, using actual age of the insured for male risks and an age not more than three (3) years younger than the actual age of the insured for female risks;

(2) For annuity and pure endowment certificates, excluding any disability and accidental death benefits in such certificates: the 1937 Standard Annuity Mortality Table or the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Commissioner of Insurance;

(3) For total and permanent disability benefits in or supplementary to life insurance certificates: Hunter's Disability Table, or the Class III Disability Table (1926) modified to conform to the contractual waiting period, or the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries with due regard to the type of benefit. Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance certificates;

(4) For accidental death benefits in or supplementary to life insurance certificates: the Inter-Company Double Indemnity Mortality Table or the 1959 Accidental Death Benefits Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates; and

(5) For noncancellable accident and health benefits: the Class III Disability Table (1926) with conference modifications or, with the consent of the Commissioner of Insurance, tables based upon the society's own experience.

The Commissioner of Insurance may, in his discretion, accept other standards for valuation if he finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The Commissioner of Insurance may, in his discretion, vary the standards of mortality applicable to all certificates of insurance onsubstandard lives or other extra hazardous lives by any society authorized to do business in this state. Whenever the mortality experience under all certificates valued on the same mortality table is in excess of the expected mortality according to

such table for a period of three (3) consecutive years, the Commissioner of Insurance may require additional reserves when deemed necessary in his judgment on account of such certificates.

Any society, with the consent of the Commissioner of Insurance of the state of domicile of the society and under such conditions, if any, which he may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

G. A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit $100 for each day during which such neglect continues, and, upon notice by the Commissioner of Insurance to that effect, its authority to do business in this state shall cease while such default continues.

Section 35. Examination of Domestic Societies

The Commissioner of Insurance, or any person he may appoint, shall have the power of visitation and examination into the affairs of any domestic society and he shall make such examination at least once in every three (3) years. He may employ assistants for the purpose of such examination, and he, or any person he may appoint, shall have free access to all books, papers and documents that relate to the business of the society. The minutes of the proceedings of the supreme legislative or governing body and of the board of directors or corresponding body of a society shall be in the English language. In making any such examination the Commissioner of Insurance may summon and qualify as witnesses under oath and examine its officers, agents and employees or other persons in relation to the affairs, transactions and condition of the society. A summary of the report of the Commissioner of Insurance and such recommendations or statements of the Commissioner of Insurance as may accompany such report, shall be read at the first meeting of the board of directors or corresponding body of the society following the receipt thereof, and if directed so to do by the Commissioner of Insurance, shall also be read at the first meeting of the supreme legislative or governing body of the society following the receipt thereof. A copy of the report, recommendations and statements of the Commissioner of Insurance shall be furnished by the society to each member of such board of directors or other governing body. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner of Insurance.

Section 36. Examination of Foreign and Alien Societies

The Commissioner of Insurance, or any person whom he may appoint, may examine any foreign or alien society transacting or applying for admission to transact business in this state. He may employ assistants and he, or any person he may appoint, shall have free access to all books, papers and documents that relate to the business of the society. He may in his discretion accept, in lieu of such examination, the examination of the Insurance Department of the state, territory, district, province or country where such society is organized. The compensation and actual expenses of the examiners making any examination or general or special valuation shall be paid by the society examined or by the society whose certificate obligations have been valued, upon statements furnished by the Commissioner of Insurance.

Section 37. No Adverse Publications

Pending, during or after an examination or investigation of a society, either domestic, foreign or alien, the Commissioner of Insurance shall make public no financial statement, report or finding, nor shall he permit to become public any financial statement, report or finding affecting the status, standing or rights of any society, until a copy thereof shall have been served upon the society at its principal office and the society shall have been afforded a reasonable opportunity to answer any such financial statement, report or finding and to make such showing in connection therewith as it may desire.

Section 38. Misrepresentation

No person shall cause or permit to be made, issued or circulated in any form:

A. Any misrepresentation or false or misleading statement concerning the terms, benefits or advantages of any fraternal insurance contract now issued or to be issued in this state, or the financial condition of any society;

B. Any false or misleading estimate or statement concerning the dividends or shares of surplus paid or to be paid by any society on any insurance contract; or

C. Any incomplete comparison of any insurance contract of one society with an insurance contract of another society or insurer for the purpose of inducing the lapse, forfeiture or surrender of any insurance contract. A comparison of insurance contracts is incomplete if it does not compare in detail:

(1) The gross rates, and the gross rates less any dividend or other reduction allowed at the date of the comparison; and

(2) Any increase in cash values, and all the benefits provided by each contract for the possible duration thereof as determined by the life expectancy of the insured; or if it omits from consideration:

(3) Any benefit or value provided in the contract;

(4) Any differences as to amount or period of rates; or

(5) Any differences in limitations or conditions or provisions which directly or indirectly affect the benefits.

In any determination of the incompleteness or misleading character of any comparison or statement, it shall be presumed that the insured had no knowledge of any of the contents of the contract involved.

Any person who violates any provision of this section or knowingly receives any compensation or commission by or in consequence of such violation, shall upon conviction be punished by a fine of not less than $100 nor more than $[insert amount] or by imprisonment in the county jail not less than thirty (30) days nor more than one year or both fine and imprisonment and shall in addition, be liable for a civil penalty in the amount of three times the sum received by such violator as compensation or commission, which penalty may be sued for and recovered by any person or society aggrieved for his or its own use and benefit in accordance with the provisions of civil practice.

Section 39. Discrimination and Rebates

No society doing business in this state shall make or permit any unfair discrimination between insured members of the same class and equal expectation of life in the premiums charged for certificates of insurance, in the dividends or other benefits payable thereon or in any other of the terms and conditions of the contracts it makes.

No society, by itself, or any other party, and no agent or solicitor, personally, or by any other party, shall offer, promise, allow, give, set off, or pay, directly or indirectly, any valuable consideration or inducement to, or for insurance, on any risk authorized to be taken by such society, which is not specified in the certificate. No member shall receive or accept, directly or indirectly, any rebate of premium, or part thereof, or agent's or solicitor's commission thereon, payable on any certificate or receive or accept any favor or advantage or share in the dividends or other benefits to accrue on, or any valuable consideration or inducement not specified in the contract of insurance.

Section 40. Taxation

Every society organized or licensed under this Article is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

Section 41. Exemptions

Except as herein provided, societies shall be governed by this Article and shall be exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state, but for every other purpose. No law hereafter enacted shall apply to them, unless they be expressly designated therein.

Section 42. Exemption of Certain Societies

Nothing contained in this Article shall be so construed as to affect or apply to:

A. Grand or subordinate lodges of societies, orders or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges;

B. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

C. Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any one year, or both; or

D. Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to any one person in any one year, or both.

Any such society or association described in Subsection C or D supra, which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in D which has more than one thousand members, shall not be exempted from the provisions of this Article but shall comply with all requirements thereof.

No society which, by the provisions of this section, is exempt from the requirements of this Article, except any society described in Subsection B, supra, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this Article except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to such society.

The Commissioner of Insurance may require from any society or association, by examination or otherwise, such information as will enable him to determine whether such society or association is exempt from the provisions of this Article.

Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of this state.

Section 43. Penalties

Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from a benefit in any society, shall upon conviction be fined not less than $100 nor more than $[insert maximum amount] or imprisonment in the county jail not less than thirty (30) days nor more than one year, or both.

Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this Article, or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefore prescribed by law.

Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction be fined not less that $50 nor more than $200.

Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this Article for which a penalty is not otherwise prescribed, shall upon conviction, be subject to a fine not exceeding $[insert maximum amount].

Section 44. Severability

If any provision of this Article or the application of such provision to any circumstance is held invalid, the remainder of the Article or the application of the provision to other circumstances, shall not be affected thereby.

Section 45. Repeal

[There should be inserted as the last section of the Bill a section as above entitled reading in such appropriate language as is necessary to effect, in the enacting state, the repeal of all acts or parts of acts inconsistent or in conflict with the provisions of this Article.]

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1955 Proc. II 300, 301-320 (adopted).
1958 Proc. I 99, 100, 101 (amended).
1962 Proc. II 433, 437-443, 448 (amended).
1963 Proc. I 151-172 (reprinted).

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What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-34-1 to 27-34-54 (1971/2014).		
Alaska			ALASKA STAT. §§ 21.84.005 to 21.84.575 (1966/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-861 to 20-893 (1994/2013).
Arkansas			ARK. CODE ANN. §§ 23-74-101 to 23-74-705 (1959/2005).
California	CAL. INS. CODE §§ 10970 to 11165 (1951/2009).		
Colorado			COLO. REV. STAT. §§ 10-14-101 to 10-14-705 (1963/2012).
Connecticut	CONN. GEN. STAT. §§ 38a-595 to 38a-640 (1949/1990).		
Delaware			DEL. CODE ANN. tit. 18, §§ 6201 to 6238 (1997).
District of Columbia			D.C. CODE §§ 31-5301 to 31-5335 (1998/2004).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 632.601 to 632.638 (1986).
Georgia			GA. CODE ANN. §§ 33-15-1 to 33-15-123 (1994).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 432:2-101 to 432:2-705 (1988/2012).
Idaho			IDAHO CODE ANN. §§ 41-3201 to 41-3239 (1996).
Illinois			215 ILL. COMP. STAT. 5/282.1 to 5/315.9 (1986/2014).
Indiana			IND. CODE §§ 27-11-1-1 to 27-11-9-4 (1985/2003).
Iowa			IOWA CODE §§ 512B.1 to 512B.36 (1991/1992).
Kansas			KAN. STAT. ANN. §§ 40-738 to 40-782 (1989).
Kentucky			KY. REV. STAT. ANN. §§ 304.29-011 to 304.29-600 (1989/2005).
Louisiana			LA. REV. STAT. ANN. §§ 22:281 to 22:317.1 (1987/2009).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 4101 to 4143 (1970/2014).		
Maryland			MD. CODE ANN., INS. §§ 8-401 to 8-468 (1998/2009).
Massachusetts			MASS. GEN. LAWS ch. 176, §§ 1 to 56 (1958/2014).
Michigan			MICH. COMP. LAWS §§ 500.8161 to 500.8199a (1990).
Minnesota			MINN. STAT. §§ 64B.01 to 64B.48 (1985/2005).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi			MISS. CODE ANN. §§ 83-29-1 to 83-29-75 (1930/2001) (small fraternals); §§ 83-30-1 to 83-30-77 (2001/2003) (larger fraternals).
Missouri			MO. REV. STAT. §§ 378.601 to 378.645 (1993).
Montana			MONT. CODE ANN. §§ 33-7-105 to 33-7-533 (1992/2003).
Nebraska			NEB. REV. STAT. §§ 44-1072 to 44-10,109 (1985).
Nevada			NEV. REV. STAT. §§ 695A.010 to 695A.580 (1971/1992).
New Hampshire			N.H. REV. STAT. ANN. §§ 418:1 to 418:37 (1945/2004).
New Jersey			N.J. STAT. ANN. §§ 17:44B-1 to 17:44B-37 (1998).
New Mexico			N.M. STAT. ANN. §§ 59A-44-1 to 59A-44-46 (1990/1999).
New York			N.Y. INS. LAW §§ 4501 to 4530 (1984/2009).
North Carolina			N.C. GEN. STAT. §§ 58-24-1 to 58-24-190; §§ 58-25-1 to 58-25-70 (1988/2003).
North Dakota			N.D. CENT. CODE §§ 26.1-15.1-01 to 26.1-15.1-37 (1984).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3921.01 to 3921.99 (1959/2014).
Oklahoma			OKLA. STAT. tit. 36, §§ 2701.1 to 2738.1 (1993/2006).
Oregon			OR. REV. STAT. §§ 748.103 to 748.990 (1987/2013).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			40 PA. STAT. ANN. §§ 991.2401 to 991.2466 (2002).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 3601 to 3642 (1964).		
Rhode Island			R.I. GEN. LAWS §§ 27-25-1 to 27-28-44 (1984/2014).
South Carolina			S.C. CODE ANN. §§ 38-38-10 to 38-38-740 (2000/2008).
South Dakota			S.D. CODIFIED LAWS §§ 58-37A-1 to 58-37A-39 (1991)
Tennessee			TENN. CODE ANN. §§ 56-25-101 to 56-25-704 (1991).
Texas			TEX. INS. CODE ANN. §§ 885.001 to 885.706 (2001).
Utah			UTAH CODE ANN. §§ 31A-9-101 to 31A-9-604 (1985/1987).
Vermont	VT. STAT. ANN. tit. 8, §§ 4461 to 4503 (1959/1971).		
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 1301 to 1311 (1968) (Mutual Non-profit Benefit Societies).
Virginia			VA. CODE ANN. §§ 38.2-4100 to 38.2-4137 (1986/2014).
Washington			WASH. REV. CODE ANN. §§ 48.36A.010 to 48.36A.901 (1988/1996); WASH. ADMIN. CODE §§ 284-36A-005 to 284-36A-065 (1996/1999).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE §§ 33-23-1 to 33-23-35 (1957/1997).		
Wisconsin			WIS. STAT. §§ 614.01 to 614.96 (1976/2003).
Wyoming			WYO. STAT. ANN. §§ 26-29-201 to 26-29-238 (1990).

INSURANCE FRAUD PREVENTION MODEL ACT

Table of Contents

Section 1. Purpose

The [insert name for state's legislature] finds that the business of insurance involves many transactions that have potential for fraud, abuse and other illegal activities. This Act is intended to permit full utilization of the expertise of the commissioner to investigate and discover fraudulent insurance acts more effectively, halt fraudulent insurance acts and assist and receive assistance from state, local and federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts.

Section 2. Definitions

As used in this Act:

A. "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or are officers, directors, agents or employees of insurers, or who are other persons authorized to act on their behalf.

B. "Commissioner" means the commissioner of insurance, the commissioner's designees or the department of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

(1) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

(a) An application for the issuance or renewal of an insurance policy or reinsurance contract;

(b) The rating of an insurance policy or reinsurance contract;

(c) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;

(d) Premiums paid on an insurance policy or reinsurance contract;

(e) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(f) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(g) The financial condition of an insurer or reinsurer;

(h) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

(i) The issuance of written evidence of insurance; or

(j) The reinstatement of an insurance policy;

(2) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(3) Removal, concealment, alteration or destruction of the assets or records of an insurer, reinsurer or other person engaged in the business of insurance;

(4) Willful embezzlement, abstracting, purloining or conversion of monies, funds, premiums, credits or other property of an insurer, reinsurer or person engaged in the business of insurance;

(5) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance; or

(6) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

D. "Insurance" means a contract or arrangement in which one undertakes to:

(1) Pay or indemnify another as to loss from certain contingencies called "risks," including through reinsurance;

(2) Pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies;

(3) Pay an annuity to another; or

(4) Act as surety.

E. "Insurer" means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the acts set forth in Subsection D of this section. A person is an insurer regardless of whether the person is acting in violation of laws requiring a certificate of authority or regardless of whether the person denies being an insurer.

Drafting Note: A state may include other persons, such as fraternal benefit societies, medical and hospital service corporations, health maintenance organizations, certain types of self insurers, "county mutuals" or other types of insurance entities in the definition of insurer. In some cases, it may be necessary to amend other laws to bring these entities within the Act since the portions of state law applicable to these entities may provide that no other portion of the insurance code applies to these entities without a specific reference to the other provision.

F. "NAIC" means the National Association of Insurance Commissioners.

G. "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, or any similar entity or any combination of the foregoing.

H. "Policy" means an individual or group policy, group certificate, contract or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

I. "Reinsurance" means a contract, binder of coverage (including placement slip) or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

Section 3. Fraudulent Insurance Acts, Interference and Participation of Convicted Felons Prohibited

A. A person shall not commit a fraudulent insurance act.

B. A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

C. (1) A person convicted of a felony involving dishonesty or breach of trust shall not participate in the business of insurance.

(2) A person in the business of insurance shall not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

Section 4. Fraud Warning Required

A. Claim forms and applications for insurance, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

> "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

B. The lack of a statement as required in Subsection A of this section does not constitute a defense in any prosecution for a fraudulent insurance act.

C. Policies issued by unauthorized insurers [use the term "unlicensed" or "nonadmitted" insurers in accordance with the terminology used in the state insurance code] shall contain a statement disclosing the status of the insurer to do business in the state where the policy is delivered or issued for delivery or the state where coverage is in force. The requirement of this subsection may be satisfied by a disclosure specifically required by [insert reference to insurance code provisions. Excess and surplus lines statutes and risk retention and purchasing group statutes are likely to be cited here in nearly every state].

D. The requirements of this section shall not apply to reinsurance claims forms or reinsurance applications.

Section 5. Investigative [and Prosecutive] Authority of the Commissioner

The commissioner may investigate suspected fraudulent insurance acts and persons engaged in the business of insurance.

A. The commissioner may investigate [and prosecute] suspected fraud.

B. The commissioner may employ and designate attorneys to specifically prosecute or assist in the prosecution of violations of this Act.

C. Funds allocated for insurance fraud prevention may be expended by the commissioner, at his or her discretion, to prosecution authorities for the purpose of insurance fraud enforcement as identified in this Act.

D. The commissioner may negotiate with an attorney representing the state to prosecute violations of the Act, to provide technical and litigation assistance to the Department of Insurance, and to allocate resources for the purpose of insurance fraud prosecution as identified in this Act.

Drafting Note: This section may be used to establish a source of funding exclusively dedicated for prosecution of insurance fraud and to establish a method to specially designate insurance department attorneys as state or federal insurance fraud prosecutors.

Section 6. Mandatory Reporting of Fraudulent Insurance Acts

A. A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

B. Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

Section 7. Immunity from Liability

A. There shall be no civil liability imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The commissioner or the commissioner's employees, agents or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents or representatives;

(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's agents, employees or representatives; or

(4) The NAIC or its employees, agents or representatives.

B. Subsection A of this section shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Subsection A of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

C. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Subsection A of this section.

Section 8. Confidentiality

A. Documents, materials or other information in the possession or control of the Department of Insurance that are provided pursuant to Section 6 of this Act or obtained by the commissioner in an investigation of suspected or actual fraudulent insurance acts shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries; provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information; and

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

Drafting Note: The language in Subsection C(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information-sharing agreement.

D. Nothing in this section shall prohibit the commissioner from providing information to or receiving information from any local, state, federal or international law enforcement authorities, including any prosecuting authority; or from complying with subpoenas or other lawful process in criminal actions; or as may otherwise be provided in this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

Section 9. Creation and Purpose of the Insurance Fraud Unit

A. The [insert name of state] insurance fraud unit is established within the [insert designation of organization, such as department of insurance]. The commissioner shall appoint the full-time supervisory and investigative personnel of the insurance fraud unit, who shall be qualified by training and experience to perform the duties of their positions. The commissioner shall also appoint clerical and other staff necessary for the insurance fraud unit to carry out its duties and responsibilities under this Act.

B. It shall be the duty of the insurance fraud unit to:

(1) Initiate independent inquiries and conduct independent investigations when the insurance fraud unit has cause to believe that a fraudulent insurance act may be, is being or has been committed;

(2) Review reports or complaints of alleged fraudulent insurance activities from federal, state and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and

(3) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

C. The insurance fraud unit shall have the authority to:

(1) Inspect, copy or collect records and evidence;

(2) Serve subpoenas;

(3) Administer oaths and affirmations;

(4) Share records and evidence with federal, state or local law enforcement or regulatory agencies;

(5) Execute search warrants and arrest warrants for criminal violations of this Act;

(6) Arrest upon probable cause without warrant a person found in the act of violating or attempting to violate a provision of this Act;

Drafting Note: If the insurance fraud unit has only civil authority, the state should omit Paragraphs (5) and (6) from Subsection C.

(7) Make criminal referrals to prosecuting authorities; and

(8) Conduct investigations outside of this state. If the information the insurance fraud unit seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the insurance fraud unit to examine at the place where the information is located. The insurance fraud unit may designate representatives, including officials of the state in which the matter is located, to inspect the information on behalf of the insurance fraud unit, and the insurance fraud unit may respond to similar requests from officials of other states.

Section 10. Other Law Enforcement or Regulatory Authority

This Act shall not:

A. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;

B. Prevent or prohibit a person from disclosing voluntarily information concerning insurance fraud to a law enforcement or regulatory agency other than the insurance fraud unit; or

C. Limit the powers granted elsewhere by the laws of this state to the commissioner or the insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

Section 11. Insurer Antifraud Initiatives

Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Antifraud initiatives may include:

A. Fraud investigators, who may be insurer employees or independent contractors; or

B. An antifraud plan submitted to the commissioner. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Section 12. Regulations

The commissioner may promulgate regulations deemed necessary by the commissioner for the administration of this Act.

Section 13. Penalties

A person who violates this Act is subject to the following:

A. Suspension or revocation of license or certificate of authority, civil penalties of up to $[insert amount] per violation, or both. Suspension or revocation of license or certificate of authority and imposition of civil penalties shall be pursuant to an order of the commissioner issued under [insert reference to statutes relating to hearings conducted by the commissioner]. The commissioner's order may require a person found to be in violation of this Act to make restitution to persons aggrieved by violations of this Act; or

B. A person convicted of a violation of Section 3 of this Act by a court of competent jurisdiction [states should insert here classifications for misdemeanor and felony penalties which match provisions in their penal codes for theft offenses]. A person convicted of a violation of Section 3 of this Act shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment; and

C. A person convicted of a felony violation of this Act pursuant to Subsection B of this section shall be disqualified from engaging in the business of insurance.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter 2, 36, 59, 61-66 (adopted).
1999 Proc. 4th Quarter 15, 1231, 1233, 1243, 1244-1245 (amended).
2001 Proc. 1st Quarter 17, 741, 746-747 (amended).
2003 Proc. 1st Quarter 798, 799-800 (amended and adopted by task force).
2003 Proc. 2nd Quarter 832 (adopted by parent committee).
2003 Proc. 3rd Quarter 14 (adopted by Plenary).

This model replaces and incorporates three earlier models:

Model Insurance Fraud Statute
1980 Proc. II 22, 25, 176, 181 (adopted).

Model Legislation Creating a Fraud Unit in a State Department of Insurance
1980 Proc. II 22, 25, 176, 179-180 (adopted).

Model Immunity Act
1983 Proc. II 16, 22, 25, 30 (adopted).
1990 Proc. I 6, 30, 840, 872, 891-893 (amended and reprinted).

INSURANCE FRAUD PREVENTION MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE FRAUD PREVENTION MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 36-19-40 to 36-19-44 (1979) (arson); §§ 27-12A-1 to 27-12A-42 (1975/2013).
Alaska			ALASKA STAT. §§ 21.36.360 to 21.36.410 (1984/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-458 (1978); § 20-463 (1991); §§ 20-466 to 20-466.04 (1954/2002).
Arkansas	ARK. CODE ANN. §§ 23-66-501 to 23-66-513 (1997/2013).		ARK. ADMIN. CODE 054.00.66 (1997); 054.00.67 (1997).
California			CAL. INS. CODE §§ 1871 to 1879.8 (1989/2014); CAL. CODE REGS. tit.10, §§ 2698.22 to 2698.98.1 (2003/2005).

INSURANCE FRAUD PREVENTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Colorado			COLO. REV. STAT. §§ 10-4-1001 to 10-4-1009 (1993/2013); §§ 10-1-128 to 10-1-129 (2003/2010); 3 COLO. CODE REGS. § 702-6:6-5-1 (2003/2013); BULLETIN B-1.8 (2007); BULLETIN B-1.11 (2007).
Connecticut			CONN. GEN. STAT. §§ 53-440 to 53-445 (1987/1993) (health insurance fraud).
Delaware			DEL. CODE ANN. tit. 18, §§ 2401 to 2415 (1994).
District of Columbia			D.C. CODE §§ 22-3225.01 to 22-3225.15 (1998/2002).
Florida			FLA. STAT. §§ 626.9541 (1982/2014); §§ 626.989 to 626.9891 (1976/1998); § 817.234 (2014).
Georgia			GA. CODE ANN. § 33-1-9 (1960/2003); §§ 33-1-16 to 33-1-17 (1990/1995); GA. COMP. R. & REGS. 120-2-72 (2005/2013).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431:2-204 (1987/1998); §§ 431:2-401 to 431:2-410 (2009).
Idaho			IDAHO CODE ANN. §§ 41-290 to 41-298 (1981/2005).
Illinois			215 ILL. COMP. STAT. 5/132.7 (1937); 5/155.23 to 5/155.24 (1984); 5/401.5 (1985/2001); 740 ILL. COMP. STAT. 92/1 to 92/45 (2002).

INSURANCE FRAUD PREVENTION MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Indiana			IND. CODE § 27-1-3-22 (1986/1992).
Iowa			IOWA CODE §§ 507E.1 to 507E.8 (1994).
Kansas			KAN. STAT. ANN. §§ 40-2,118 to 40-2,119 (1985/2011).
Kentucky			KY. REV. STAT. ANN. §§ 304.47-010 to 304.47-080 (1994/2002); 806 KY. ADMIN. REGS. 47:010 (1995/2014).
Louisiana			LA. REV. STAT. ANN. 22:1931 to 22:1931.13 (2012); §§ 22:2131 to 22:2135 (2004); § 22:1801 (2006/2010); § 22:572.1 (2006/2010); §§ 22:1921 to 22:1929 (1994); BULLETIN 9-3-2010 (2010).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2186 to 2187 (1998).		ME. REV. STAT. ANN. tit. 24-A, §§ 2178 to 2179 (1979/1991); § 4143 (2003) (fraternals); CODE ME. R. tit. 02-031 Ch. 920 §§ 1 to 5 (1999).
Maryland			MD. CODE ANN., INS. §§ 2-401 to 2-408 (1992/2014); §§ 27-401 to 27-408 (1992/2009); §§ 27-801 to 27-806 (1992/2014); MD. CODE REGS. 31.04.15.01 to 31.04.15.06 (1996); BULLETIN 24-2009 (2009).
Massachusetts			MASS. GEN. LAWS ch. 175H, §§ 1 to 8 (1988) (health care claims).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan			MICH. COMP. LAWS §§ 500.4501 to 500.4511 (1996).
Minnesota			MINN. STAT. §§ 60A.951 to 60A.956 (1994/2003); § 45.0135 (2002/2009).
Mississippi			MISS. CODE. ANN.§ 11-69-1 (2018).
Missouri			MO. REV. STAT. §§ 375.144 to 375.146 (1961/2005); §§ 375.991 to 375.994 (1990/2005).
Montana			MONT. CODE ANN. §§ 33-1-1201 to 33-1-1211 (1995/2013); §§ 33-1-1301 to 33-1-1304 (1997).
Nebraska			NEB. REV. STAT. §§ 44-3,134 to 44-3,142 (1987/1997); §§ 44-6601 to 44-6608 (1995/2002).
Nevada			NEV. REV. STAT. §§ 679B.630 to 679B.700 (1983/2001); § 679B.159 (1985); §§ 686A.290 to 686A.291 (1983/2001).
New Hampshire			N.H. REV. STAT. ANN. §§ 638:20 (2010); §§ 417.23 to 417.31 (1993/2000); § 400-A:36-b (1988/1994); BULLETIN No. 99-012-AB (1999).
New Jersey			N.J. REV. STAT. §§ 17:33A-1 to 17:33A-30 (1983/2010); §§ 2C:21-4.4 to 2C:21-4.7 (2003); N.J. ADMIN. CODE §§ 11:16-1.1 to 11:16-6.11 (1986/2014).
New Mexico			N.M. STAT. ANN. §§ 59A-16C-1 to 59A-16C-17 (1998/2005).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York			N.Y. INS. LAW §§ 401 to 411 (1984/2011); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 86.1 to 86.7 (1991/2003); OFF. GEN. COUNS. 6-20-2006 (2006).
North Carolina			N.C. GEN. STAT. §§ 58-2-160 to 58-2-164 (1985/1995).
North Dakota	N.D. CENT. CODE §§ 26.1-02.1-01 to 26.1-02.1-11 (1993/2013).		N.D. CENT. CODE §§ 26.1-02-24.1 to 26.1-02-24.2 (1987/2001); N.D. ADMIN. CODE § 45-15-01-01 (2004).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3901.03 (1953/1998); § 3901.44 (1988/2002); § 3905.49 (1986/2000); § 3999.31 (1986/1998); §§ 3999.41 to 3999.42 (1998).
Oklahoma			OKLA. STAT. tit. 36, §§ 361 to 363 (1999/2012); §§ 1219.1 to 1219.6 (2000) (health care fraud prevention).
Oregon			BULLETIN 2010-3 (2010) (fraud warning).
Pennsylvania			40 PA. STAT. ANN. §§ 325.1 to 352.62 (2002); 31 PA. CODE §§ 119.22 to 119.26 (1993).
Puerto Rico			26 P.R. LAWS § 2720 (1974).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS §§ 27-54.1-1 to 27-54.1-6 (2010).		R.I. GEN. LAWS §§ 27-49-1 to 27-49-6 (1992/2002) (motor vehicle fraud); §§ 31-50-1 to 31-50-6 (1993/1996) (Office of Automobile Theft and Insurance Fraud); §§ 27-54-1 to 27-54-11 (1994/1997); BULLETIN 2010-3 (2010); BULLETIN 2010-6 (2010).
South Carolina			S.C. CODE ANN. § 38-55-170 (1987/1993); § 38-43-245 (1988); §§ 38-55-510 to 38-55-590 (1994).
South Dakota			S.D. CODIFIED LAWS §§ 58-4A-1 to 58-4A-17 (1999/2013); §§ 58-33-37 to 58-33-37.1 (1996/1999); §§ 58-33-75 to 58-33-82 (1993).
Tennessee			TENN. CODE ANN. §§ 56-53-101 to 56-53-112 (2001); TENN. CODE ANN. §§ 56-47-101 to 56-47-112 (1996) (workers' compensation).
Texas			TEX. CODE ANN., INS. §§ 701.001 to 701.154 (2005/2013); §§ 704.001 to 706.005 (2005); TEX. CODE ANN., PENAL CODE §§ 35.01 to 35.04 (1995).
Utah			UTAH CODE ANN. §§ 31A-31-101 to 31A-31-112 (1994/2013).
Vermont			VT. STAT. ANN. tit. 8, § 4750 (2005).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-229 (1986); §§ 52-36 to 52-44 (1999).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington			WASH. REV. CODE ANN. §§ 48.30A.005 to 48.30A.900 (1995/2005).
West Virginia	W. VA. CODE §§ 33-41-1 to 33-41-12 (1997/2005).		W. VA. CODE R. §§ 114-71-1 to 114-71-3 (2005); INFORMATIONAL LETTER 154 (2005).
Wisconsin			WIS. STAT. § 895.486 (1996).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2003

INSURANCE FRAUD PREVENTION MODEL ACT (#680)

1. Project Description

The Federal/State Coordinating Working Group of the Antifraud (G) Task Force proposed amendments to Section 8 of the Insurance Fraud Prevention Model Act regarding confidentiality to add statutory language so that a commissioner could provide prosecutors with information concerning fraud. The changes would strike references to law enforcement in Section 8C(1) and 8C(2), would delete Section 8C(3), and add a new Section 8D that would provide for information sharing with law enforcement and prosecutorial authorities.

2. Group Responsible for Drafting Model and States Participating

The Federal/State Coordinating Working Group of the Antifraud (G) Task Force initially addressed the issue after reviewing background behind model laws for information sharing and agreed to examine the changes at the NAIC Fall 2002 meeting. Mike Bownes of Alabama chaired the working group and Joe Cohen of Kentucky proposed the changes. The following states were members of the working group: Alabama, Arkansas, California, Connecticut, District of Columbia, Delaware, Iowa, Kentucky, Louisiana, North Carolina, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Texas, and Utah.

3. Charge Authorizing Project

Coordinate with federal, state, and international law enforcement officials in addressing antifraud issues relating to the insurance industry and develop material that will assist state regulators and law enforcement agencies in their efforts to combat fraud.

4. General Description of Drafting Process

The drafting process was very open as the Federal/State Coordinating Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. All of the meeting and conference calls of the working group were open to all parties. All revised language of the draft were posted on the NAIC website and circulated for comment. The working group received no comments, and the Task Force adopted the amendments to Section 8 of the Insurance Fraud Prevention Model Act on a February 19, 2003, conference call.

5. Significant Issues Raised

There were no significant issues raised.

SERVICE CONTRACTS MODEL ACT

Table of Contents

Section 1. Scope and Purposes

A. The purposes of this Act are to:

(1) Create a legal framework within which service contracts may be sold in this state;

(2) Encourage innovation in the marketing and development of more economical and effective means of providing services under service contracts, while placing the risk of innovation on the providers rather than on consumers; and

(3) Permit and encourage fair and effective competition among different systems of providing and paying for these services.

Drafting Note: This model assumes that service contracts are exempt from the insurance code.

B. This Act shall not apply to:

(1) Warranties;

(2) Maintenance agreements;

(3) Commercial transactions;

(4) Warranties, service contracts or maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by [insert name of the state agency that regulates public utilities]; and

(5) Service contracts sold or offered for sale to persons other than consumers.

C. Manufacturer's service contracts on the manufacturer's products need only comply with Sections 5A, 5D to 5N, 6 and 10, as applicable, of this Act.

Drafting Note: States should determine whether to totally exempt manufacturers' service contracts from this Act.

D. This Act shall not apply to service contracts:

(1) Paid for with separate and additional consideration;

(2) Issued at the point of sale, or within sixty (60) days of the original purchase date of the property; and

(3) Where the tangible property has a purchase price of $[insert monetary threshold] or less, exclusive of sales tax.

Section 2. Definitions

As used in this Act:

A. "Administrator" means the person who is responsible for the administration of the service contracts or the service contracts plan and who is responsible for any filings required by the Act.

B. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Consumer" means a natural person who buys other than for purposes of resale any tangible personal property that is distributed in commerce and that is normally used for personal, family or household purposes and not for business or research purposes.

D. "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only.

E. "Manufacturer" means a person that:

(1) Manufactures or produces the property and sells the property under its own name or label;

(2) Is a wholly owned subsidiary of the person who manufactures or produces the property;

(3) Is a corporation which owns 100 percent of the person who manufactures or produces the property;

(4) Does not manufacture or produce the property, but the property is sold under its trade name label;

(5) Manufactures or produces the property and the property is sold under the trade name or label of another person; or

(6) Does not manufacture or produce the property but, pursuant to a written contract, licenses the use of its trade name or label to another person that sells the property under the licensor's trade name or label.

F. "Mechanical breakdown insurance" means a policy, contract or agreement issued by an authorized insurer that provides for the repair, replacement or maintenance of property or indemnification for repair, replacement or service, for the operational or structural failure of the property due to a defect in materials or workmanship or to normal wear and tear.

G. "Non-original manufacturer's parts" means replacement parts not made for or by the original manufacturer of the property, commonly referred to as "after market parts."

H. "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal, syndicate or any similar entity or combination of entities acting in concert.

I. "Premium" means the consideration paid to an insurer for a reimbursement insurance policy.

J. "Provider" means a person who administers, issues, makes, provides, sells or offers to sell a service contract, or who is contractually obligated to provide service under a service contract such as sellers, administrators and other intermediaries.

K. "Provider fee" means the consideration paid for a service contract in excess of the premium.

L. "Reimbursement insurance policy" means a policy of insurance issued to a provider and pursuant to which the insurer agrees, for the benefit of the service contract holders, to discharge all of the obligations and liabilities of the provider under the terms of the service contracts in the event of non-performance by the provider. "All obligations and liabilities" include, but are not limited to, failure of the provider to perform

under the service contract and the return of the unearned provider fee in the event of the provider's unwillingness or inability to reimburse the unearned provider fee in the event of termination of a service contract.

M. "Service contract" means a contract or agreement for a separately stated consideration or for a specific duration to perform the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance, for the operational or structural failure due to a defect in materials, workmanship or normal wear and tear, with or without additional provision for incidental payment of indemnity under limited circumstances, including, but not limited to, towing, rental and emergency road service, but does not include mechanical breakdown insurance or maintenance agreements.

N. "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a service contract.

O. "Warranty" means a warranty made solely by the manufacturer, importer or seller of property or services without charge, that is not negotiated or separated from the sale of the product and is incidental to the sale of the product, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor or other remedial measures, such as repair or replacement of the property or repetition of services.

Section 3. Requirements For Doing Business

A. Service contracts shall not be issued, sold or offered for sale in this state unless the administrator or its designee has:

(1) Provided a receipt for the purchase of the service contract to the contract holder;

(2) Provided a copy of the service contract to the service contract holder within a reasonable period of time from the date of purchase; and,

(3) Complied with this Act.

B. All administrators of service contracts sold in this state shall file a registration with the commissioner on a form, at a fee and at a frequency prescribed by the commissioner.

C. In order to assure the faithful performance of a provider's obligations to its contract holders, each provider who is contractually obligated to provide service under a service contract shall:

(1) Insure all service contracts under a reimbursement insurance policy issued by an insurer authorized to transact insurance in this state or issued pursuant to [insert code section permitting surplus lines business] or;

(2) (a) Maintain a funded reserve account for its obligations under its contracts issued and outstanding in this state. The reserves shall not be less than forty percent (40%) of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts. The reserve account shall be subject to examination and review by the commissioner; and

(b) Place in trust with the commissioner a financial security deposit, having a value of not less than five percent (5%) of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than $25,000, consisting of one of the following:

(i) A surety bond issued by an authorized surety;

(ii) Securities of the type eligible for deposit by authorized insurers in this state;

(iii) Cash;

(iv) A letter of credit issued by a qualified financial institution; or

(v) Another form of security prescribed by regulations issued by the commissioner; or

Drafting Note: States allowing a letter of credit to serve as security should adopt a definition of "qualified financial institution." The definition in Section 4 of the Model Law on Credit for Reinsurance is the appropriate definition.

(3) (a) Maintain a net worth of $100 million; and

(b) Upon request, provide the Commissioner with a copy of the provider's or, if the provider's financial statements are consolidated with those of its parent company, the provider's parent company's most recent Form 10-K filed with the Securities and Exchange Commission (SEC) within the last calendar year, or if the company does not file with the SEC, a copy of the company's audited financial statements, which shows a net worth of the provider or its parent company of at least $100 million. If the provider's parent company's Form 10-K or audited financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the obligor relating to service contracts sold by the provider in this state.

D. Premium Taxes:

(1) Provider fees collected on service contracts shall not be subject to premium taxes.

(2) Premiums for reimbursement insurance policies shall be subject to applicable taxes.

E. Except for the registration requirement in Section 3B, persons marketing, selling or offering to sell service contracts for providers that comply with this Act are exempt from this state's licensing requirements.

F. Providers complying with this Act are not required to comply with other provisions of Chapter [cite rate regulation and other applicable state insurance statutes], except as specifically provided.

Section 4. Required Disclosures—Reimbursement Insurance Policy

Reimbursement insurance policies insuring service contracts issued, sold or offered for sale in this state shall conspicuously state that, upon failure of the provider to perform under the contract, such as failure to return the unearned provider fee, the insurer that issued the policy shall pay on behalf of the provider any sums the provider is legally obligated to pay or shall provide the service which the provider is legally obligated to perform according to the provider's contractual obligations under the service contracts issued or sold by the provider.

Section 5. Required Disclosures—Service Contracts

A. Service contracts issued, sold or offered for sale in this state shall be written in clear, understandable language and the entire contract shall be printed or typed in easy to read ten point type or larger and conspicuously disclose the requirements in this section, as applicable.

B. Service contracts insured under a reimbursement insurance policy pursuant to Section 3C(1) of this Act shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are guaranteed under a service contract reimbursement insurance policy. If the provider fails to pay or provide service on a claim within sixty (60) days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the insurance company." A claim against the provider shall also include a claim for return of the unearned provider fee. The service contract shall also conspicuously state the name and address of the insurer.

C. Service contracts not insured under a reimbursement insurance policy pursuant to Section 3C(1) of this Act shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed only by the full faith and credit of the provider (issuer) and are not guaranteed under a service contract reimbursement insurance policy." A claim against the provider shall also include a claim for return of the unearned provider fee. The service contract shall also conspicuously state the name and address of the provider.

D. Service contracts shall identify any administrator, the provider obligated to perform the service under the contract, the service contract seller, and the service contract holder to the extent that the name and address of the service contract holder has been furnished by the service contract holder.

E. Service contracts shall conspicuously state the total purchase price and the terms under which the service contract is sold. The purchase price is not required to be pre-printed on the service contract and may be negotiated at the time of sale with the service contract holder.

F. If prior approval of repair work is required, the service contracts shall conspicuously state the procedure for obtaining prior approval and for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining emergency repairs performed outside of normal business hours.

G. Service contracts shall conspicuously state the existence of any deductible amount.

H. Service contracts shall specify the merchandise and services to be provided and any limitations, exceptions or exclusions.

I. Service contracts shall state the conditions upon which the use of non-original manufacturers' parts, or substitute service, may be allowed. Conditions stated shall comply with applicable state and federal laws.

J. Service contracts shall state any terms, restrictions or conditions governing the transferability of the service contract.

K. Service contracts shall state the terms, restrictions or conditions governing termination of the service contract by the service contract holder. The provider of the service contract shall mail a written notice to the contract holder within fifteen (15) days of the date of termination.

L. Service contracts shall require every provider to permit the service contract holder to return the contract within at least twenty (20) days of the date of mailing of the service contract or within at least ten (10) days if the service contract is delivered at the time of sale or within a longer time period permitted under the contract. If no claim has been made under the contract, the contract is void and the provider shall refund to the contract holder the full purchase price of the contract. A ten percent (10%) penalty per month shall be added to a refund that is not paid within thirty (30) days of return of the contract to the provider. The applicable free-look time periods on service contracts shall only apply to the original service contract purchaser.

M. Service contracts shall set forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage and the requirement for certain service and maintenance.

N. Service contracts shall clearly state whether or not the service contract provides for or excludes consequential damages or preexisting conditions.

Section 6. Prohibited Acts

A. A provider shall not use in its name the words insurance, casualty, guaranty, surety, mutual or any other words descriptive of the insurance, casualty, guaranty or surety business; or a name deceptively similar to the name or description of any insurance or surety corporation, or any other provider. This section shall not apply to a company that was using any of the prohibited language in its name prior to the effective date of this Act. However, a company using the prohibited language in its name shall conspicuously disclose in its service contracts a statement in substantially the following: "This agreement is not an insurance contract."

B. A provider or its representative shall not in its service contracts or literature make, permit or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted, in connection with the sale, offer to sell or advertisement of a service contract.

C. A person, such as a bank, savings and loan association, lending institution, manufacturer or seller of any product, shall not require the purchase of a service contract as a condition of a loan or a condition for the sale of any property.

Section 7. Recordkeeping Requirements

A. Books and Records:

(1) An administrator shall keep accurate accounts, books and records concerning transactions regulated under this Act.

(2) An administrator's accounts, books, and records shall include:

(a) Copies of each type of service contract issued;

(b) The name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder;

(c) A list of the provider locations where service contracts are marketed, sold or offered for sale; and

(d) Claims files which shall contain at least the dates, amounts and description of all receipts, claims and expenditures related to the service contracts.

(3) Except as provided in Section 7B, an administrator shall retain all records pertaining to each service contract holder for at least three (3) years after the specified period of coverage has expired.

(4) An administrator may keep all records required under this Act on a computer disk or other similar technology. If an administrator maintains records in other than hard copy, records shall be accessible from a computer terminal available to the commissioner and be capable of duplication to legible hard copy.

B. An administrator discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to contract holders in this state.

C. An administrator shall make all accounts, books and records concerning transactions regulated under this Act or other pertinent laws available to the commissioner upon request.

Section 8. Termination of Reimbursement Insurance Policy

As applicable, an insurer that issued a reimbursement insurance policy shall not terminate the policy until a notice of termination in accordance with [insert citation to the law that governs the termination of insurance contracts] has been mailed or delivered to the commissioner. The termination of a reimbursement insurance policy shall not reduce the issuer's responsibility for service contracts issued by providers prior to the date of the termination.

Section 9. Obligation of Reimbursement Insurance Policy Insurers

A. Providers are considered to be the agent of the insurer which issued the reimbursement insurance policy for purposes of [insert citation to the law that obligates an insurer for the acts of its agents, including the collection of moneys not forwarded]. In cases where a provider is acting as an administrator and enlists other providers, the provider acting as the administrator shall notify the insurer of the existence and identities of the other providers.

B. This Act shall not prevent or limit the right of an insurer which issued a reimbursement insurance policy to seek indemnification or subrogation against a provider if the issuer pays or is obligated to pay the service contract holder sums that the provider was obligated to pay pursuant to the provisions of the service contract or under a contractual agreement.

Section 10. Enforcement Provisions

A. The commissioner may conduct investigations or examinations of providers, administrators, insurers or other persons to enforce the provisions of this Act and protect service contract holders in this state.

B. The commissioner may take action which is necessary or appropriate to enforce the provisions of this Act and the commissioner's regulations and orders, and to protect service contract holders in this state.

(1) The commissioner may order a service contract provider to cease and desist from committing violations of this Act or the commissioner's regulations or orders, may issue an order prohibiting a service contract provider from selling or offering for sale service contracts, or may issue an order imposing a civil penalty, or any combination of these, if the provider has violated this Act or the commissioner's regulations or orders.

(a) A person aggrieved by an order issued under this paragraph may request a hearing before the commissioner. The hearing request shall be filed with the commissioner within [20] days of the date the commissioner's order is effective;

(b) Pending the hearing and the decision by the commissioner, the commissioner shall suspend the effective date of the order; and

(c) At the hearing, the burden shall be on the commissioner to show why the order issued pursuant to this paragraph is justified. The provisions of [insert citation to statutes concerning hearings before the commissioner] shall apply to a hearing requested under this paragraph.

(2) The commissioner may bring an action in [insert court] Court for an injunction or other appropriate relief to enjoin threatened or existing violations of this Act or of the commissioner's orders or regulations. An action filed under this paragraph may also seek restitution on behalf of persons aggrieved by a violation of this Act or orders or regulations of the commissioner.

(3) A person in violation of this Act or orders or regulation of the commissioner may be assessed a civil penalty not to exceed $[insert amount] per violation.

C. The authority of the commissioner under this section is in addition to other authority of the commissioner.

Drafting Note: It is recommended that states review the enforcement procedures in their insurance laws and administrative procedure laws to ensure that adequate enforcement provisions are in place.

Section 11. Authority to Develop Regulations

The commissioner may promulgate regulations necessary to effectuate this Act.

Section 12. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 4th Quarter 11, 33, 998, 1027-1033 (adopted).

SERVICE CONTRACTS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SERVICE CONTRACTS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 8-32-1 to 8-32-12 (1997).		
Alaska			ALASKA STAT. § 21.03.021 (1968/2014) (service contract is not insurance).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1095 to 20-1095.10 (1982); ARIZ. ADMIN. CODE R20-6-407 (1987).
Arkansas	ARK. CODE ANN. §§ 4-114-101 to 4-114-112 (2007/2009).		ARK. CODE ANN. §§ 4-90-501 to 4-90-512 (1993) (motor vehicle service contracts).
California			CAL. INS. CODE §§ 12140 to 12311 (1935/2004) (motor clubs); §§ 12800 to 12865 (2004/2010) (motor vehicle service contracts); CAL. BUS. & PROF. CODE §§ 9855 to 9855.9 (1993/1998); CAL. CIV. CODE §§ 1791 to 1794.4 (1970/2004).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Colorado			COLO. REV. STAT. §§ 10-4-1601 to 10-4-1609 (2014); 3 COLO. CODE REGS. § 702-5:5-1-12 (2013) (warranties and service contracts).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	D.C. CODE ANN. §§ 31-2351.01 to 31-2351.13 (2019).		
Florida			FLA. STAT. §§ 634.011 to 634.271 (1959/2005) (motor vehicle service contracts); §§ 634.301 to 634.444 (1977/1999); MEMORANDUM 2011-04M (2011).
Georgia			GA. CODE ANN. § 33-7-6 (1960/2013); GA. COMP. R. & REGS. 120-2-47-.01 to 120-2-47-.14 (1989/2013) (motor vehicle service contracts).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 481X-1 to 481X-12 (2000).
Idaho			IDAHO CODE ANN. § 41-114A (2000).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Illinois			215 ILL. COMP. STAT. 152/1 to 152/99 (1998/2013).
Indiana			IND. CODE ANN. §§ 27-1-43.2-1 to 27-1-43.2-19 (2014).
Iowa			IOWA ADMIN. CODE r. 191-103.1 to 191-103.15 (2016) (motor vehicle service contracts).
Kansas	NO CURRENT ACTIVITY		
Kentucky			806 KY. ADMIN. REGS. 5:060 (1997).
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 7101 to 7112 (2012).		BULLETIN 393 (2014).
Maryland			MD. CODE ANN., COM. LAW §§ 14-401 to 14-410 (1975/2002).
Massachusetts			MASS. GEN. LAWS ANN. ch. 175, § 149N (2011).
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. STAT. §§ 59B.01 to 59B.11 (2005).		
Mississippi			MISS. CODE ANN. § 75-24-91 (2003).
Missouri			MO. REV. STAT. §§ 385.200 to 385.436 (2007/2011) (auto); MO. CODE REGS. ANN. tit. 20, §§ 200-18.010 to 200-18.120 (2012).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana			MONT. CODE ANN. §§ 61-12-301 to 61-12-315 (1931/1947) (motor vehicle service clubs).
Nebraska			NEB. REV. STAT. §§ 44-3520 to 44-3527 (1990); §§ 44-3701 to 44-3721 (1981); 210 NEB. ADMIN. CODE § 58 (1994/2012) (motor vehicle service contracts); BULLETIN CB-106 (2008).
Nevada			NEV. REV. STAT. §§ 690C.010 to 690C.330 (2000); §§ 696A.010 to 696A.360 (1971/2006) (motor vehicle service clubs); NEV. ADMIN. CODE §§ 690C.010 to 690C.120 (2000).
New Hampshire			N.H. REV. STAT. ANN. §§ 415-C:1 to 415-C:12 (2005/2009).
New Jersey			N.J. STAT. ANN. § 56:12-88 (2013).
New Mexico			N.M. STAT. ANN. §§ 59A-58-1 to 59A-58-18 (2002/2013).
New York	N.Y. INS. LAW §§ 7901 to 7913 (1997/2012).		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 390.1 to 390.13 (2001/2003) (Reg. 155); CIRCULAR LETTER 2006-19 (2006); CIRCULAR LETTER 2009-19 (2009).
North Carolina			N.C. GEN. STAT. §§ 66-370 to 66-374 (1992/1995) (motor vehicle service and home service contracts).
North Dakota			N.D. CENT. CODE § 9-01-21 (2001) (property service contract is not insurance).
Northern Marianas	NO CURENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio			OHIO REV. CODE ANN. § 3905.422 (2004) (home service contract is not insurance).
Oklahoma			OKLA. STAT. tit. 36, §§ 3101 to 3112 (1973) (motor vehicle service clubs); OKLA. STAT. tit. 15, §§ 141.1 to 141.35 (2012/2014) (service warranty).
Oregon			OR. REV. STAT. §§ 646A.150 to 646A.172 (1995/2005); §§ 742.390 to 742.392 (1995); OR. ADMIN. R. 836-200-0000 to 836-200-0060 (1996/2006).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 2101 to 2134 (1961/1979) (motor vehicle service contracts).
Rhode Island			R.I. GEN. LAWS ANN. § 6-57-2 (2019) (service contracts are not insurance).
South Carolina	S.C. CODE ANN. §§ 38-78-10 to 38-78-120 (2000).		S.C. CODE ANN. §§ 39-61-10 to 39-61-200 (1987) (motor club); S.C. CODE ANN. REG. 69-61 (2001).
South Dakota			S.D. CODIFIED LAWS § 58-1-3 (1966/2001) (exempts service contracts).
Tennessee			TENN. CODE ANN. § 56-2-126 (2011) (service contracts are not insurance).
Texas	NO CURRENT ACTIVITY		
Utah	UTAH CODE ANN. §§ 31A-6a-101 to 31A-6a-111 (1992/2003).		UTAH ADMIN. CODE R590-166-1 to R590-166-6 (2009/2014).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont			VT. STAT. ANN. tit. 8, §§ 4247 to 4256 (1998).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 59.1-435 to 59.1-441 (1991/1997).
Washington	WASH. REV. CODE ANN. §§ 48.110.010 to 48.110.904 (1999/2014).		
West Virginia			W. VA. CODE § 33-4-2 (2000) (exempts service contracts from insurance code).
Wisconsin			WIS. STAT. §§ 616.71 to 616.82 (1933/1979) (motor vehicle service clubs).
Wyoming	WYO. STAT. ANN. §§ 26-49-101 to 26-49-111 (1999).		WYO. STAT. ANN. §§ 31-14-101 to 31-14-131 (1969/1984) (motor vehicle service clubs).

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Table of Contents

Article I. Purposes

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; *provided*, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

Drafting Note: Although consideration was given to including in the model legislation definitions for "life insurance," "annuity," "disability income insurance" and "long-term care insurance," it was determined that such definitions would be more appropriately addressed through the Commission's rule-making process. Not all of the states currently have definitions for "life insurance" or "annuity." Additionally, the evolutionary nature of these products in the marketplace raises issues as to whether statutory definitions would be sufficiently broad enough to address future contingencies, and it would be difficult for compacting states to amend the compact if modifications are required. It is recognized that product standards will only apply to specific products, and the interstate commission would be able to define those products at the time it develops the standards through its rulemaking process.

Examples of product definitions that could be developed through the rulemaking process include the following: "Life Insurance" is insurance primarily for the purpose of coverage on human lives, including incidental benefits, as may be determined by the Compact Commission. "Annuity" is a contract the primary purpose of which is to obligate an insurer to make periodic payments, including incidental benefits, as may be determined by the Compact Commission. "Disability Income Insurance" is insurance primarily for the purpose of coverage that provides payments when an insured is disabled or unable to work because of illness, disease, or injury, including incidental benefits, as may be determined by the Compact Commission. "Long-Term Care Insurance" is insurance primarily for the purpose of providing coverage when the insured is unable to perform specified activities of daily living or related functions, or have a cognitive impairment, including incidental benefits, as may be determined by the Compact Commission.

Article III. Establishment of the Commission and Venue

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; *provided*, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

Article IV. Powers of the Commission

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, *provided,* that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, *provided further,* that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

Drafting Note: With respect to Advertisement, it is recommended that the Commission develop and adopt Uniform Standards for Advertisement regarding Products covered under the Compact. With the exception of long-term care insurance products, the Commission would generally not receive and approve any Advertisement.

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; *provided,* that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; *provided* that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; *provided* that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

Drafting Note: It is recognized that the Commission must have authority to enforce compliance by Compacting States with the Bylaws, Rules or Operating Procedures of the Commission.

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

Drafting Note: The Compact allows each Compacting State to select the person who will represent the State in making policy and administrative decisions of the Compact. Ordinarily, it is presumed the member will be the insurance commissioner who is otherwise responsible for such decisions within the State and is supported by the professional staff of the insurance department. The Compact allows for exceptions if the State electing to join the Compact feels a different selection is merited.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting *en toto* or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

Drafting Note: In developing the composition of the Management Committee, consideration was given to the role of Compacting States in governance and operational issues. It is desirable to achieve a proper balance on the Management Committee between the Compacting States based on premium volume and geographical diversity. Accordingly, factors such as a Compacting State's premium volume for annuity, individual and group life insurance, disability income, and long-term care insurance products, as well as geographical representation using the zone regions of the NAIC were utilized. There are certain advantages to having Compacting States with large premium markets play a significant role on the Management Committee. It is also recognized that Compacting States with smaller premium volume may raise issues with respect to the overall balancing of interests of members on the Management Committee.

Additional Note: The concept of serving on a "rotating basis" involves giving each Compacting State in the group the opportunity to serve the same number of terms on the Management Committee before any other Compacting State in the group serves an additional term. For example, those members representing Compacting States in the group shall each serve one term on the Management Committee before any such State serves a second term.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; *provided* that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; *provided* that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

Drafting Note: It is anticipated that the number and manner of selecting members of these committees will be addressed in the Bylaws. Additionally, consideration will be given to the creation of other advisory committees depending on the needs of the Commission

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; *provided,* that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; *provided,* that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and *provided further*, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, *provided,* that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

Article VII. Rules and Operating Procedures: Rulemaking Functions of the Commission and Opting Out of Uniform Standards

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. *Effective Date and Opt Out of a Uniform Standard.* A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; *provided, however,* that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. *Opt Out Procedure*. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

   Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

Drafting Note: States joining the Compact are encouraged to refrain from using this so-called "front end" opt out for long-term care insurance products. It is recognized that there are many important factors which support the development of Uniform Standards for long-term care insurance products, including: the mobile nature of the population in this country and the need for greater uniformity among the States regarding product standards for long-term care insurance products; the assertion that long-term care insurance products serve as a retirement security product that competes with other products offered by financial institutions; and long-term care insurance products are used in connection with life insurance and annuity products and therefore should also be eligible for consideration of appropriate Uniform Standards.

5. *Effect of Opt Out.* If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

   Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. *Stay of Uniform Standard.* If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; *provided*, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; *provided*, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII. Commission Records and Enforcement

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

Drafting Note: The Commission will generally develop rules establishing conditions and procedures for making information available to the public. However, the reference in this section to the confidential treatment of insurer information is limited to trade secrets. Article X provides for the development of rules by the Commission to address the manner in which the public will be given access to product filing information, which is recognized as proprietary information of insurers.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; *provided,* that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; *and further provided,* that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

   a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

   b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Drafting Note: It is not intended for the Compact to preempt a Compacting State's regulatory authority to enforce State law pertaining to the manner in which the Products approved by the Commission are marketed, sold and administered in a Compacting State.

Article IX. Dispute Resolution

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X. Product Filing and Approval

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

Article XII. Finance

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request *provided, however*, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. Compacting States, Effective Date and Amendment

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; *provided*, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV. Withdrawal, Default and Termination

1. Withdrawal

   a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; *provided,* that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

   b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

   c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

   d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

   e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

   f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV. Severability and Construction

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. Binding Effect of Compact and Other Laws

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

Drafting Note: In those states where a state official other that the attorney general enforces general consumer protection laws, the title of the official should be inserted into the model act in place of the attorney general. It is not intended for the Compact to empower the Commission with authority beyond what has been traditionally given to state insurance regulators. For example, the Compact is not intended to affect the application, if any, of a state's general consumer fraud statutes, deceptive or unfair trade practices act or claims handling laws or the enforcement of such laws by the state attorney general or other appropriate official. Additionally, nothing in the interstate compact legislation is designed to alter the current rules of construction in a state, such as the rule that any ambiguity will be construed against the drafter of the policy.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Appendix A

Interstate Insurance Product Regulation Compact

Language for Preamble:

"An Act intended to help States join together to establish an interstate compact to regulate designated insurance products.

Pursuant to terms and conditions of this Act, the State of _____ seeks to join with other States and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. [Insert title or position of person] is hereby designated to serve as the representative of this State to the Commission."

Alternatively, for those States using a specific selection process, (such as where the Governor or a joint conference of the state house and senate appoint the Member) the following sentence could be used as replacement for the second sentence in this paragraph: "The representative of this State to the Commission shall be selected as follows: [insert procedure for selection of Member].

Language for those States where Preamble is considered insufficient:

It is suggested that for those states where a preamble will not be sufficient, a separate section in the "unallocated" portion of the bill be used to incorporate the same language in the preamble. This will allow the body of compact legislation to remain consistent from state to state. Note: It will probably be necessary to coordinate with the legislative liaison in the insurance departments to confirm the correct approach for each state.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2002 Proc. 4th Quarter 9-14, 14-24 (adopted).
2003 Proc. 3rd Quarter 35, 36-46 (amended and reprinted).

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-60-1 to 27-60-3 (2011).		
Alaska	ALASKA STAT. § 21.42.700 (2006).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-3251 (2014).		
Arkansas	ARK. CODE ANN. §§ 23-67-601 to 23-67-602 (2013).		
California	NO CURRENT ACTIVITY		
Colorado	COLO. ADMIN. INS. REG. 24-60-3001 (2006).		
Connecticut	CONN. GEN. STAT. § 38a-37 (2017).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	D.C. CODE §§ 31-1392.01 to 31-1392.02 (2019).		D.C. CODE § 31-1391 (2006) (authority to enter into compact).
Florida			FLA. STAT. §§ 626.9931 to 626.9938 (2013).

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. CODE ANN. §§ 33-59-1 to 33-59-2 (2006).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAWAII REV. STAT. §§ 431:30-101 to 431:30-124 (2004/2010).		
Idaho	IDAHO CODE §§ 41-5701 to 41-5702 (2005).		
Illinois	45 ILL COMP. STAT. 160/1 to 160/99 (1996/2007).		
Indiana	IND. CODE §§ 27-8-31-1 to 27-8-31-20 (2005).		IND. CODE ANN. § 2-21-1 (2011).
Iowa	IOWA CODE § 505A.1 (2003/2005).		
Kansas	KS. STAT. ANN.§ 40-5301 (2006)		
Kentucky	KY. REV. STAT. ANN. § 304.51-010 (2006).		
Louisiana	LA. REV. STAT. ANN. §§ 22:2381 to 22:2382 (2008/2009).		
Maine	ME. REV. STAT. ANN. TIT. 24-A §§ 2471 to 2487 (2004).		
Maryland	MD. ANN. CODE INS. §§ 29-101 to 29-102 (2005).		
Massachusetts	MASS. GEN. LAWS. ch. 175K §§ 1 to 16 (2006).		
Michigan	MICH. COMP. LAWS. § 3.1031 (2007).		
Minnesota	MINN. STAT. §§ 60A.99 to 60A.991 (2006).		
Mississippi	MISS. CODE ANN. §§ 357-1 to 357-2 (2009).		

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO REV. STAT. §§ 374.351 to 374.352 (2009).		
Montana	MONT. CODE ANN. §§ 33-39-101 to 33-39-103 (2013).		
Nebraska	NEB. REV. STAT. § 44-7801 (2005).		
Nevada	NEV. REV. STAT. §§ 687C.010 to 687C.030 (2011/2013).		
New Hampshire	N.H. REV. STAT. ANN. §§ 408-C:1 to 408-C:16 (2004).		
New Jersey	N.J. ADMIN. CODE §§ 3:C.17B-37.1 to 3:C.17B-37-17 (2011).		
New Mexico	N.M. STAT. § 59A-2 (2009).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-91-1 to 58-91-80 (2005).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3915.16 (2006).		
Oklahoma	OKLA. STAT. tit. 36, § 7004 (2006).		
Oregon	OR. REV. STAT. §§ 732.820 to 732.825 (2011/2012).		
Pennsylvania	PA. CONS. STAT. §§ 40-4101 to 4103 (2006).		
Puerto Rico	P.R. LAWS ANN. tit. 26 §§ 8081 to 8096 (2005).		
Rhode Island	R.I. GEN. LAWS §§ 27-2.5-1 to 27-2.5-2 (2004/2005).		

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. § 38 (2008).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. CODE ANN. §§ 56-58-101 to 56-58-103 (2007/2012).		
Texas	TEX. INS. CODE ANN. §§ 5001.001 to 5001.002 (2005).		
Utah	UTAH CODE ANN. § 31A-39-101 (2004).		
Vermont	VT. STAT. ANN. tit. 8 §§ 8500 to 8517 (2005).		VT. STAT. ANN. tit. 8, § 3661 (2009).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE §§ 38.2-6100 to 38.2-6101 (2004).		
Washington	WASH. REV. CODE ANN. § 48.130 (2005).		
West Virginia	W.V. CODE §§ 38-47-1 to 33-47-17 (2004).		
Wisconsin	WIS. CODE ANN. § 601.59 (2008).		
Wyoming	WYO. STAT. § 26-15-201 (2006).		

MARKET CONDUCT SURVEILLANCE MODEL LAW

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Market Conduct Surveillance Law.

Section 2. Purpose and Legislative Intent

The purpose of this Act is to establish a framework for Insurance Department market conduct actions, including:

A. Processes and systems for identifying, assessing and prioritizing market conduct problems that have a substantial adverse impact on consumers, policyholders and claimants;

B. Market conduct actions by a commissioner to substantiate such market conduct problems and a means to remedy significant market conduct problems; and

C. Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources.

Section 3. Definitions

A. "Commissioner" means the chief insurance regulatory official of the state.

Drafting Note: Where the word "commissioner" appears, the appropriate designation for the chief insurance regulatory official of the state, if different, should be substituted.

B. "Complaint" means a written or documented oral communication primarily expressing a grievance, meaning an expression of dissatisfaction.

C. "Market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of insurers that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

D. "Market conduct action" means any of the full range of activities that the commissioner may initiate to assess and address the market practices of insurers, beginning with market analysis and extending to targeted examinations. The commissioner's activities to resolve an individual consumer complaint or other report of a specific instance of misconduct are not market conduct actions for purposes of this Act.

E. "Market conduct surveillance personnel" means those individuals employed or contracted by the commissioner to collect, analyze, review or act on information on the insurance marketplace that identifies patterns or practices of insurers.

F. "National Association of Insurance Commissioners" (NAIC) means the organization of insurance regulators from the fifty (50) states, the District of Columbia and the four (4) U.S. territories.

Drafting Note: If statutory drafting conventions require further description, the following language should be used: "Its mission is to assist insurance regulators in protecting the public interest, promoting competitive markets, facilitating the fair and equitable treatment of insurance consumers, promoting the reliability, solvency and financial solidity of insurance institutions, and supporting and improving state regulation of insurance."

G. "NAIC *Market Analysis Handbook*" means the outline of the elements and objectives of market analysis developed and adopted by the NAIC, and the process by which states can establish and implement market analysis programs.

H. "NAIC *Market Conduct Examiner's Handbook*" means the set of guidelines developed and adopted by the NAIC that documents established practices to be used by market conduct surveillance personnel in developing and executing an examination.

I. "NAIC *Market Conduct Uniform Examination Procedures*" means the set of guidelines developed and adopted by the NAIC designed to be used by market conduct surveillance personnel in conducting an examination.

J. "NAIC Standard Data Request" means the set of field names and descriptions developed and adopted by the NAIC for use by market conduct surveillance personnel in an examination.

K. "Qualified contract examiner" means a person under contract to the commissioner, who is qualified by education, experience and, where applicable, professional designations, to perform market conduct actions.

L. "Targeted examination" means a focused exam, based on the results of market analysis indicating the need to review either a specific line of business or specific business practices, including but not limited to underwriting and rating, marketing and sales, complaint handling operations/management, advertising materials, licensing, policyholder services, nonforfeitures, claims handling, or policy forms and filings. A targeted examination may be conducted by desk examination or by an on-site examination.

(1) "Desk examination" means a targeted examination that is conducted by an examiner at a location other than the insurer's premises. A desk examination is usually performed at the Insurance Department's offices with the insurer providing requested documents by hard copy, microfiche, discs or other electronic media, for review.

(2) "On-site examination" means a targeted examination conducted at the insurer's home office or the location where the records under review are stored.

M. "Third party model or product" means a model or product provided by an entity separate from and not under direct or indirect corporate control of the insurer using the model or product.

Section 4. Market Analysis Procedures

A. (1) The commissioner shall gather information from data currently available to the Insurance Department, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry.

(2) The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review insurers or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer. The commissioner shall use the NAIC *Market Analysis Handbook* as one resource in performing this analysis. [Additional language will be necessary to conform with the options chosen in Section 5D, which addresses changes to the NAIC work products.]

B. (1) If the commissioner determines, as a result of market analysis, that further inquiry into a particular insurer or practice is needed, the following continuum of market conduct actions may be considered prior to conducting a targeted, on-site market conduct examination. The action selected shall be made known to the insurer in writing if the action involves insurer participation or response. These actions may include, but are not limited to:

(a) Correspondence with the insurer;

(b) Insurer interviews;

(c) Information gathering;

(d) Policy and procedure reviews;

(e) Interrogatories;

(f) Review of insurer self-evaluation (if not subject to a privilege of confidentiality) and compliance programs, including membership in a best practices organization; and

Drafting Note: A best practices organization has as its central mission the promotion of high ethical standards in the marketplace.

(g) Desk examinations.

(2) The commissioner shall select a market conduct action that is cost effective for the Insurance Department and the insurer, while still protecting the insurance consumer.

C. The commissioner shall take those steps reasonably necessary to eliminate duplicative inquiries and coordinate market conduct actions and findings with other states.

Section 5. Protocols for Market Conduct Actions

A. Market conduct actions taken as a result of a market analysis shall focus on the general business practices and compliance activities of insurers rather than identifying infrequent or unintentional random errors that do not cause significant consumer harm.

B. (1) The commissioner is authorized to determine the frequency and timing of such market conduct actions. The timing shall depend upon the specific market conduct action to be initiated, unless extraordinary circumstances indicating a risk to consumers require immediate action.

(2) If the commissioner has information that more than one insurer is engaged in common practices that may violate statute or regulations, the commissioner may schedule and coordinate multiple examinations simultaneously.

C. The insurer may be given an opportunity to resolve matters that arise as a result of a market analysis to the satisfaction of the commissioner before any additional market conduct actions are taken against the insurer.

D. For any change made to an NAIC work product referenced in this Act that [states shall select one of the following three provisions]

Option One

[materially changes the way in which market conduct actions are conducted, the Commissioner shall give notice and provide parties with an opportunity for a public hearing pursuant to [cite appropriate state administrative procedures act]. If no hearing is held, the commissioner shall use the versions of the work products most recently developed and adopted by the NAIC.]

Option Two

[materially changes the way in which market conduct actions are conducted, the Commissioner shall give notice and provide parties with an opportunity for a public hearing pursuant to [cite appropriate state administrative procedures act]. If a hearing is requested and not held, the commissioner shall use the versions of the work products most recently developed and adopted by the NAIC. For the purpose of this subsection, "material change" means any change that would require a statutory or rule change.]

Option Three

[changes the way in which market conduct actions are conducted, the Commissioner shall give notice and provide parties with an opportunity for a public hearing pursuant to [cite appropriate state administrative procedures act] in the following circumstances:

(1) Any change that would necessitate a change in statute, regulation or rule; or

(2) If a commissioner deviates from the most recently adopted NAIC work product.]

E. Except as otherwise provided by law, every insurer or person from whom information is sought, its officers, directors and agents shall provide the commissioner convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the insurer. The officers, directors, employees, insurance producers and agents of the insurer or person shall facilitate market conduct actions and aid in market conduct actions so far as it is in their power to do so.

Section 6. Targeted On-Site Market Conduct Examinations

A. When the commissioner determines that other market conduct actions identified in Section 4B are not appropriate, the commissioner has the discretion to conduct targeted, on-site market conduct examinations in accordance with the NAIC *Market Conduct Uniform Examination Procedures* and the *Market Conduct Examiners Handbook.* [Additional language will be necessary to conform with the options chosen in Section 5D, which addresses changes to the NAIC work products.]

B. Concomitant with the notification requirements established in Subsection E of this section, the commissioner shall post notification on the NAIC *Examination Tracking System,* or successor NAIC product as determined by the commissioner, that a market conduct examination has been scheduled.

C. In lieu of an examination of a foreign or alien insurer licensed in this state under this Act, the commissioner may accept an examination report of another state provided that the state has a market surveillance system the commissioner deems comparable to the market surveillance system set forth in this law.

Drafting Note: It is anticipated that as states adopt this model law or similar statutes, the practice of "domestic deference," and other appropriate forms of interstate collaboration, whereby states rely on market conduct examinations performed by other states, will reduce and eventually eliminate unnecessary duplication of effort in the area of market conduct regulation.

D. (1) Prior to commencement of a targeted on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan consisting of the following:

(a) The name and address of the insurer being examined;

(b) The name and contact information of the examiner-in-charge;

(c) The justification for the targeted, on-site examination;

(d) The scope of the targeted, on-site examination;

(e) The date the on-site examination is scheduled to begin;

(f) Notice of any non-insurance department personnel who will assist in the examination;

(g) A time estimate for the targeted, on-site examination;

(h) A budget for the targeted, on-site examination if the cost of the examination is billed to the insurer; and

(i) An identification of factors that will be included in the billing if the cost of the examination is billed to the insurer.

(2) Market conduct examinations shall, to the extent feasible, utilize desk examinations and data requests prior to a targeted on-site examination.

(3) Market conduct examinations shall be conducted in accordance with the provisions set forth in the NAIC *Market Conduct Examiners Handbook* and the NAIC *Market Conduct Uniform Examinations Procedures* [Additional language will be necessary to conform with the options chosen in Section 5D, which addresses changes to the NAIC work products.]

(4) The department shall use the NAIC Standard Data Request, (or successor product adopted by regulation that is substantially similar to the foregoing NAIC product).

E. Announcement of the examination shall be sent to the insurer and posted on the NAIC's *Examination Tracking System* (or successor NAIC product, as determined by the commissioner) as soon as possible but in no case later than sixty (60) days before the estimated commencement of the on-site examination, except where the exam is conducted in response to extraordinary circumstances as described in Section 5B(1). The announcement sent to the insurer shall contain the examination work plan and a request for the insurer to name its examination coordinator.

F. The commissioner shall conduct a pre-examination conference with the insurer examination coordinator and key personnel to clarify expectations thirty (30) days prior to commencement of the examination.

G. Prior to the conclusion of a targeted on-site market conduct examination, the individual among the market conduct surveillance personnel who is designated as the examiner-in-charge shall schedule an exit conference with the insurer.

H. (1) The commissioner shall adhere to the following timeline, unless a mutual agreement is reached with the insurer to modify the timeline:

(a) The commissioner shall deliver the draft report to the insurer within sixty (60) days of the completion of the examination. Completion of the examination shall be defined as the date the commissioner confirms in writing that the examination is completed.

(b) The insurer shall respond with written comments within thirty (30) days of receipt of the draft report.

(c) The department shall make a good faith effort to resolve issues informally and prepare a final report within thirty (30) days of receipt of the insurer's written comments, unless a mutual agreement is reached to extend the deadline. The commissioner may make corrections and other changes, as appropriate.

(d) The insurer shall, within thirty (30) days, accept the final report, accept the findings of the report or request a hearing. An additional thirty (30) days shall be allowed if agreed to by the commissioner and the insurer. Any such hearing request shall be made in writing and shall follow [insert reference to appropriate administrative procedure act].

(2) States shall include the insurer's response in the final report. The response may be included as an appendix or in the text of the examination report. The insurer is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response except to acknowledge their involvement.

Drafting Note: States should rely upon the NAIC *Market Conduct Examiners Handbook* to establish specific standards for examination reports.

I. (1) Upon adoption of the examination report pursuant to Subsection H, the commissioner shall continue to hold the content of the examination report as private and confidential for a period of thirty (30) days, except to the extent provided for in Paragraph (2) of this subsection. Thereafter, the commissioner shall open the report for public inspection, provided no court of competent jurisdiction has stayed its publication.

(2) Nothing contained in this Act shall prevent or be construed as preventing the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Insurance Department of this or any other state or agency of the federal government at any time, provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this Act.

J. (1) Where the reasonable and necessary costs of a market conduct examination are to be assessed against the insurer under examination, the fees shall be consistent with that otherwise authorized by law. The fees shall be itemized and bills shall be provided to the insurer on a monthly basis for review prior to submission for payment.

(2) The commissioner shall maintain active management and oversight of examination costs, including costs associated with the commissioner's own examiners and with retaining qualified contract examiners necessary to perform an on-site examination. To the extent the commissioner retains outside assistance, the commissioner shall have in writing protocols that:

(a) Clearly identify the types of functions to be subject to outsourcing;

(b) Provide specific timelines for completion of the outsourced review;

(c) Require disclosure of contract examiners' recommendations;

(d) Establish and utilize a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination fees; and

(e) Require disclosure of the terms of the contracts with the outside consultants that will be used, specifically the fees and/or hourly rates that can be charged.

(3) The commissioner shall review and affirmatively endorse detailed billings from the qualified contract examiner before the detailed billings are sent to the insurer.

Section 7. Confidentiality Requirements

A. Except as otherwise provided by law, market conduct surveillance personnel shall have free and full access to all books and records, employees, officers and directors, as practicable, of the insurer during regular business hours. An insurer utilizing a third-party model or product for any of the activities under examination shall cause, upon the request of market conduct surveillance personnel, the details of such models or products to be made available to such personnel. All documents, including but not limited to working papers, third party models or products, complaint logs, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of any market conduct actions made pursuant to this Act, or in the course of market analysis by the commissioner of the market conditions of an insurer, or obtained by the NAIC as a result of any of the provisions of this Act, shall be confidential by law and privileged, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.

Drafting Note: If the state has enacted an insurer self-evaluative privilege law, the provisions of Section 7A may need to be revised to be consistent and that law.

B. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section.

C. Market conduct surveillance personnel shall be vested with the power to issue subpoenas and examine insurance company personnel under oath when the action is ordered by the commissioner pursuant to [cite the appropriate state authority].

D. Notwithstanding the provisions of Subsection A of this section, in order to assist in the performance of the commissioner's duties, the commissioner may:

(1) Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, with other state, federal and international regulatory agencies and law enforcement authorities and the NAIC and its affiliates and subsidiaries, provided that the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, communication or other information;

(2) Receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) Enter into agreements governing the sharing and use of information consistent with this subsection.

Drafting Note: States may consider enacting an insurer self-evaluation privilege law, which some believe encourages insurers' to identify and remedy insurance and other compliance problems. Such laws typically provide for a limited expansion of the protection against disclosure.

Section 8. Market Conduct Surveillance Personnel

A. Market conduct surveillance personnel shall be qualified by education, experience and, where applicable, professional designations. The commissioner may supplement the in-house market conduct surveillance staff with qualified outside professional assistance if the commissioner determines that the assistance is necessary.

B. Market conduct surveillance personnel have a conflict of interest, either directly or indirectly, if they are affiliated with the management, have been employed by, or own a pecuniary interest in the insurer subject to any examination under this Act. This section shall not be construed to automatically preclude an individual from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantee of a mortgage or similar instrument on the individual's residence from a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise permissible holdings have been placed.

Section 9. Immunity for Market Conduct Surveillance Personnel

A. No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or an examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. A person identified in Subsection A shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

D. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified Subsection A.

Section 10. Fines and Penalties

A. Fines and penalties levied as a result of a market conduct action or other provisions of the state Insurance Law shall be consistent, reasonable and justified.

B. The commissioner shall take into consideration actions taken by insurers to maintain membership in, and comply with the standards of, best-practices organizations that promote high ethical standards of conduct in the marketplace, and the extent to which insurers maintain regulatory compliance programs to self assess, self-report and remediate problems detected and may include those considerations in determining the appropriate fines levied in accordance with Subsection A.

Drafting Note: It is anticipated that best practices organizations such as the Insurance Marketplace Standards Association (IMSA) in the life insurance industry, and the National Committee for Quality Assurance (NCQA) and URAC in the health insurance industry, will play an important role in market conduct by expanding the frequency of voluntary insurer compliance programs. To the extent that these or similar organizations, through their compliance qualification process and procedures, can foster a culture of compliance, their contribution to market conduct surveillance should be recognized. The NAIC Best Practices Organization White Paper discusses the operational and performance standards for a best practices organization that seeks regulatory recognition for the entities the best practice organization accredits.

Section 11. Participation in National Market Conduct Databases

A. The commissioner shall collect and report market data to the NAIC's market information systems, including the Complaint Database System, the Examination Tracking System, and the Regulatory Information Retrieval System, or other successor NAIC products as determined by the commissioner.

B. Information collected and maintained by the Insurance Department shall be compiled in a manner that meets the requirements of the NAIC.

Section 12. Coordination with Other States Through the NAIC

The commissioner shall share information and coordinate the Insurance Department's market analysis and examination efforts with other states through the NAIC.

Drafting Note: The NAIC Market Analysis Working Group is the national, confidential forum established by the NAIC to provide regulators with opportunities to share and coordinate the results of their market analysis programs and market conduct actions. States participating in the working group are expected to conduct their market analysis programs in a manner consistent with guidelines adopted by the NAIC. Adoption of this (or a similar) law, coupled with expanded participation in the working group by states, will help foster the goal of domestic deference and other appropriate forms of interstate collaboration, thereby helping to fulfill the goal of making market conduct surveillance a national system of regulation that is more standard and uniform.

Section 13. Additional Duties of the Commissioner

A. At least once per year, or more frequently if deemed necessary, the commissioner shall provide in an appropriate manner to insurers and other entities subject to the scope of [cite Insurance Code citation] information on new laws and regulations, enforcement actions and other information the commissioner deems pertinent to ensure compliance with market conduct requirements. The failure of the commissioner to provide information shall not be a defense for an insurer that fails to comply with any insurance law of this state.

B. The commissioner shall designate a specific person or persons within the Insurance Department whose responsibilities shall include the receipt of information from employees of insurers and licensed entities concerning violations of laws, rules or regulations by employers, as defined in this section. These persons shall be provided with proper training on the handling of such information, which shall be deemed a confidential communication for the purposes of this section.

Drafting Note: The provisions of Subsection B relating to the designation by the commissioner of an employee to receive "whistleblower" type complaints may be added to an existing whistleblower statute, added as drafted above or omitted.

Drafting Note: States that choose to impose additional duties or responsibilities on their own insurance commissioners may insert additional subsections to this section.

Section 14. Effective Date

This Act shall take effect [insert effective date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2004 Proc. 2nd Quarter 1007, 1008-1019 (adopted by parent committee)
2004 Proc. 3rd Quarter 55-56 (adopted by Plenary).

MARKET CONDUCT SURVEILLANCE MODEL LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MARKET CONDUCT SURVEILLANCE MODEL LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			BULLETIN 5-2012 (2012).
California	NO CURRENT ACTIVITY		
Colorado	COLO. REV. STAT. ANN. § 10-1-301 to 10-1-312 (2018).		3 COLO. CODE REGS. § 702-6:6-3-1 (2018).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia			D.C. CODE §§ 31-1401 to 31-1407 (1993)
Florida			FLA. STAT. § 624.307 (1959); § 624.316 (1959); § 624.319 (1982).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

MARKET CONDUCT SURVEILLANCE MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/132 (1937/1991).
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE §§ 507.1 to 507.17 (1949/1995).
Kansas			KAN. STAT. ANN. § 40-222 (1927); § 40-225 (1927).
Kentucky	KY. REV. STAT. ANN. §§ 304.2-090 to 304.2-300 (2008).		KY. REV. STAT. ANN. § 304.2-250 (2010).
Louisiana	LA. REV. STAT. ANN. § 22:1984 (2010); § 22:46 (2008).		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. 31.04.20.01 to 31.04.20.10 (2009).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. § 60A.031 (1961/1992).
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. ANN. §§ 374.202 to 324.207 (1992); MO. CODE REGS. ANN. tit. 20, §§ 100-7.002 to 100-7.005 (2008).
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		

MARKET CONDUCT SURVEILLANCE MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire			N.H. REV. STAT. ANN. § 400-A:37 (1971/2008); §§ 400-B:2 to 400-B:3 (2005/2009).
New Jersey			N.J. STAT. ANN. §§ 17:23-20 to 17:23-26 (1993).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina			N.C. GEN. STAT. § 58-2-240 (2005/2007).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3901.011 (1957); § 3901.48 (1957).
Oklahoma			OKLA. STAT. tit. 36, § 311.4 (2009/2014).
Oregon			OR. REV. STAT. § 731.296 (1975).
Pennsylvania			40 PA. STAT. ANN. §§ 323.1 to 323.8 (1921/1992).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-71-1 to 27-71-15 (2008).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. § 56-8-107 (2009).
Texas	TEX. INS. CODE ANN. §§ 751.001 to 751.351 (2005).		
Utah			UTAH CODE ANN. § 31A-2-202 (1985/2006).

MARKET CONDUCT SURVEILLANCE MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont			VT. STAT. ANN. tit. 8, 3561 (2009).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-1317.2 (2008).
Washington	WASH. REV. CODE §§ 48.37.005 to 48.37.140 (2007); WASH. ADMIN. CODE § 284-37-040 (2007).		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2004

MARKET CONDUCT SURVEILLANCE MODEL ACT (#693)

1. Project Description

The model act establishes a legislative framework for the implementation of structured market analysis, uniform targeted examinations and interstate collaboration. More specifically, the purpose of the model act is to accomplish the following: (1) establish a system for identifying, assessing and prioritizing market regulatory problems that have a substantial adverse impact on consumers, policyholders and claimants; (2) set forth a broader continuum of regulatory responses that a commissioner might take to substantiate market problems; and (3) develop procedures to communicate and coordinate market regulatory actions among states to foster the most efficient and effective use of resources.

The National Conference of Insurance Legislators (NCOIL) was heavily involved in the process since NCOIL adopted the model act prior to the NAIC. Subsequent to NCOIL's initial adoption of its model act in February of 2004, the NAIC provided additional comment. As a result of these comments, NCOIL modified its model act and adopted a revised model act in July of 2004.

2. Group Responsible for Drafting Model and States Participating

The Market Conduct and Consumer Affairs (D) Committee was responsible for revising and providing comment on the NCOIL model act. Once NCOIL considered the NAIC's comments, the model was provided to the NAIC Executive Committee for adoption. The following states are members of the D Committee: Oregon (chair), Massachusetts (vice-chair), Delaware, Florida, Idaho, Illinois, Michigan, Missouri Nebraska, Nevada, Ohio, Pennsylvania and Wyoming. In addition to D Committee participation, all NAIC members were provided with a copy of the NCOIL model for comment.

3. Charge Authorizing Project

There was no specific charge addressing this project since NCOIL initially developed the model act. To ensure NCOIL appropriately addressed NAIC policies and concerns, the D Committee took a lead role in coordinating and providing NAIC input into NCOIL's drafting of the model act.

4. General Description of Drafting Process

The NAIC provided formal comment on the NCOIL model act as it was being drafted. NCOIL adopted its initial model act in February of 2004. The D Committee adopted the NCOIL model on April 29, 2004. The states of Oregon, Massachusetts, Florida, Illinois, Michigan, Nebraska, Nevada, Ohio, Pennsylvania, and Wyoming voted yes. The states of Delaware, Idaho and Missouri abstained. The model was then presented to the NAIC Executive Committee and Plenary at NAIC Summer National Meeting. Because the draft did not address all of the NAIC concerns based upon further solicitation of input from all NAIC members, the NAIC requested NCOIL to reopen the model to consider further NAIC comment. As a result of this request, NCOIL modified its model act and adopted a revised model act in July of 2004. The NAIC Executive Committee considered the revised model act during the NAIC Fall National Meeting and adopted the NCOIL model act as a NAIC model act.

The drafting process was very open as the D Committee and Executive Committee solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. All meetings and conference calls adhered to the NAIC's Open Meeting Policy.

5. Significant Issues Raised

Some states expressed concern that the model act places restrictions on a state's authority to conduct regulatory investigations and examinations. Contrary to this opinion, is the opinion that the model act sets forth a regulatory structure that will create greater uniformity and consistency of market regulation among the states.

Interested parties were concerned that specific references to NAIC products may permit the NAIC to change market regulatory standards by changing its work products without going through the legislative process. The three options of subsection 5D, which address a "material change" to a NAIC work product and opportunity for a hearing address this issue.

There was significant discussion regarding the use of "budget" or "cost estimate" in subsection 6D(1)(h). The term "budget" is used. Since a budget is a list of proposed expenditures, which is dependent upon the time estimate and, ultimately, the actual time it takes to complete a targeted examination, the term budget provides states the necessary flexibility during the examination process.

The drafting note of subsection 7A was discussed in detail since the NAIC has not adopted a formal position on self-evaluative privilege laws. This drafting note includes the following language: "States may consider enacting an insurer self-evaluation privilege law, which some believe encourages insurers to identify and remedy insurance and other compliance problems. Such laws typically provide for a limited expansion of the protection against disclosure"

Some states considered the conflict-of-interest provision found in subsection 8B too restrictive.

6. Other Pertinent Information

The Financial Services Committee of the United States Congress has included market regulatory reforms within its review and draft State Modernization and Regulatory Transparency Act (SMART Act). Because of potential Federal activity, there is a heightened need for state insurance regulators and state insurance legislators to work in a coordinated fashion to implement market regulatory reforms.

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION

Table of Contents

Section 1. Authority

This rule is issued pursuant to the authority vested in the commissioner of the State of [insert state] under [insert citation for authority].

Section 2. Purpose

A. The purpose of this regulation is to prescribe:

(1) The terms and conditions under which life insurance companies may issue group annuity contracts and other agreements that in whole or in part establish the insurer's obligation by reference to a segregated portfolio of assets that is not owned by the insurer;

(2) The essential operational features of the segregated portfolio of assets; and

(3) The reserve requirements for these group annuity contracts and agreements.

B. This regulation is intended to aid in the timely approval of such products by the commissioner, and recognizes that timely approval is essential given the competitive nature of the market for these products.

Section 3. Scope and Application

A. This regulation applies to that portion of a group annuity contract or other agreement described in Section 4W and issued by a life insurer:

(1) That functions as an accounting record for an accumulation fund; and

(2) That has benefit guarantees relating to a principal amount and levels of interest at a fixed rate of return specified in advance.

B. The fixed rates of return:

(1) Shall be constant over the applicable rate periods;

(2) May reflect prior and current market conditions with respect to the segregated portfolio; and

(3) Shall not reference future changes in market conditions.

C. This regulation is applicable to all contracts issued after the effective date of this regulation. Contracts that have been negotiated prior to the effective date need not be refiled with the commissioner.

Drafting Note: This regulation is not intended to apply to contingent deferred annuities (CDAs), defined in the Contingent Deferred Annuity (A) Working Group recommendation on CDAs adopted by the Life Insurance and Annuities (A) Committee on April 7, 2013 (NAIC Proceedings, Spring 2013, Volume 1, pdf page 416) as "an annuity contract that establishes a life insurer's obligation to make periodic payments for the annuitant's lifetime at the time designated investments, which are not owned or held by the insurer, are depleted to a contractually defined amount due to contractually permitted withdrawals, market performance, fees and/or other charges."

Drafting Note: This explanation of the fixed rate of return is intended to clarify the fact that the regulation excludes products such as those that guarantee the future performance of a stated index. It is recognized that versions of synthetics other than those described in the scope section may evolve over time; the intent of the regulation is not to preclude the issuance of such products, but rather to describe how a specific set of synthetics (those described in the scope) should be regulated.

Drafting Note: It is expected that individual regulators, where applicable, will retain the right to withdraw approval of previously filed contract forms for new issuance if they do not conform to the regulation. Therefore, no language explicitly withdrawing approval of previously filed forms was included.

Section 4. Definitions

As used in this regulation, the following terms shall have these meanings:

A. "Account assets" means the assets in the segregated portfolio plus any assets held in the general account or a separate account to meet the asset maintenance requirements.

B. "Actuarial opinion and memorandum" means the opinion and memorandum of the valuation actuary required to be submitted to the commissioner pursuant to Section 10B of this regulation.

C. "Affirmatively approved" means approval of an insurer's plan of operation for a class of contracts containing the form of contract under review, after the plan of operation associated with the class of contracts has been reviewed by the insurer's domiciliary insurance department, and the plan of operation has been found to be in compliance with the NAIC Synthetic Guaranteed Investment Contracts Model Regulation by the domiciliary insurance department. Affirmatively approved does not mean approval as a result of the deemer provision.

D. "Appointed actuary" means the qualified actuary appointed or retained either directly by or by the authority of the board of directors through an executive officer of the company to prepare the annual statement of actuarial opinion for the company as a whole pursuant to Section [insert reference to standard valuation law].

E. "Asset maintenance requirement" means the requirement to maintain assets to fund contract benefits in accordance with Section 10 of this regulation.

F. "Class of contracts" means the set of all contracts to which a given plan of operation pertains.

G. "Contract value record" means an accounting record, provided by the contract in relation to a segregated portfolio of assets, that is credited with a fixed rate of return over regular periods, and that is used to measure the extent of the insurer's obligation to the contractholder. The fixed rate of return credited to the contract value record is determined by means of a crediting rate formula or declared at the inception of the contract and valid for the entire term of the contract.

H. "Crediting rate formula" means a mathematical formula used to calculate the fixed rate of return credited to the contract value record during any rate period and based in part upon the difference between the contract value record and the market value record amortized over an appropriate period. The fixed rate of return calculated by means of this formula may reflect prior and current market conditions with respect to the segregated portfolio, but may not reference future changes in market conditions.

I. "Date of filing," with respect to a filing for approval of a contract form under this regulation, means the date as defined by the applicable statutes or regulations of the state of issue with regard to contract filings.

Drafting Note: Individual states may wish to insert a specific reference to the applicable statute or regulation.

J. "Duration" means, with respect to the segregated portfolio assets or guaranteed contract liabilities, a measure of price sensitivity to changes in interest rates, such as the Macaulay duration or option-adjusted duration.

K. "Fair market value" means a reasonable estimate of the amount that a knowledgeable buyer of an asset would be willing to pay, and a knowledgeable seller of an asset would be willing to accept, for the asset without duress in an arm's length transaction. In the case of a publicly traded security, the fair market value is the price at which the security is traded or, if no price is available, a price that appropriately reflects the latest bid and asked prices for the security. In the case of a debt instrument that is not publicly traded, the fair market value is the discounted present value of the asset calculated at a reasonable discount rate. For all other non-publicly traded assets, fair market value will be determined in accordance with valuation practices customarily used within the financial industry.

L. "Guaranteed minimum benefits" means contract benefits on a specified date that may be either:

(1) A principal guarantee, with or without a fixed minimum interest rate guarantee, related to the segregated portfolio;

(2) An assurance as to the future investment return or performance of the segregated portfolio; or

(3) The fair market value of the segregated portfolio, to the extent that the fair market value of the assets determines the contractholder's benefits.

M. (1) "Hedging instrument" means:

(a) An interest rate futures agreement or foreign currency futures agreement, an option to purchase or sell an interest rate futures agreement or foreign currency futures agreement, or any option to purchase or sell a security or foreign currency, used in a bona fide hedging transaction; or

(b) A financial agreement or arrangement entered into with a broker, dealer or bank, qualified under applicable federal and state securities or banking law and regulation, in connection with investment in one or more securities in order to reduce the risk of changes in market valuation or to create a synthetic investment that, when added to the portfolio, reduces the risk of changes in market valuation.

(2) An instrument shall not be considered a hedging instrument or a part of a bona fide hedging transaction if it is purchased in conjunction with another instrument where the effect of the combined transaction is an increase in the portfolio's exposure to market risk.

N. "Investment guidelines" means a set of written guidelines, established in advance by the person with investment authority over the segregated portfolio, to be followed by the investment manager. The guidelines shall include a description of:

(1) The segregated portfolio's investment objectives and limitations;

(2) The investment manager's degree of discretion;

(3) The duration, asset class, quality, diversification, and other requirements of the segregated portfolio; and

(4) The manner in which derivative instruments may be used, if at all, in the segregated portfolio.

O. "Investment manager" means the person (including the contractholder) responsible for managing the assets in the segregated portfolio in accordance with the investment guidelines in a fiduciary capacity to the owner of the assets.

P. "Market value record" means an accounting record provided by the contract to reflect the fair market value of the segregated portfolio.

Q. "Permitted custodial institution" means a bank, trust company or other licensed fiduciary services provider.

Drafting Note: When adopting this regulation, individual regulators may wish to review their applicable state laws to ensure that this definition hasn't inadvertently authorized an entity to act as a custodial institution that it would not wish to do so.

R. "Plan of operation" means a written plan meeting the requirements of Section 5B(1) of this regulation.

S. "Qualified actuary" means an individual who meets the qualification standards set forth in [insert reference to section of the regulations related to actuarial opinions and memoranda].

T. "Rate period" means the period of time during which the fixed rate of return credited to the contract value record is applicable between crediting rate formula adjustments.

U. "Segregated portfolio" means:

(1) A portfolio or sub-portfolio of assets to which the contract pertains that is held in a custody or trust account by the permitted custodial institution and identified on the records of the permitted custodial institution as special custody assets held for the exclusive benefit of the retirement plans or other entities on whose behalf the contractholder holds the contract; and

(2) Any related cash or currency received by the permitted custodial institution for the account of the contractholder and held in a deposit account for the exclusive benefit of the retirement plans or other entities on whose behalf the contractholder holds the contract.

V. "Spot rate"

(1) "Treasury-based spot rate" corresponding to a given time of benefit payment means the yield on a zero-coupon non-callable and non-prepayable United States government obligation maturing at that time, or the zero-coupon yield implied by the price of a representative sampling of coupon-bearing, non-callable and non-prepayable United States government obligations in accordance with a formula set forth in the plan of operation.

(2) "Index spot rate" corresponding to a given time of benefit payment means the zero-coupon yield implied by (x) the Barclays Short Term Corporate Index (for a given time of benefit payment under one year) or (y) the zero-coupon yield implied by the Barclays U.S. Corporate Investment Grade Bond Index (for a given time of benefit payment greater than or equal to one year).

(3) "Blended spot rate" corresponding to a given time of benefit payment means a blend of 50% each of (i) the treasury-based spot rate, and (ii) the index spot rate. To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country rated in one of the two (2) highest rating categories by an independent nationally recognized United States rating agency acceptable to the commissioner and are supported by investments denominated in the currency of the foreign country, the treasury-based spot rate component of the blended spot rate may be determined by reference to substantially similar obligations of the government of the foreign country. For liabilities other than those described above, the blended spot rate shall be determined on a basis mutually agreed upon by the insurer and the commissioner.

W. "Synthetic guaranteed investment contract" or "contract" means a group annuity contract or other agreement that establishes the insurer's obligations by reference to a segregated portfolio of assets that is not owned by the insurer. The contract functions as an accounting record for an accumulation fund and the fixed rate of return credited to the fund reflects an amortization of the segregated portfolio's market gains and losses based on the period specified in the crediting formula, subject to any minimum interest rate guarantee.

X. "Unilateral contract termination event" means an event allowing the insurer to unilaterally and immediately terminate the contract, without future liability or obligation to the contractholder.

Y. "United States government obligation" means a direct obligation issued, assumed, guaranteed or insured by the United States of America or by an agency or instrumentality of the United States government.

Z. "Valuation actuary" means the appointed actuary or, alternatively, a qualified actuary designated by the appointed actuary to render the actuarial opinion pursuant to Section 10. Written documentation of any such designation shall be on file at the company and available for review by the commissioner upon request.

Section 5. Financial Requirements and Plan of Operation

A contract may not be delivered or issued for delivery in this state unless the issuing insurer is licensed as a life insurance company in this state and is financially qualified under the provisions of Subsection A of this section. In addition, a domestic insurer may not deliver or issue for delivery, either in this state or outside this state, a contract belonging to a specific class of contracts unless the insurer has satisfied the requirements of Subsection B of this section with respect to that class.

A. An insurer will be financially qualified under this section if its most recent statutory financial statements reflect at least $1 billion in admitted assets or $100 million in capital and surplus, and its risk-based capital results do not place it at a regulatory level of action. In lieu of the requirements in the preceding sentence, the insurer may be required to satisfy such other financial qualification requirements set forth by the commissioner as having been deemed necessary or appropriate in a particular case to protect the insurer's policyholders and the public.

B. A domestic insurer will satisfy the requirements of this section with respect to a class of contracts if the insurer has filed a plan of operation pertaining to the class of contracts, together with copies of the forms of contract in the class, with the commissioner and the filing of the plan of operation has been approved or has not been disapproved within the sixty-day period following the date of filing, in which event the plan of operation shall be deemed approved.

(1) The plan of operation for a class of contracts shall describe the financial implications for the insurer of the issuance of contracts in the class, and shall include at least the following:

(a) A statement that the plan of operation will be administered in accordance with the requirements prescribed by the commissioner pursuant to this regulation, along with a statement that the insurer will comply with the plan of operation in its administration of the contract;

(b) A statement describing the methods and procedures used to value statutory liabilities for purposes of Section 10;

(c) A description of the criteria used by the insurer in approving the investment manager for the segregated portfolio of assets associated with a contract in the class, if the investment manager is an entity other than the insurer or its wholly owned subsidiary;

(d) A description of the insurer's requirement for reports concerning the assets in each segregated portfolio and transactions involving the assets, and a description of how the insurer can use the information in a report to determine that the segregated portfolio is being managed in accordance with its investment guidelines. The insurer shall require that the report be prepared no less frequently than quarterly, and include a complete statement of segregated portfolio holdings and their fair market value;

(e) A demonstration of financial results for one or more sample contracts from the class of contracts, showing at a minimum the projected contract value records, the applicable fixed rate or rates of return, and the projected market value records, describing how the investments in the segregated portfolio reflect provision for benefits insured by the contract and how the contract value and market values and the rates of return may be affected by changes in the investment returns of the segregated portfolio and reasonably anticipated deposits to and withdrawals from the segregated portfolio by the contractholder, as well as any advances made by the insurer to the contractholder. The sample contracts shall be chosen to reasonably represent the range of results that could be expected from possible combinations of contract provisions of all contracts within the class. The demonstration shall include at least three (3) hypothetical return scenarios (level, increasing and decreasing) and for each of these scenarios, at least three (3)

withdrawal scenarios (zero, moderate and high) shall be modeled. The commissioner may require additional scenarios if deemed necessary to fully understand the risks under the class of contracts. The demonstration period shall be the greater of five (5) years or the minimum period the insurer must underwrite the risk;

(f) A statement that all contracts in the class of contract satisfy the requirement of Section 9 regarding unilateral contract terminations, together with a description of all termination events, discontinuation triggers and options, notice requirements, corrective action procedures, all other contract safeguards, and the procedures to be followed when a unilateral contract termination event occurs;

(g) A description of the allowable investment parameters (such as objectives, derivative strategies, asset classes, quality, duration and diversification requirements applied to the assets held within the segregated portfolio) to be reflected in the investment guidelines applicable to each contract issued in the class to which the submitted plan of operation applies; and a description of the procedures that will be followed by the insurer in evaluating the appropriateness of any specific investment guidelines submitted by the contractholder. If the insurer chooses to operate a contract in accordance with investment guidelines not meeting the criteria established pursuant to this subparagraph, the non-conforming set of investment guidelines shall be filed with the commissioner in accordance with the filing requirements of this subsection;

(h) A description of the criteria used by the insurer in approving for contract issuance a pooled fund representing multiple employer-sponsored plans and in approving the investment manager for the segregated portfolio of assets associated with such pooled fund contract;

Guidance Note: A pooled fund is an arrangement in which multiple, unaffiliated employer sponsored plans invest in a shared trust. Pooled funds generally allow plan sponsors the right to exit the fund at book value subject to advance notification requirements. In describing the criteria used by the insurer in evaluating the potential issuance of a contract, discuss the insurer's advance notification requirements and how any actual advance notifications will be monitored and reflected in the risk management of the contract.

(i) A description of risk-mitigation techniques used by the insurer in connection with contracts issued to pooled funds representing multiple employer-sponsored plans;

(j) An unqualified opinion by a qualified actuary with expertise in these matters as to the adequacy of the consideration charged by the insurer for the risks it has assumed with respect to the contracts in the class to which the plan of operation applies;

(k) A statement that the actuarial opinion and memorandum required by Section 10 shall include, with respect to the class of contracts to which the plan of operation applies:

(i) If a payment has been made by the insurer in the prior reporting period under a contract in the class, the amount of aggregate risk charges (net of administrative expenses) for contracts in the class, and the aggregate amount of any losses incurred; and

(ii) An inventory of all material unilateral contract termination events in the class that have not been cured within the time period specified and that have occurred during the prior reporting period but where the company decided not to terminate the contract.

(2) Review of the plan of operation by the commissioner may necessitate requests for information to supplement that furnished pursuant to Paragraph (1). Replies made in compliance with this paragraph should be made in sufficient detail that any follow-up correspondence can be held to a minimum.

Section 6. Required Contract Provisions and Filing Requirements

Drafting Note: This section may be omitted in its entirety if a state does not require contracts to be filed for approval, and the state wishes to eliminate required contract provisions. Subsection B of this section may be omitted if a state does not require contracts to be filed for approval, but wishes to maintain required contract provisions.

A contract may not be delivered or issued for delivery in this state unless the contract satisfies the requirements of Subsection A of this section and the issuing insurer has satisfied the requirements of Subsection B of this section with respect to the contract.

A. The contract shall:

(1) Provide that the assets to which the contract pertains and for which a contract value record is established will be maintained in a segregated portfolio of a permitted custodial institution;

(2) Grant the insurer the right to perform audits and inspections of assets held in the segregated portfolio from time to time upon reasonable notice to the permitted custodial institution;

(3) Provide that the insurer will receive prior notice of and the right to approve any appointment or change of investment managers;

(4) Give a description of how the contract value record will be determined, and, where applicable, adjusted by a crediting rate formula;

(5) State the maximum rate period between crediting rate formula recalculations that will be permitted, if any;

(6) Provide the insurer with the right to refuse to recognize any new deposits to the segregated portfolio unless there is a written agreement between the insurer and the contractholder as to the permissible levels and timing of new deposits;

(7) Clearly identify all circumstances under which insurer payments or advances to the contractholder are to be made;

(8) Clearly identify the types of withdrawals made on a market value basis;

(9) Provide either a fixed maturity schedule or a settlement option permitting the contractholder to receive the contract value record over time, provided that no unilateral contract termination event has occurred; and

(10) Include a provision stating, or substantially similar to, the following:

"No waiver of remedies by the insurer that is a party to this agreement, following the breach of any contractual provision of the agreement or of the investment guidelines applicable to it, or failure to enforce the provisions or guidelines, which constitutes grounds for termination of this agreement for cause by the insurer, and is not cured within thirty (30) days following the insurer's discovery of it, shall be effective against an insurance commissioner in any future rehabilitation or insolvency proceedings against the insurer unless approved in advance in writing by the commissioner."

Drafting Note: An adopting state may wish to add an "entire contract" provision in this section if such a provision is not required elsewhere in the adopting state's insurance code.

B. An insurer will satisfy the filing and approval requirements of this section with respect to a contract if the insurer has filed the form of the contract with the commissioner and it is accompanied by the items specified in Paragraphs (1), (2), and (3) of this subsection, and the form has been approved or has not been disapproved within the thirty-day period following the date of filing, in which event the form of contract shall be deemed approved. Notwithstanding the foregoing, the requirement for filing and approval of the form of contract may be waived at the discretion of the commissioner.

(1) The form of contract filed for approval shall be accompanied by a statement that the contract meets the conditions of Subsection A of this section.

(2) The form of contract filed for approval shall be accompanied by a statement:

(a) Specifying the range of variation of variable contract provisions, if any, that could have a material effect on the risk assumed by the insurer under the contract, including withdrawal methodology, crediting rate formula and termination events;

Drafting Note: Contract forms covered by this regulation frequently incorporate variable provisions. The statement required by this subparagraph is intended to provide the information regulators need to evaluate the risks associated with such variability.

(b) Describing how the fair market value will be determined, including a description of the rules for valuing securities and other assets that are not publicly traded;

(c) Describing the crediting rate formula, if any, and how it will operate to take into account the difference between the market value record and the contract value record over time; and

(d) Listing events that give the insurer the right to terminate the contract immediately.

(3) (a) In the case that the plan of operation pertaining to the class of contracts to which the contract belongs has been affirmatively approved by the commissioner of the state in which the issuing insurer is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating the receipt of approval, and that the approval was an affirmative approval.

(b) In the case that the plan of operation pertaining to the class of contracts to which the contract belongs has been deemed approved in the state in which the issuing insurer is domiciled, the form of contract filed for approval shall be accompanied by a statement indicating that the issuing insurer has met the requirements for deemed approval.

(c) In the case that the plan of operation pertaining to the class of contracts to which the contract belongs has not been approved, either affirmatively or by deemer, in the state in which the issuing insurer is domiciled, the form of contract filed for approval shall be accompanied by a statement of this fact, together with a plan of operation pertaining to the contract.

Drafting Note: The state of filing may request the plan of operation for informational purposes and may take it into account in deciding whether to approve the form. It is not anticipated that the state of filing would review and approve the plan of operation, but may use it in connection with the review of the form of contract.

Drafting Note: In the case that the plan of operation has not been approved, either affirmatively or by deemer, in the state of domicile of the issuing insurer, the state of issue, in issuing contract approvals, may wish to establish requirements to be met by the issuing insurer (e.g., notice requirement if the plan of operation subsequently changes, or requirement that the contract be operated in compliance with the plan of operation) in order to maintain its approval.

Section 7. Investment Management of the Segregated Portfolio

A. The investment manager must have full responsibility for, and control over, the management of all segregated portfolio assets within the constraints specified in the investment guidelines.

Drafting Note: In the event that the segregated portfolio has multiple managers, all of these managers will be covered by the investment guidelines.

B. The investment guidelines shall be submitted to the insurer for underwriting review before the contract becomes effective.

C. If the insurer accepts a proposed change to the investment guidelines or allows the contract to operate in accordance with investment guidelines not meeting the criteria established in Section 5B(1)(g), approval of the non-conforming investment guidelines must be obtained pursuant to Section 5B.

Section 8. Purchase of Annuities

For contracts that are group annuity contracts, and that make available to the contractholder the purchase of immediate or deferred annuities for the benefit of individual members of the group, an annuity may not be purchased without the delivery of the contractually agreed upon consideration in cash to the insurer from the segregated portfolio for allocation to the insurer's general account or a separate account. The insurer shall collect adequate consideration for the cost of annuities purchased under contract option by transfer from the segregated portfolio.

Section 9. Unilateral Contract Terminations

A contract subject to this regulation shall allow the insurer to unilaterally and immediately terminate, without future liability of the insurer or obligation to provide further benefits, upon the occurrence of any one of the following events that is material and that is not cured within thirty (30) days following the insurer's discovery of it:

A. The investment guidelines are changed without the advance consent of the insurer and the investment manager is not controlling, controlled by or under common control with the insurer;

B. The segregated portfolio, if managed by an entity that is not controlling, controlled by or under common control with the insurer, is invested in a manner that does not comply with the investment guidelines; or

C. Investment discretion over the segregated portfolio is exercised by or granted to anyone other than the investment manager.

Section 10. Reserves

A. Asset maintenance requirements for segregated portfolios governed by this regulation.

(1) At all times an insurer shall hold minimum reserves in the general account or one or more separate accounts, as appropriate, equal to the excess, if any, of the value of the guaranteed contract liabilities, determined in accordance with Paragraphs (6) and (7) of this subsection, over the market value of the assets in the segregated portfolio less the deductions provided for in Paragraph (2) of this subsection. The reserve requirements of this subsection shall be applied on a contract-by-contract basis.

(2) In determining compliance with the asset maintenance requirement and the reserve for guaranteed contract liabilities specified in Paragraph (1) of this subsection, the insurer shall deduct a percentage of the market value of an asset as follows:

(a) For debt instruments, the percentage shall be the NAIC asset valuation reserve "reserve objective factor," but the factor shall be increased by fifty percent (50%) for the purpose of this calculation if the difference in durations of the assets and liabilities is more than one-half year. The above notwithstanding, in the event that, under the terms of the synthetic guaranteed investment contract, the asset default risk for debt instruments is borne solely by the contractholder, there shall be no asset valuation reserve percentage deduction from the market value of an asset, for purposes of complying with the asset maintenance requirement and the reserve for guaranteed contract liabilities specified in Paragraph (1) of this subsection.

(b) For assets that are not debt instruments, the percentage shall be the NAIC asset valuation reserve “maximum reserve factor.”

(3) To the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by segregated portfolio assets denominated in the currency of the foreign country, the percentage deduction for these assets under Paragraph (2) of this subsection shall be that for a substantially similar investment denominated in the currency of the United States.

(4) To the extent that guaranteed contract liabilities are denominated in the currency of the United States and are supported by segregated portfolio assets denominated in the currency of a foreign country, and to the extent that guaranteed contract liabilities are denominated in the currency of a foreign country and are supported by segregated portfolio assets denominated in the currency of the United States, the deduction for debt instruments under Paragraph (2) of this subsection shall be increased by fifteen percent (15%) of the market value of the assets unless the currency exchange risk on the assets has been adequately hedged, in which case the percentage deduction under Paragraph (2) of this subsection shall be increased by one-half percent (.5%). No guaranteed contract liabilities denominated in the currency of a foreign country shall be supported by segregated portfolio assets denominated in the currency of another foreign country without the approval of the commissioner. For purposes of this paragraph, the currency exchange risk on an asset is deemed to be adequately hedged if:

(a) It is an obligation of

(i) A jurisdiction that is rated in one of the two (2) highest rating categories by an independent nationally recognized United States rating agency acceptable to the commissioner;

(ii) Any political subdivision or other governmental unit of such a jurisdiction, or any agency or instrumentality of jurisdiction, political subdivision or other governmental unit; or

(iii) An institution that is organized under the laws of any such jurisdiction; and

(b) At all times the principal amount of the obligation and scheduled interest payments on the obligation are hedged against the United States dollar pursuant to contracts or agreements that are:

(i) Issued by or traded on a securities exchange or board of trade regulated under the laws of the United States or Canada or a province of Canada;

(ii) Entered into with a United States banking institution that has assets in excess of $5 billion and that has obligations outstanding, or has a parent corporation that has obligations outstanding, that are rated in one of the two (2) highest rating categories by an independent, nationally recognized, United States rating agency, or with a broker-dealer registered with the Securities and Exchange Commission that has net capital in excess of $250 million; or

(iii) Entered into with any other banking institution that has assets in excess of $5 billion and that has obligations outstanding, or has a parent corporation that has obligations outstanding, that are rated in one of the two (2) highest rating categories by an independent, nationally recognized, United States rating agency and that is organized under the laws of a jurisdiction that is rated in one of the two (2) highest rating categories by an independent, nationally recognized United States rating agency.

(5) These contracts may provide for the allocation to one or more separate accounts of all or any portion of the amount needed to meet the asset maintenance requirement. If the contract provides that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurer, the insurer shall maintain in a distinct separate account that is so chargeable:

(a) That portion of the amount needed to meet the asset maintenance requirement that has been allocated to separate accounts; less

(b) The amounts contributed to separate accounts by the contractholder in accordance with the contract and the earnings on the contract.

(6) For purposes of this section, the minimum value of guaranteed contract liabilities is defined to be the sum of the expected guaranteed contract benefits, each discounted at a rate corresponding to the expected time of payment of the contract benefit that is not greater than the spot rate supportable by the expected return from the segregated portfolio assets, and in no event greater than the blended spot rate as described in the plan of operation (pursuant to Section 5) or the actuary's opinion and memorandum, (pursuant to Section 10B), except that if the expected time of payment of a contract benefit is more than thirty (30) years, it shall be discounted from the expected date of payment to year thirty (30) at a rate of no more than eighty percent (80%) of the thirty-year blended spot rate and from year thirty (30) to the date of valuation at a rate not greater than the thirty-year blended spot rate.

(7) In calculating the minimum value of guaranteed contract benefits:

(a) All guaranteed benefits potentially available to the contractholder on an ongoing basis shall be considered in the valuation process and analysis, and the reserve held must be sufficient to fund the greatest present value of each independent guaranteed contract benefit. For purposes of this subparagraph, the right granted to the contractholder to exit the contract by discharging the insurer of its guarantee obligation under the contract and taking control of the assets in the segregated portfolio shall not be considered a guaranteed benefit.

(b) To the extent that future guaranteed cash flows are dependent upon the benefit responsiveness of an employer-sponsored plan, a best estimate based on company experience, or other reasonable criteria if company experience is not available, shall be used in the projections of future cash flows.

(c) The minimum value of guaranteed contract benefits under a contract issued to a pooled fund representing multiple employer-sponsored plans shall be determined so as to reflect projected plan sponsor contract value withdrawals available to the member plans in the pooled fund.

Projections of such future cash flows shall take into account (i) known plan sponsor withdrawals, and (ii) a prudent estimate of future plan sponsor withdrawals. The prudent estimate shall be based on company experience and other relevant criteria.

Drafting Note: Other relevant criteria include, but are not limited to, the pooled fund's profile (e.g. number of employer-sponsored plans, and the minimum, maximum and average size of such plans), the minimum notice that plan sponsors are required to give in order to effectuate a plan sponsor withdrawal, the percentage of the pooled fund that is investment-only and that is full service, and economic conditions.

A single valuation rate shall be determined, consistent with Paragraph (6) of this subsection, equal to the lesser of:

(i) The expected return from the segregated portfolio of assets, or

(ii) The blended spot rate based on the duration of the segregated portfolio of assets.

This single valuation rate shall be used to model future market values of the segregated portfolio of assets. Future credited interest rates shall be modeled according to the contractually defined crediting rate formula. Modeled future contract values shall reflect modeled future market values, modeled future credited interest rates, known future plan sponsor withdrawals, the prudent estimate of future plan sponsor withdrawals, future withdrawals consistent with Paragraph (7)(b) of this subsection and any remaining final payment at the modeled contract termination date. All such modeled withdrawals and termination payments shall be discounted using the single valuation rate and the modeled times of those withdrawals and payments. The sum of these present values shall be deemed the minimum value of the guaranteed contract liabilities for a pooled fund contract.

B. Actuarial opinion and memorandum for segregated portfolios governed by this regulation.

(1) An insurer that issues a synthetic guaranteed investment contract subject to this regulation shall submit an actuarial opinion and, upon request, a memorandum to the commissioner annually by March 1 following the December 31 valuation date showing the status of the accounts as of the prior December 31. The actuarial opinion and memorandum shall be in form and substance satisfactory to the commissioner.

Drafting Note: The state may wish to include the information contained in the actuarial opinion and memorandum as a part of its overall filing requirements, rather than mandating a separate filing for synthetic guaranteed investment contracts.

(2) The actuarial memorandum required by this regulation is deemed to be confidential to the same extent, and under the same conditions, as the actuarial memorandum required by [insert reference to state law equivalent to Section 3 of the NAIC Model Standard Valuation Law].

Drafting Note: A thorough review should be performed of the specific laws and regulations in a state which may affect the confidential status of the memorandum.

(3) Except in cases of fraud or willful misconduct, the valuation actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(4) The statement of actuarial opinion submitted in accordance with Section 10B(1) shall consist of:

(a) A paragraph identifying the valuation actuary and his or her qualification;

(b) A scope paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the valuation actuary's work;

(c) A reliance paragraph describing those areas, if any, where the valuation actuary has deferred to other experts in developing data, procedures or assumptions;

(d) An opinion paragraph expressing the valuation actuary’s opinion with respect to the matters described in Subparagraphs 5A and 5B below; and

(e) One or more additional paragraphs may be needed in individual company cases as follows:

(i) If the valuation actuary considers it necessary to state a qualification of his or her opinion;

(ii) If the valuation actuary must disclose an inconsistency in the method of analysis used at the prior opinion date with that used for this opinion;

(iii) If the valuation actuary chooses to add a paragraph briefly describing the assumptions which form the basis of the actuarial opinion.

(5) Contents of the opinion paragraph of the actuarial opinion.

(a) The actuarial opinion shall state that, after taking into account any risk charge payable, the segregated portfolio assets, and the amount of any reserve liability with respect to the asset maintenance requirement, the account assets make adequate provision for contract liabilities.

(b) The opinion shall also state that:

(i) Reserves for contract liabilities are calculated pursuant to the requirements of Section 10A(1);

(ii) After taking into account any reserve liability with respect to the asset maintenance requirement, the amount of the account assets satisfied the asset maintenance requirement;

(iii) The fixed-income segregated portfolio conformed to and justified the rates used to discount contract liabilities for valuation pursuant to Section 10A(6);

(iv) Whether any rates used pursuant to Section 10A(6) to discount guaranteed contract liabilities and other items applicable to the segregated portfolio were modified from the rate or rates described in the plan of operation filed pursuant to Section 5; and

(v) The level of risk charges, if any, retained in the general account was appropriate in view of such factors as the nature of the guaranteed contract liabilities and losses experienced in connection with account contracts and other pricing factors.

(6) The opinion shall be accompanied by a certificate of an officer of the insurance company responsible for monitoring compliance with the asset maintenance requirements for synthetic guaranteed investment contracts describing the extent to and manner in which, during the preceding year:

(a) Actual benefit payments conformed to the benefit payment estimated to be made as described in the plan of operation;

(b) The determination of the fair market value of the segregated portfolio conformed to the valuation procedures described in the plan of operation, including a statement of the procedures and sources used during the year; and

(c) Any assets were transferred to or from the insurer's general account, or any amounts were paid to the insurer by any contractholder to support the insurer's guarantee.

(7) The actuarial memorandum shall:

(a) Substantially conform with those portions of Section [insert reference to section of the regulations related to actuarial memoranda] of these regulations that are applicable to asset adequacy testing and either:

(i) Demonstrate the adequacy of account assets based upon cash flow analysis, or

(ii) Explain why cash flow testing analysis is not appropriate, describe the alternative methodology of asset adequacy testing used, and demonstrate the adequacy of account assets under that methodology;

(b) Clearly describe the assumptions the valuation actuary used in support of the actuarial opinion, including any assumptions made in projecting cash flows under each class of assets, and any dynamic portfolio hedging techniques utilized and the tests performed on the utilization of the techniques;

(c) Clearly describe how the valuation actuary has reflected the cost of capital;

(d) Clearly describe how the valuation actuary has reflected the risk of default on obligations and mortgage loans, including obligations and mortgage loans that are not investment grade;

(e) Clearly describe how the valuation actuary has reflected withdrawal risks, if applicable, including a discussion of the positioning of the contracts within the benefit withdrawal priority order pertaining to the contracts, the impact of any dynamic lapse assumption and the results of sensitivity testing the prudent estimate of future plan sponsor withdrawals pursuant to Section 10A(7)(c);

(f) If the plan of operation provides for investments in segregated portfolio assets other than United States government obligations, demonstrate that the rates used to discount contract liabilities pursuant to Section 10A(6) conservatively reflect expected investment returns, taken into account any foreign exchange risks;

(g) If the contracts provide that in certain circumstances they would cease to be funded by a segregated portfolio and, instead would become contracts funded by the general account, clearly describe how any increased reserves would be provided for if and to the extent these circumstances occurred;

(h) State the amount of account assets maintained in a separate account that are not chargeable with liabilities arising out of any other business of the insurance company;

(i) State the amount of reserves and supporting assets as of December 31 and where the reserves are shown in the annual statement;

(j) State the amount of any contingency reserve carried as part of surplus;

(k) State the market value of the segregated asset portfolio; and

(l) Where separate account assets are not chargeable with liabilities arising out of any other business of the insurance company, describe how the level of risk charges payable to the general account provides an appropriate compensation for the risk taken by the general account.

C. When the insurer issues a synthetic guaranteed investment contract and complies with the asset maintenance requirements of Section 10A, it need not maintain an asset valuation reserve with respect to those account assets.

D. This section describes the reserve valuation requirements for contracts subject to this regulation.

(1) Reserves for synthetic investment contracts subject to this regulation shall be an amount equal to the sum of the following:

(a) The amounts determined as the minimum reserve as required under Section 10A(l);

(b) Any additional amount determined by the insurer's valuation actuary as necessary to make adequate provision for all contract liabilities; and

(c) Any additional amount determined as necessary by the commissioner due to the nature of the benefits.

(2) The amount of any reserves required by Paragraph (1) of this subsection may be established by either:

(a) Allocating sufficient assets to one or more separate accounts; or

(b) Setting up the additional reserves in the general account.

Section 11. Severability

If any provision of this regulation or its application to any person or circumstances is judged invalid by a court of competent jurisdiction, the judgment shall not affect or impair the validity of the other provisions of this regulation.

Section 12. Effective Date

This regulation shall take effect [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1998 Proc. 4th Quarter 16, 17, 609, 638-647 (adopted).
2015 Proc. 3rd Quarter Vol. I 115, 128, 135-138, 182-200, 344 (amended).

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. INS. CODE § 10507.5 (1996); BULLETIN 95-10 (1995/2003).
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. AGENCIES REGS. §§ 38a-459-1 to 38a-459-9 (2002/2019).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE R. §§ 191-96.1 to 191-96.12 (2012/2017).		
Kansas	NO CURRENT ACTIVITY		
Kentucky			BULLETIN 2017-4 (2017) (synthetic GICs are not insurance).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota			BULLETIN 97-3 (1997).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. ADMIN. CODE tit. 210, ch. 80, §§ 001 to 011 (2005/2018).		NEB. REV. STAT. § 44-708.01 (2004).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. ADMIN. CODE §§ 11:4-46.1 to 11:4-46.8 (1997).
New Mexico	NO CURRENT ACTIVITY		
New York			CIRCULAR LETTER 1995-12; Supplement 1 (1995).

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		TEX. INS. CODE ANN. § 1154.001 to 1154.101 (2015).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			ADMIN LETTER 1995-11 (1995) (synthetic GICs are not insurance).
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2015

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS MODEL REGULATION (#695)

1. Description of the Project, Issues Addressed, etc.

Revisions were made to the *Synthetic Guaranteed Investment Contracts Model Regulation* (#695) to modify the valuation methodology and to clarify its application to contingent deferred annuities (CDAs). The language in Section 3 was modified to improve readability. Also, a drafting note was added to Section 3 clarifying that the model is not intended to apply to CDAs. Definitions of "Treasury-based spot rate," "index spot rate," and "blended spot rate" were added, as well as revisions to the definition of "Synthetic guaranteed investment contract" or "contract," which defines the product in a manner that distinguishes it from other group annuities. Section 5B(g) and Section 5B(h) also were revised to provide further definition. Section 10A(2)(a), Section 10A(6) and Section 10A(7) were all revised to provide additional parameters to consider when calculating the reserve. Section 10B(7)(e) was modified to enhance the actuarial memorandum requirements.

2. Name of Group Responsible for Drafting the Model and States Participating

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for the drafting note revisions.

States Participating:

Ted Nickel, Chair	Wisconsin	Roger A. Sevigny/Keith Nyhan	New Hampshire
Robert Chester	Connecticut	Joseph Torti III/Elizabeth Dwyer	Rhode Island
Jim Mumford	Iowa	Michael Humphreys	Tennessee
Jason Lapham	Kansas	Tomasz Serbinowski	Utah
Bruce R. Ramge	Nebraska		

The Life Actuarial (A) Task Force was responsible for the revisions to the text.

States Participating:

Mike Boerner, Chair	Texas	Rhonda Ahrens	Nebraska
Pete Weber, Vice Chair	Ohio	Felix Schirripa	New Jersey
Perry Kupferman	California	William Carmello	New York
Andy Rarus	Connecticut	Frank Stone	Oklahoma
Mike Yanacheak	Iowa	Tomasz Serbinowski	Utah
Fred Andersen	Minnesota		

3. Project Authorized by What Charge and Date First Given to the Group

The project relative to CDAs was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

The remaining revisions to the model were authorized in 2014 by the following charge to the Life Actuarial (A) Task Force: Consider any revisions, as appropriate, for the *Synthetic Guaranteed Investment Contracts Model Regulation* (#695).

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions to Model #695 were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group and Task Force adopted a draft of the proposed revisions at the 2015 Summer National Meeting, which were then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2015 Summer National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Contingent Deferred Annuity (A) Working Group and the Life Actuarial (A) Task Force met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 at the Spring National Meeting until adopting the revisions at the 2015 Summer National Meeting.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

None

7. Any Other Important Information (e.g., amending an accreditation standard)

None

VIATICAL SETTLEMENTS MODEL ACT

Table of Contents

Drafting Note: In implementing this model act, states may elect to use terminology referring to life settlements rather than viatical settlements.

Section 1. Short Title

This Act may be cited as the Viatical Settlements Act.

Section 2. Definitions

A. **"**Advertising" means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to [purchase or] sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy purs to [purchase or] sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract.

Drafting Note: Throughout this document text related to investments in viatical settlements is in brackets. It should be considered for inclusion in states where securities regulators do not regulate the investment side of the transaction or adapted for inclusion in the securities code.

B. "Business of viatical settlements" means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating or in any other manner, acquiring an interest in a life insurance policy by means of a viatical settlement contract.

C. "Chronically ill" means:

(1) Being unable to perform at least two (2) activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence);

(2) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) Having a level of disability similar to that described in Paragraph (1) as determined by the Secretary of Health and Human Services.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

E. (1) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

(a) Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

(b) Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

(2) "Financing entity" does not include a non-accredited investor or a viatical settlement purchaser.

F. "Fraudulent viatical settlement act" includes:

(1) Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

(a) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, [viatical settlement investment agent,] financing entity, insurer, insurance producer or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

(i) An application for the issuance of a viatical settlement contract or insurance policy;

(ii) The underwriting of a viatical settlement contract or insurance policy;

(iii) A claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(iv) Premiums paid on an insurance policy[, or as a result of a viatical settlement purchase agreement];

(v) Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, [viatical settlement purchase agreement] or insurance policy;

(vi) The reinstatement or conversion of an insurance policy;

(vii) In the solicitation, offer, effectuation or sale of a viatical settlement contract, insurance policy [or viatical settlement purchase agreement];

(viii) The issuance of written evidence of viatical settlement contract, [viatical settlement purchase agreement] or insurance; or

(ix) A financing transaction; and

(b) Employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.

(2) In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

(a) Remove, conceal, alter, destroy or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(b) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer or other person;

(c) Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of viatical settlements; or

(d) File with the commissioner or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the commissioner;

(3) Embezzlement, theft, misappropriation or conversion of monies, funds, premiums, credits or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner or any other person engaged in the business of viatical settlements or insurance;

(4) Recklessly entering into, negotiating, brokering, otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the person or the persons intended to defraud the policy's issuer, the viatical settlement provider or the viator. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct;

(5) Facilitating the change of state of ownership of a policy or certificate or the state of residency of a viator to a state or jurisdiction that does not have a law similar to this Act for the express purposes of evading or avoiding the provisions of this Act; or

(6) Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

G. "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to [insert reference to applicable producer licensing statute, with specific reference to a life insurance or equivalent line of authority].

H. "Person" means a natural person or a legal entity, including, without limitation, an individual, partnership, limited liability company, association, trust, or corporation.

I. "Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state , regardless of whether delivered or issued for delivery in this state.

J. "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlementprovider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

K. "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

(1) For a financing entity or licensed viatical settlement provider; or

(2) (i) In connection with a transaction in which the securities in the special purposes entity are acquired by the viator or by "qualified institutional buyers" as defined in Rule 144 promulgated under the Securities Act of 1933, as amended; or

(ii) The securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

L. "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less.

M. "Viatical settlement broker" means a person, including a life insurance producer as provided for in Section 3 of this Act, who working exclusively on behalf of a viator and for a fee, commission or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

N. (1) "Viatical settlement contract" means a written agreement between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy , in return for the viator's present or future assignment, transfer, sale, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance.

(2) "Viatical settlement contract" includes a premium finance loan made for a life insurance policy by a lender to viator on, before or after the date of issuance of the policy where:

(a) The viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy; or

(b) The viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(3) "Viatical settlement contract" does not include:

(a) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(b) Loan proceeds that are used solely to pay:

(i) Premiums for the policy;

(ii) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(c) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this Act;

(d) A loan made by a lender that does not violate [insert reference to state's insurance premium finance law], provided that the premium finance loan is not described in Paragraph (2) of this subsection;

(e) An agreement where all the parties (x) are closely related to the insured by blood or law or (y) have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(f) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(g) A bona fide business succession planning arrangement:

(i) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trust established by its shareholders;

(ii) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trust established by its partners; or

(iii) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trust established by its members;

(h) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(i) Any other contract, transaction or arrangement exempted from the definition of viatical settlement contract by the commissioner based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by this Act.

[O. "Viatical settlement investment agent" means a person who is an appointed or contracted agent of a licensed viatical settlement provider who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

(1) A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or insured or have knowledge of the identity of the viator or insured.

(2) A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.]

P. (1) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract with a viator resident in this state.

(2) "Viatical settlement provider" does not include:

(a) A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan;

(b) A premium finance company making premium finance loans and exempted by the commissioner from the licensing requirement under the premium finance laws that takes an assignment of a life insurance policy solely as collateral for a loan;

(c) The issuer of the life insurance policy;

(d) An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity or related provider trust;

(e) A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(f) A financing entity;

(g) A special purpose entity;

(h) A related provider trust;

(i) A viatical settlement purchaser; or

(j) Any other person that the commissioner determines is not the type of person intended to be covered by the definition of viatical settlement provider.

[Q. "Viatical settlement purchase agreement" means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.]

R. (1) "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit.

(2) "Viatical settlement purchaser" does not include:

(a) A licensee under this Act;

(b) An accredited investor or qualified institutional buyer as defined, respectively, in Rule 501(a) or Rule 144A promulgated under the Federal Securities Act of 1933, as amended;

(c) A financing entity;

(d) A special purpose entity; or

(e) A related provider trust.

Drafting Note: States should consider ways to encourage cooperation between the regulators of the sale of the insurance policy and the regulators of the purchase of the interest by an investor if these are regulated by different state agencies. States should also review securities laws as they might apply to transactions governed under this Act.

S. "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

T. (1) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a viatical settlement contract. For the purposes of this Act, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than one viator on a single policy and the viators are residents of different states, the transaction shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all the viators.

(2) "Viator" does not include:

(a) A licensee under this Act, including a life insurance producer acting as a viatical settlement broker pursuant to this Act;

(b) Qualified institutional buyer as defined, respectively, in Rule 144A promulgated under the Federal Securities Act of 1933, as amended;

(c) A financing entity;

(d) A special purpose entity; or

(e) A related provider trust.

Section 3. License and Bond Requirements

A. (1) A person shall not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the commissioner of the state of residence of the viator.

[(2) A person shall not operate as a viatical settlement investment agent without first obtaining a license from the commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the viatical settlement purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.]

Drafting Note: Regulators should be aware of the potential for conflict between the laws governing the sale and purchase of interests in life insurance policies and consider procedures to address any conflicts.

(3) (a) A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a viatical settlement broker.

(b) Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the life insurance producer shall notify the commissioner that he or she is acting as a viatical settlement broker on a form prescribed by the commissioner, and shall pay any applicable fee to be determined by the commissioner. Notification shall include an acknowledgement by the life insurance producer that he or she will operate as a viatical settlement broker in accordance with this Act.

(c) The insurer that issued the policy being viaticated shall not be responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

Drafting Note: Section 3A(3)(a) and (b) would only apply to states that do not require the viatical settlement broker to obtain a separate license or registration. A life insurance producer operating in a state that requires a separate viatical settlement broker license or registration may be required to obtain such license or registration prior to operating as a viatical settlement broker in that state.

(4) A person licensed as an attorney, certified public accountant or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider, may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

B. Application for a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by the fees specified in Section [insert appropriate section].

C. Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fees specified in Section [insert appropriate section]. Failure to pay the fees by the renewal date results in expiration of the license.

D. The applicant shall provide information on forms required by the commissioner. The commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees, and the commissioner may, in the exercise of the commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards of this Act.

E. A license issued to a legal entity authorizes all partners, officers, members and designated employees to act as viatical settlement providers, viatical settlement brokers [or viatical settlement investment agents,] as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

F. Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(1) If a viatical settlement provider, has provided a detailed plan of operation;

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

(3) Has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied for;

(4) (a) If a viatical settlement provider, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of $250,000.

(b) If a viatical settlement broker, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of $250,000.

(c) The commissioner may ask for evidence of financial responsibility at any time the commissioner deems necessary.

(d) Any surety bond issued pursuant to Paragraph (4) shall be in the favor of this state and shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud or conviction of unfair practices by the viatical settlement provider or viatical settlement broker.

(e) Notwithstanding any provision of this section to contrary, the commissioner shall accept, as evidence of financial responsibility, proof that financial instruments in accordance with the requirements in this paragraph have been filed with one state where the applicant is licensed as a viatical settlement provider or viatical settlement broker.

(5) If a legal entity, provides a certificate of good standing from the state of its domicile; and

(6) If a viatical settlement provider or viatical settlement broker, has provided an anti-fraud plan that meets the requirements of Section 14G of this Act.

G. The commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the commissioner, the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

H. A viatical settlement provider, viatical settlement broker or viatical settlement investment agent shall provide to the commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members or designated employees within thirty (30) days of the change.

I. An individual licensed as a viatical settlement broker shall complete on a biennial basis fifteen (15) hours of training related to viatical settlements and viatical settlement transactions, as required by the commissioner; provided, however, that a life insurance producer who is operating as a viatical settlement broker pursuant to Subsection A(3) shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the commissioner.

Section 4. License Revocation and Denial

A. The commissioner may refuse to issue, suspend, revoke or refuse to renew the license of a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] if the commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member or key management personnel has been found guilty of, or has pleaded guilty or *nolo contendere* to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this Act;

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract [or a viatical settlement purchase agreement];

(7) The licensee no longer meets the requirements for initial licensure;

(8) The viatical settlement provider has assigned, transferred or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in Rule 501(a) or Rule 144A promulgated under the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

(9) The licensee or any officer, partner, member or key management personnel has violated any provision of this Act.

B. The commissioner may suspend, revoke or refuse to renew the license of a viatical settlement broker or a life insurance producer operating as a viatical settlement broker pursuant to this Act if the commissioner finds that the viatical settlement broker or life insurance producer has violated the provisions of this Act or has otherwise engaged in of bad faith conduct with one or more viators.

C. If the commissioner denies a license application or suspends, revokes or refuses to renew the license of a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent,] or suspends, revokes, or refuses to renew a license of a life insurance producer operating as a viatical settlement broker pursuant to this Act the commissioner shall conduct a hearing in accordance with [insert reference to state's administrative procedure act].

Section 5. Approval of Viatical Settlement Contracts and Disclosure Statements

A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement form in this state unless first filed with and approved by the commissioner. The commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of Sections 8, 10, 13 and 14B of this Act or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the commissioner's discretion, the commissioner may require the submission of advertising material.

Section 6. Reporting Requirements and Privacy

A. Each viatical settlement provider shall file with the commissioner on or before March 1 of each year an annual statement containing such information as the commissioner may prescribe by regulation. Such information shall be limited to only those transactions where the viator is a resident of this state. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial and health information of the viator or insured shall be filed with the commissioner on a confidential basis.

B. Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, [viatical settlement investment agent,] insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(2) Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;]

(3) Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of Section 14C;

(4) Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(5) Is necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(6) Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

(7) Is required to purchase stop loss coverage or financial guaranty insurance.

Drafting Note: In implementing this section, states should keep in mind privacy considerations of insureds. However, the language needs to be broad enough to allow licensed entities to notify commissioners of unlicensed activity and for insurers to make necessary disclosures to insurers and in similar situations.

Section 7. Examination or Investigations

A. Authority, Scope and Scheduling of Examinations

(1) (a) The commissioner may conduct an examination under this Act of a licensee as often as the commissioner in his or her discretion deems appropriate after considering the factors set forth in this paragraph.

(b) In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider such matters as the consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, report of independent certified public accountants, and other relevant criteria as determined by the commissioner.

(2) For purposes of completing an examination of a licensee under this Act, the commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the licensee.

(3) In lieu of an examination under this Act of any foreign or alien licensee licensed in this state, the commissioner may, at the commissioner's discretion, accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

(4) As far as practical, the examination of a foreign or alien licensee shall be made in cooperation with the insurance supervisory officials of other states in which the licensee transacts business.

B. Record Retention Requirements

(1) A person required to be licensed by this Act shall for five (5) years retain copies of all:

(a) Proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later;

(b) All checks, drafts or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date the transaction; and

(c) All other records and documents related to the requirements of this Act.

(2) This section does not relieve a person of the obligation to produce these documents to the commissioner after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

C. Conduct of Examinations

(1) Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the *Examiners Handbook* adopted by the National Association of Insurance Commissioners (NAIC). The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(2) Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to Section [insert reference to cease and desist statute or other law having a post-order hearing mechanism].

(3) The commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(4) When making an examination under this Act, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this Act shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be *prima facie* evidence in any legal or regulatory action.

(6) Nothing contained in this Act shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his or her sole discretion, deem appropriate.

Drafting Note: In many states examination work papers remain confidential. The previous paragraph should be adjusted to conform to state statute and practice.

D. Examination Reports

(1) Examination reports shall be comprised of only facts appearing upon the books, records or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) In the event the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

E. Confidentiality of Examination Information

(1) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the commissioner, unless required by law.

(2) Except as otherwise provided in this Act, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this Act, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(3) Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the NAIC and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

(a) Created, produced or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this Act, or assisting a commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(b) Disclosed to the NAIC and its affiliates and subsidiaries under Subsection E(4) by a commissioner.

(c) For the purposes of Subsection E(2), "Act" includes the law of another state or jurisdiction that is substantially similar to this Act.

(4) Neither the commissioner nor any person that received the documents, material or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection E(1).

(5) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection E(1), with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information;

(b) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the jurisdiction that is the source of the document, material or information; and

(c) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

(6) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection E(4).

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(8) Nothing contained in this Act shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Act.

F. Conflict of Interest

(1) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section shall not be construed to automatically preclude an examiner from being:

(a) A viator;

(b) An insured in a viaticated insurance policy; or

(c) A beneficiary in an insurance policy that is proposed to be viaticated.

(2) Notwithstanding the requirements of this clause, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

G. Cost of Examinations

Drafting Note: The NAIC Model State Insurance Department Funding Bill or such funding mechanism as may be currently authorized by law should be incorporated here by reference. Any funding mechanism should assure that the manner in which examinations are funded does not influence the scheduling, scope or conduct of examination.

H. Immunity from Liability

(1) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

(2) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Paragraph (1).

(3) A person identified in Paragraph (1) or (2) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

I. Investigative Authority of the Commissioner

The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

Section 8. Disclosure to Viator

A. With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

(1) There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

(2) That a viatical settlement broker represents exclusively the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator.

(3) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

(4) Proceeds of the viatical settlement could be subject to the claims of creditors.

(5) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(6) The viator has the right to rescind a viatical settlement contract before the earlier of sixty (60) calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty (30) calendar days after the viatical settlement proceeds have been paid to the viator, as provided in Section 10F. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given, and the viator repays all proceeds and any premiums, loans and loan interest paid on account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment by the viator or the viator's estate of all viatical settlement proceeds and any premiums, loans and loan interest the viatical settlement within sixty (60) days of the insured's death.

(7) Funds will be sent to the viator within three (3) business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(8) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

(9) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless another form is developed or approved by the commissioner.

(10) The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(11) Following execution of a viatical contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in this Act. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less. All such contracts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.

B. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

(2) The document shall include the name, business address and telephone number of the viatical settlement provider;

(3) Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser.

(4) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

(5) State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and

(6) State whether the funds will be escrowed with an independent third party during the transfer process, and if so, provide the name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

C. A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) The name, business address and telephone number of the viatical settlement broker;

(2) A full, complete and accurate description of all offers, counter-offers, acceptances and rejections relating to the proposed viatical settlement contract;

(3) A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts;

(4) The amount and method of calculating the broker's compensation, which term "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy; and

(5) Where any portion of the viatical settlement broker's compensation, as defined in Paragraph (3) of this subsection, is taken from a proposed viatical settlement offer, the broker shall disclose the total amount of the viatical settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker's compensation.

D. If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty (20) days after the change.

E. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures prior to the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosure to the viatical settlement purchaser:

(1) The purchaser will receive no returns (i.e., dividends and interest) until the insured dies and a death claim payment is made.

(2) The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual "guaranteed" rate of return is not determinable.

(3) The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

(4) The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

(5) The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

(6) The purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health. Disclose the amount of such premiums, if applicable.

(7) State the name, business address and telephone number of the independent third party providing escrow services and the relationship to the broker.

(8) The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

(9) State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract if the policy is later determined to be null and void.

(10) Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

(11) Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

(12) Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.

(13) Describe the experience and qualifications of the person who determines the life expectancy of the insured, i.e., in-house staff, independent physicians and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the viatical settlement provider, if any.

(14) Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless one is developed by the commissioner.]

F. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

(1) Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

(2) State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

(3) State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

(4) Disclose the type of policy offered or sold, i.e., whole life, term life, universal life or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy.

(5) If the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

(6) State whether the policy is contestable.

(7) State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated.

(8) State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.]

[G. The viatical settlement purchase agreement is voidable by the purchaser at any time within three (3) days after the disclosures mandated by Subsections E and F of this section are received by the purchaser.]

Section 9. Disclosure to Insurer

Prior to the initiation of a plan, transaction or series of transactions, a viatical settlement broker or viatical settlement provider shall fully disclose to an insurer a plan, transaction or series of transactions, to which the viatical settlement broker or viatical settlement provider is a party, to originate, renew, continue or finance a life insurance policy with the insurer for the purpose of engaging in the business of viatical settlements at anytime prior to, or during the first five (5) years after, issuance of the policy.

Section 10. General Rules

A. (1) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(a) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(b) A document in which the insured consents to the release of his or her medical records to a licensed viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

(2) Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by Paragraph (3).

(3) The viatical provider shall deliver a copy of the medical release required under Paragraph (1)(b), a copy of the viator's application for the viatical settlement contract, the notice required under Paragraph (2) and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The NAIC's form for verification of coverage shall be used unless another form is developed and approved by the commissioner.

Drafting Note: The NAIC's forms are Appendices B and C of the Viatical Settlements Model Regulation.

(4) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form or any other form approved by the commissioner. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection shall be a violation of Section 11C and Section 16 of this Act.

(5) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(6) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

Drafting Note: A state may wish to make specific reference to the privacy provisions adopted in response to the requirements of the Gramm-Leach-Bliley Act, such as the state equivalent to the NAIC's Privacy of Consumer Financial and Health Information Regulation. Consider whether the state's privacy provision allows continual sharing of medical information or whether permission must be renewed.

C. All viatical settlement contracts entered into in this state shall provide the viator with an absolute right to rescind the contract before the earlier of sixty (60) calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty (30) calendar days after the viatical settlement proceeds have been send to the viator as provided in Section 10F. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans and loan interest that have been paid by the viatical settlement provider or purchaser, which shall be paid within sixty (60) calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within five business days following receipt of written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

[D. The purchaser shall have the right to rescind a viatical settlement contract within three (3) days after the disclosures mandated by Section 8D and 8E are received by the purchaser.]

E. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within three (3) business days after the date the escrow agent receives the document (or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider), the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

F. Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to Section 8A(7) renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds shall be deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator or places a check for delivery to the viator via United States Postal Service or other nationally recognized delivery service.

G. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three (3) months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

Section 11. Prohibited Practices

A. It is a violation of this Act for any person to enter into a viatical settlement contract at any time prior to the application or issuance of a policy which is the subject of viatical settlement contract or within a five-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least sixty (60) months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

(a) The viator or insured is terminally or chronically ill;

(b) The viator's spouse dies;

(c) The viator divorces his or her spouse;

(d) The viator retires from full-time employment;

(e) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment; or

(f) A final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee or liquidator to all or a substantial part of the viator's assets; or

(3) The viator enters into a viatical settlement contract more than two (2) years after the date of issuance of a policy and, with respect to the policy, at all times prior to the date that is two (2) years after policy issuance, the following conditions are met:

(a) Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured or a person described in Section 2N(3)(e);

(b) There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan; and

(c) Neither the insured nor the policy has been evaluated for settlement.

B. Copies of the independent evidence described in Subsection A(2) and documents required by Section 10A shall be submitted to the insurer when the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

C. If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in and the independent evidence required by Subsection A(2) when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

D. No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, require that the viator, insured, viatical settlement provider or viatical settlement broker sign any forms, disclosures, consent or waiver form that has not been expressly approved by the commissioner for use in connection with viatical settlement contracts in this state.

E. Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty (30) calendar days with written acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Section 12. Prohibited Practices and Conflicts of Interest

A. With respect to any viatical settlement contract or insurance policy, no viatical settlement broker knowingly shall solicit an offer from, effectuate a viatical settlement with or make a sale to any viatical settlement provider, viatical settlement purchaser, [viatical settlement investment agent], financing entity or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

B. With respect to any viatical settlement contract or insurance policy, no viatical settlement provider knowingly may enter into a viatical settlement contract with a viator, if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, [viatical settlement investment agent], financing entity or related provider trust that is involved in such viatical settlement contract.

C. A violation of Subsection A or Subsection B shall be deemed a fraudulent viatical settlement act.

D. No viatical settlement provider shall enter into a viatical settlement contract unless the viatical settlement promotional, advertising and marketing materials, as may be prescribed by regulation, have been filed with the commissioner. In no event shall any marketing materials expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause a viator to reasonably believe that the insurance is free for any period of time shall be considered a violation of this Act.

E. No life insurance producer, insurance company, viatical settlement broker, viatical settlement provider or viatical settlement investment agent shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

Section 13. Advertising for Viatical Settlements [and Viatical Settlements Purchase Agreements]

The purpose of this section is to provide prospective viators [and viatical settlement purchasers] with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful and adequate disclosure of the benefits, risks, limitations and exclusions of any viatical settlement contract [or viatical settlement purchase agreement bought or sold]. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

A. This section shall apply to any advertising of viatical settlement contracts, [viatical purchase agreements] or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

B. Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products and services. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the viatical settlement licensees, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

C. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract [or viatical settlement purchase agreement, product or service] shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

[D. Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not limited to, the following representations:

(1) "Guaranteed," "fully secured," "100 percent secured," "fully insured," "secure," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," or "state guaranty funds," or similar representations;

(2) "No risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;

(3) "Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;

(4) Utilization of the word "guaranteed" to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) "No sales charges or fees" or similar representations;

(6) "High yield," "superior return," "excellent return," "high return," "quick profit," or similar representations; and

(7) Purported favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.]

E. The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(1) An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving viators, [purchasers or prospective purchasers] as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract [or viatical settlement purchase agreement] offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract [or viatical settlement purchase agreement] includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

[(3) An advertisement shall not represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract or viatical settlement purchase agreement in order to maintain that policy, unless that is the fact.]

(4) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable or in any manner an incorrect or improper practice.

(5) The words "free," "no cost," "without cost," "no additional cost," at no extra cost," or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(6) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract [or viatical settlement purchase agreement,] product or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators [or purchasers] as to the nature or scope of the testimonials, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis, a licensee under this Act makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(a) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the party making use of the testimonial, appraisal, analysis or endorsement, either directly or through a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(b) An advertisement shall not state or imply that a viatical settlement contract [or viatical settlement purchase agreement,] benefit or service has been approved or endorsed by a group of individuals, society, association or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(c) When an endorsement refers to benefits received under a viatical settlement contract [or viatical settlement purchase agreement] all pertinent information shall be retained for a period of five (5) years after its use.

F. An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

G. An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services or methods of marketing.

H. The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract [or viatical settlement purchase agreements], products or services, and if any specific viatical settlement contract [or viatical settlement purchase agreement] is advertised, the

viatical settlement contract [or viatical settlement purchase agreement] shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

I. An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract [or viatical settlement purchase agreement].

J. An advertisement shall not use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators [or purchasers] into believing that the solicitation is in some manner connected with a government program or agency.

K. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] is licensed.

L. An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its viatical settlement contracts [or viatical settlement purchase agreement forms] are recommended or endorsed by any government entity.

M. The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

N. An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the U. S. government endorses, approves or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability or advisability of any viatical settlement contract or [viatical settlement purchase agreement];

(3) Any viatical settlement contract or [viatical settlement purchase agreement]; or

(4) Any life insurance policy or life insurance company.

O. If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

P. If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six (6) months.

Section 14. Fraud Prevention and Control

A. Fraudulent Viatical Settlement Acts, Interference and Participation of Convicted Felons Prohibited.

(1) A person shall not commit a fraudulent viatical settlement act.

(2) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

(3) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

B. Fraud Warning Required.

(1) Viatical settlements contracts [and purchase agreement forms] and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in [an application for insurance or viatical settlement contract][a viatical settlement purchase agreement] is guilty of a crime and may be subject to fines and confinement in prison."

Drafting Note: The preceding will be tailored to whether the form is related to a viatical settlement contract or purchase agreement.

(2) The lack of a statement as required in Paragraph (1) of this subsection does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

C. Mandatory Reporting of Fraudulent Viatical Settlement Acts.

(1) Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent viatical settlement act is being, will be or has been committed shall provide to the commissioner such information as required by, and in a manner prescribed by, the commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

D. Immunity from Liability.

(1) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(a) The commissioner or the commissioner's employees, agents or representatives;

(b) Federal, state or local law enforcement or regulatory officials or their employees, agents or representatives;

(c) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees or representatives;

(d) The National Association of Insurance Commissioners (NAIC), National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities or investment fraud; or

(e) The life insurer that issued the life insurance policy covering the life of the insured.

(2) Paragraph (1) of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action shall plead specifically any allegation that Paragraph (1) does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) A person furnishing information as identified in Paragraph (1) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated. However, such an award does not apply to any person furnishing information concerning his or her own fraudulent viatical settlement acts.

(4) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Paragraph (1).

E. Confidentiality.

(1) The documents and evidence provided pursuant to Subsection D or obtained by the commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Paragraph (1) does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(a) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(b) To federal, state or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts or to the NAIC; or

(c) At the discretion of the commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(3) Release of documents and evidence under Paragraph (2) does not abrogate or modify the privilege granted in Paragraph (1).

F. Other Law Enforcement or Regulatory Authority.

This Act shall not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

(3) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

G. Viatical Settlement Antifraud Initiatives.

(1) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent viatical settlement acts. At the discretion of the commissioner, the commissioner may order, or a licensee may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(2) Antifraud initiatives shall include:

(a) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(b) An antifraud plan, which shall be submitted to the commissioner. The antifraud plan shall include, but not be limited to:

(i) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) A description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner;

(iii) A description of the plan for antifraud education and training of underwriters and other personnel; and

(iv) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(3) Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Section 15. Injunctions; Civil Remedies; Cease and Desist

A. In addition to the penalties and other enforcement provisions of this Act, if any person violates this Act or any regulation implementing this Act, the commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the commissioner determines are necessary to restrain the person from committing the violation.

B. Any person damaged by the acts of a person in violation of this Act may bring a civil action against the person committing the violation in a court of competent jurisdiction.

[C. A violation of this Act attendant to the execution of a viatical settlement purchase agreement renders the viatical settlement purchase agreement voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy received to the viatical settlement provider. Suit for rescission may be brought in a court of competent jurisdiction or where the alleged violator resides or has a principal place of business or where the alleged violation occurred.]

D. The commissioner may issue, in accordance with [cite the state administrative procedure act], a cease and desist order upon a person that violates any provision of this Act, any regulation or order adopted by the commissioner, or any written agreement entered into with the commissioner.

E. When the commissioner finds that an activity in violation of this Act presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety (90) days. If the commissioner begins non-emergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to [cite the state administrative procedure act].

Drafting Note: States should review their laws to see if the provisions of Subsections D and E are already in state law.

F. In addition to the penalties and other enforcement provisions of this Act, any person who violates this Act is subject to civil penalties of up to $[insert amount] per violation. Imposition of civil penalties shall be pursuant to an order of the commissioner issued under [insert reference to statutes relating to hearings conducted by the commissioner]. The commissioner's order may require a person found to be in violation of this Act to make restitution to persons aggrieved by violations of this Act.

G. A person convicted of a violation of this Act by a court of competent jurisdiction [insert classifications for misdemeanor and felony penalties that match provisions in state's penal codes for theft offenses]. A person convicted of a violation of this Act shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

H. Except for a fraudulent viatical settlement act committed by a viator, the enforcement provisions and penalties of this section shall not apply to a viator.

Drafting Note: The following is an example of a graded sentencing requirement and a stay of the statute of limitations.

A person convicted of a violation of this Act by a court of competent jurisdiction may be sentenced in accordance with Paragraphs (1), (2), (3) or (4) based on the greater of (i) the value of property, services, or other benefit wrongfully obtained or attempted to obtain, or (ii) the aggregate economic loss suffered by any person as a result of the violation. A person convicted of a fraudulent viatical settlement act must be ordered to pay restitution to persons aggrieved by the fraudulent viatical settlement act. Restitution must be ordered in addition to a fine or imprisonment but not in lieu of a fine or imprisonment.

(1) To imprisonment for not more than 20 years or to payment of a fine of not more than $100,000, or both, if the value of viatical settlement contract is more than $35,000;

(2) To imprisonment for not more than ten years or to payment of a fine of not more than $20,000, or both, if the value of viatical settlement contract is more than $2,500 but not more than $35,000;

(3) To imprisonment for not more than five years or to payment of a fine of not more than $10,000, or both, if the value of viatical settlement contract is more than $500 but not more than $2,500; or

(4) To imprisonment for not more than one year or to payment of a fine of not more than $3,000, or both, if the value of viatical settlement contract is $500 or less.

In any prosecution under this section under Paragraphs (1), (2), (3) and (4) the value of the viatical settlement contracts within any six-month period may be aggregated and the defendant charged accordingly in applying the provisions of this section; provided that when two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in any county in which one of the offenses was committed for all of the offenses aggregated under this section. The applicable statute of limitations provision under [states should insert here the applicable statute of limitations provision cite] shall not begin to run until the insurance company or law enforcement agency is aware of the fraud, but in no event may the prosecution be commenced later than seven years after the act has occurred.

Section 16. Unfair Trade Practices

A violation of this Act, including the commission of a fraudulent viatical settlement act, shall be considered an unfair trade practice under Sections [insert reference to state's Unfair Trade Practices Act] subject to the penalties contained in that Act.

Section 17. Authority to Promulgate Regulations

The commissioner shall have the authority to:

A. Promulgate regulations implementing this Act;

B. Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy insuring the life of a person that is chronically or terminally ill;

C. Establish appropriate licensing requirements, fees and standards for continued licensure for viatical settlement providers, brokers [and viatical settlement investment agents];

Drafting Note: Fees need not be mentioned if the fee is set by statute.

D. Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

E. Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers, viatical settlement brokers [and viatical settlement investment agents] during the viatication of a life insurance policy or certificate.

Section 18. Severability

If any portion of this Act or any amendments thereto, or its applicability to any person or circumstance is held invalid by a court, the remainder of this Act or its applicability to other persons or circumstances shall not be affected.

Section 19. Effective Date

This Act shall take effect on [insert date]. A viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] transacting business in this state may continue to do so pending approval or disapproval of the provider, broker [or investment agent's] application for a license as long as the application is filed with the commissioner by [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. 3rd Quarter 7, 30, 427-428, 435-439 (adopted).
1998 Proc. 1st Quarter 14, 17, 678, 701-706 (amended and reprinted).
2000 Proc. 4th Quarter 16, 17, 103-104, 107-126 (amended and reprinted).
2007 Proc. 2nd Quarter 50-105, 184-185, 240-273 (amended).

VIATICAL SETTLEMENTS MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VIATICAL SETTLEMENTS MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.96.110 (2000); ALASKA ADMIN. CODE tit. 3, §§ 31.300 to 31.449 (2002/2011).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-443.02 (2008).
Arkansas			ARK. CODE ANN. §§ 23-81-801 to 23-81-818 (2009/2013); DIRECTIVE 1-2009 (2009).
California			CAL. INS. CODE §§ 10113.1 to 10113.35 (1990/2011); BULLETIN 2012-2 (2012).
Colorado			COLO. REV. STAT. §§ 10-7-601 to 10-7-620 (2006); § 11-51-201 (1990/2006) (Investments).
Connecticut			CONN. GEN. STAT. §§ 38a-465 to 38a-465p (1998/2013).

VIATICAL SETTLEMENTS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	DEL. CODE ANN. tit. 18, §§ 7501 to 7520 (2017).		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. STAT. §§ 626.991 to 626.99295 (2017); § 517.021 (1978/2005) (Investments).		MEMORANDUM 2010-007 (2010).
Georgia			GA. CODE ANN. §§ 33-59-1 to 33-59-17 (2005/2009); § 10-5-2 (2008); § 10-5-12 (1973/2002) (Investments).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431C-1 to 431C-53 (2012).
Idaho	IDAHO CODE ANN. §§ 41-1950 to 41-1965 (2009) (portions of model).		BULLETIN 2007-3 (2007); BULLETIN 2009-6 (2009).
Illinois	215 ILL. COMP. STAT. 159/1 to 159/999 (2010).		
Indiana			IND. CODE §§ 27-8-19.8-1 to 27-8-19.8-26 (1994/2003); § 27-1-12-44 (2008).
Iowa	IOWA CODE §§ 508E.1 to 508E.20 (2008/2009) (portions of model).		IOWA ADMIN. CODE r. 191-48.1 to 191-48.14 (2002/2009); BULLETIN 2011-5 (2011).
Kansas			KAN. STAT. ANN. §§ 40-5001 to 40-5016 (2002/2009).
Kentucky	KY. REV. STAT. ANN. § 304.15-020 (2008) (portions of model).		KY. REV. STAT. ANN. §§ 304.15-700 to 304.15-726 (1998/2010).
Louisiana			LA. REV. STAT. ANN. §§ 22:1791 to 22:1805 (2003/2010).

VIATICAL SETTLEMENTS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 6801 to 6819 (1997/2009) (portions of previous version of model); ME. REV. STAT. ANN. tit. 32, § 16102 to 16105 (1985/1999); § 16511 (1999/2005) (related to viatical investments).
Maryland			MD. CODE ANN., INS. §§ 8-601 to 8-611 (2004/2010).
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 212 to 223F (2001/2013); 940 CODE MASS. REGS. §§ 18.01 to 18.08 (1997).
Michigan			MICH. COMP. LAWS §§ 550.521 to 550.528 (1997/1999).
Minnesota	MINN. STAT. §§ 60A. 957 to 60A.9585 (2009) (portions of model).		
Mississippi			MISS. CODE ANN. §§ 83-7-201 to 83-7-223 (2000).
Missouri	NO CURRENT ACTIVITY		
Montana			MONT. CODE ANN. §§ 33-20-1301 to 33-20-1318 (1997/2009).
Nebraska	NEB. REV. STAT. §§ 44-1101 to 44-1117 (2001/2008).		
Nevada	NEV. REV. STAT. §§ 688C.010 to 688C.510 (2001/2011) (portions of model).		BULLETIN 2006-007 (2006).
New Hampshire			N.H. REV. STAT. ANN. §§ 408-D:1 to 408-D:19 (2010).
New Jersey			N.J. STAT. ANN. §§ 17B:30B-1 to 17B:30B-20 (2005); BULLETIN 2006-07 (2006).

VIATICAL SETTLEMENTS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico			N.M. STAT. ANN. §§ 59A-20A-1 to 59A-20A-11 (2000).
New York			N.Y. INS. LAW §§ 7810 to 7820 (2009); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 380.1 to 380.10 (Reg. No. 148) (1994); §§ 381.1 to 381.3 (2010/2012); OFF. GEN. COUNSEL 11-6-2006 (2006).
North Carolina			N.C. GEN. STAT. §§ 58-58-200 to 58-58-310 (2002/2007); § 78A-2 (1925/2002); §§ 78A-13 to 78A-14 (2002) (Securities law); §78A-17 (1973); § 78A-27 (1973); § 78A-49; § 78A-56 (1925/2002) (Investments).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3916.01 to 3916.99 (2000/2013) (portions of model).		
Oklahoma	OKLA. STAT. tit. 36, §§ 4055.1 to 4055.17 (2008) (portions of model).		BULLETIN 3-6-2009 (2009); BULLETIN 4-9-2009 (2009).
Oregon	OR. REV. STAT. §§ 744.321 to 744.384 (1995/2009).		
Pennsylvania			40 PA. STAT. ANN. §§ 626.1 to 626.17 (2002).
Puerto Rico	26 LAWS OF P.R. §§ 4221 to 4235 (2006).		
Rhode Island			R.I. GEN. LAWS §§ 27-72-1 to 27-72-18 (2009).

VIATICAL SETTLEMENTS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. CODE ANN. §§ 56-50-101 to 56-50-117 (2001/2009) (portions of model).		
Texas			BULLETIN B-0026-07 (2007); BULLETIN B-0028-08 (2008); BULLETIN B-0036-11 (2011).
Utah			UTAH CODE ANN. §§ 31A-36-101 to 31A-36-119 (2003/2009); § 31A-21-104 (1985/2003) (insurable interest); § 31A-23A-117 (2003) (licensing requirement).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-6000 to 38.2-6016 (2003); § 38.2-1865.1 (2001/2003) (licensing of brokers).
Washington	WASH. REV. CODE ANN. §§ 48.102.001 to 48.102.193 (1995/2009) (portions of model).		WASH. ADMIN. CODE § 284-97-020 (2011).
West Virginia	W. VA. CODE §§ 33-13C-1 to 33-13C-18 (2008).		
Wisconsin	WIS. STAT. § 632.69 (2019/2013).		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2007

VIATICAL SETTLEMENTS MODEL ACT (#697)

1. Description of the project, issues addressed, etc.

The revisions propose a number of significant changes to the Viatical Settlements Model Act to address the issue of stranger-originated life insurance and regulatory issues in the life settlement industry, including the following:

- ***Enhanced Disclosure Requirements for Viatical Settlement Brokers and Providers***

Viatical settlement brokers must disclose to sellers all offers, counteroffers, acceptances and rejections relating to a proposed viatical settlement contract. Brokers must also disclose any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed viatical settlement contract. In addition, brokers must disclose the total amount of a viatical settlement contract offer and the percentage of the offer comprised by the broker's compensation in the situation where any portion of the broker's compensation is taken from the proposed viatical settlement contract offer. Viatical settlement brokers must also clearly disclose to policy owners that the broker represents the policy owner, not the viatical settlement provider. Brokers must clearly disclose that they owe a fiduciary duty to the policy owner and must act in the policy owner's best interest.

Viatical settlement providers must also disclose any affiliations or contractual arrangements between the provider and the viatical settlement purchaser.

- ***New Bonding Requirements for Viatical Settlement Brokers and Providers***

In order to receive and maintain a license, the proposed revisions require a viatical settlement provider or broker to demonstrate evidence of financial responsibility through either a surety bond or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of $250,000. The surety bond must be issued in the favor of the state and must specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud or conviction of unfair practices by the provider or broker. The commissioner may ask for evidence of financial responsibility at any time the commissioner deems necessary. The revisions make clear that a provider or broker that is licensed in more than one state is not required to file multiple bonds in each state.

- ***New Continuing Education Requirements for Viatical Settlement Brokers***

The proposed revisions require an individual licensed as a viatical settlement broker to complete on a biennial basis 15 hours of training related to viatical settlements and viatical settlement transactions. A life insurance producer who is operating as a viatical settlement broker is not subject to this requirement.

- ***Longer Time Frame for Rescinding Viatical Settlement Contract***

The proposed revisions extend the time within which a viator has the right to rescind a viatical settlement contract from 15 calendar days to the earlier of: (1) 60 calendar days after the date on which the viatical settlement contract was executed; or (2) 30 days after the viatical settlement proceeds have been paid to the viator.

- ***Five-Year Ban on Life Settlements***

Under the proposed revisions, a life insurance policy may not be sold within 5 years after its date of issuance unless one of the exceptions below is met:

- The policy was issued upon the viator's exercise of conversion rights;
- The viator or the insured is terminally or chronically ill;
- The viator's spouse dies;
- The viator divorces his or her spouse;
- The viator retires from full-time employment;
- The viator becomes physically or mentally disabled; or
- The viator enters into a viatical settlement contract more than 2 years after the date of the policy is issued and, with respect to the policy, at all times prior to the date that is 2 years after policy issuance, the following conditions are met:

- Policy premiums have been funded exclusively with unencumbered assets, including an interest in the policy that is financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by the insured or a person described in Section 2N(3)(d) of the Act;
- There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan; and
- Neither the insured nor the policy has been evaluated for settlement.

- ***Key Definition Revisions***

  - *"Fraudulent viatical settlement act"* – the proposed revisions expand the scope of this definition to include facilitating the change of state of ownership of a policy or certificate or the state of residency of a viator to a state or jurisdiction that does not have a law similar to this Act for the express purpose of evading or avoiding the provisions of this Act.
  - *"Viatical settlement contract"* – the proposed revisions expand this definition to include premium finance loans made for a life insurance policy by a lender to a viator on, before or after the date of policy issuance where: (a) the viator or the insured receives on the date of the loan a guarantee of a future viatical settlement value of the policy; or (b) the viator or the insured agrees on the date of the loan to sell the policy or any portion of its death benefit on any date following the date of policy issuance. The proposed revisions, however, carve out specific exceptions under the definition, including: (a) loan proceeds that are used solely to pay: (i) premiums for the policy; and (ii) the costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third party collateral provider fees and expenses, including fees payable to letter of credit issuers; (b) a loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on such loan and the policy is transferred, the transfer of such a policy by the lender, provided that the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this Act; further assignment of such policy by the lender; or (c) an agreement where all of the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties.

2. Name of group responsible for draft the model:

Life Insurance and Annuities (A) Committee

States Participating:

North Dakota, Chair	Kansas
Kentucky, Vice Chair	Louisiana
Alabama	Nebraska
Arkansas	New York
California	Ohio
Florida	Pennsylvania
Iowa	

3. Project authorized by what charge and date first given to the group:

The following charge was given to the Life Insurance and Annuities (A) Committee in 2006:
Consider changes to Viatical Settlements Model Act in response to concerns about investor initiated life insurance.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The amendments to the model act were drafted by the Committee.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Beginning with the NAIC 2006 Summer National Meeting, drafts of the proposed revisions were reviewed and discussed at each National Meeting and during Committee conference calls. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions and comments received on those drafts were posted on the NAIC web site and distributed by email to over 200 interested parties. Comments were received by numerous groups, including industry groups such as the American Council of Life Insurance (ACLI), National Association of Insurance and Financial Advisors (NAIFA), Association for Advanced Life Underwriting (AALU); National Association of Independent Life Brokerage Agencies (NAILBA); Life Settlement Institute (LSI), Life Insurance Finance Association (LIFA), Life Insurance Settlement Association (LISA), and American Bankers Insurance Association (ABIA); and consumer groups, such as Center for Economic Justice (CEJ) and University of Georgia.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

The most significant controversial issue raised during the drafting process was the proposed 5-year ban on life settlements. Those opposed to this proposal asserted that the 5-year prohibition was overly onerous, would hurt consumers, and was not well designed to address the STOLI issue. It also would not protect the consumer; it would not prevent STOLI arrangements; and would deprive consumers of a legal property right. Some of those interested parties not directly opposed to the 5-year ban expressed a belief that the proposed 5-year ban could make STOLI arrangements less appealing. They also countered the argument that the 5-year ban adversely impacted a consumer's legal property right by stating that there is no inherent property right in STOLI arrangements. These were contrived transactions that attempt to circumvent state insurable interest laws. As a matter of public policy, the Committee voted to adopt the revisions related to the 5-year ban as a means to address STOLI.

7. Any other important information (e.g., amending an accreditation standard).

None.

VIATICAL SETTLEMENTS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted by the commissioner pursuant to the authority in Section [insert reference to state statute equivalent to Section 15 of the Viatical Settlements Model Act].

Drafting Note: States considering adoption of this version of the regulation should be sure the corresponding elements contained in the current Viatical Settlements Model Act have been put in place.

Section 2. Definitions

In addition to the definitions in Section [insert reference to equivalent to Section 2 of the Viatical Settlements Model Act], the following definitions apply to this regulation:

A. "Insured" means the person covered under the policy being considered for viatication.

B. "Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider considering medical records and appropriate experiential data.

C. "Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

D. "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

Section 3. License Requirements

A. (1) (a) An applicant for a viatical settlement broker's license or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity shall pass the Viatical Settlements Brokers Examination designated by the department.

(b) An applicant or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity who holds or has held a life insurance producer's license for more than one year and is in good standing with the insurance department shall be exempt from the life insurance portion of the examination.

(2) (a) No existing viatical settlement broker's license shall be renewed or reissued until the licensee or individual authorized to act as a viatical settlement broker under a license issued to a legal entity has passed the Viatical Settlement Brokers Examination.

(b) A viatical settlement broker or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity who holds or has held a life insurance producer's license for more than one year and is in good standing with the insurance department shall be exempt from the life insurance portion of the examination.

Drafting Note: Paragraphs (1)(b) and (2)(b) are intended to exempt life insurance producers in good standing with the department from taking the life insurance portion of the examination. They would be subject to all other licensing requirements in Section 3. Individuals licensed only with a limited lines license associated with life insurance are not exempt from the examination procedure.

(3) A passing score for the Viatical Settlements Brokers Examination shall be a minimum score of seventy percent (70%).

(4) If the individual passes the Viatical Settlement Brokers Examination that is administered by another state that is a participant in the Viatical Settlement Brokers Examination process, then the individual has satisfied the testing requirements of this state.

B. In addition to the information required in Section [insert reference to state law equivalent to Section 3 of the Viatical Settlements Model Act], the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] complies with the requirements of Section [insert reference to state law equivalent to Section 3 of Viatical Settlements Model Act].

Drafting Note: Throughout this document text related to investments in viatical settlements is in brackets. It should be considered for inclusion in states where securities regulators do not regulate the investment side of the transaction or adapted for inclusion in the securities code.

C. The application shall be accompanied by a fee of $[insert amount]. The license may be renewed yearly by payment of $[insert amount] and a current copy of a letter of good standing obtained from the filing officer of the applicant's state of domicile. If a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] fails to pay the renewal fee within the time prescribed, or a viatical settlement provider or broker fails to submit the reports required in Section 6 of this regulation, the nonpayment or failure to submit the required reports shall result in lapse of the license. If a viatical settlement provider has, at the time of renewal, viatical settlements where the insured has not died, it shall do one of the following:

Drafting Note: States should consider whether they intend to seek a certification from the secretary of state of the domicile that the corporation is in good standing, or whether they intend to seek assurance from the domicile insurance department before non-resident licensing. The wording should be adjusted to reflect the procedures the state wishes to follow. If the state of residence of the applicant does not license viatical settlement providers or brokers, a state should consider what type of documentation to require.

Drafting Note: States should consider using a license renewal period that matches license renewals for insurance producers.

(1) Renew or maintain its current license status until the earlier of the following events:

(a) The date the viatical settlement provider properly assigns, sells or otherwise transfers the viatical settlements where the insured has not died; or

(b) The date that the last insured covered by viatical settlement transaction has died.

(2) Appoint, in writing, either the viatical settlement provider that entered into the viatical settlement, the broker who received commissions from the viatical settlement, if applicable, or any other viatical settlement provider or broker licensed in this state to make all inquiries to the viator, or the viator's designee, regarding health status of the insured or any other matters.

Drafting Note: If fees are covered in state law or a comprehensive fee regulation, delete reference to fees in Subsection C.

D. (1) An individual licensed as a viatical settlement broker or authorized to act under a license issued to a licensed entity as a viatical settlement broker shall complete [insert number] hours of department-approved continuing education during each continuing education biennium.

(2) The required continuing education hours shall include a minimum of:

(a) [Insert number] hours in life insurance;

(b) [Insert number] hours in viaticals; and

(c) [Insert hours] hours in ethics.

(3) The same hours may be credited towards the individual's continuing education requirements for the viatical settlement broker license and the applicable producer license, if any.

(4) Each continuing education biennium shall begin on [insert time frame to begin] and end two (2) years later.

Drafting Note: States should insert numbers in Subsection D consistent with those required for insurance producers.

(5) The license of an individual who fails to comply with this continuing education requirement and who has not been granted an extension of time to comply in accordance with Section [insert citation for continuing education laws] shall terminate and shall be promptly surrendered to the commissioner without demand.

E. (1) A viatical settlement broker or viatical settlement provider shall file with the commissioner, and thereafter for as long as the license remains in effect shall keep in force, evidence of financial responsibility in the sum of not less than $[insert number] per occurrence, and the sum of $[insert number] in the aggregate, for all occurrences within one year. This evidence shall be in the form of an errors and omissions insurance policy issued in accordance with the [cite state law for financial responsibility], a bond issued by an authorized corporate surety, a deposit, or any combination of these evidences of financial responsibility. The policy, bond, deposit or combination thereof shall not be terminated without thirty (30) days prior written notice to the licensee and the commissioner.

(2) The commissioner may also accept as evidence of financial responsibility proof that a financial instrument in accordance with the requirements in Paragraph (1) has been filed with the commissioner of any other state where the viatical settlement broker or viatical settlement provider is licensed as a viatical settlement broker or viatical settlement provider.

F. The license issued to a viatical settlement provider, viatical settlement broker or [viatical settlement investment agent] shall be a limited license that allows it to operate only within the scope of its license.

[G. An individual licensed as a viatical settlement investment agent shall be licensed by the appropriate regulatory agencies to engage in the business of securities in this state.]

Drafting Note: A state should identify which securities license will be required in the state and insert it in Subsection G.

H. A person shall be deemed to meet the licensing requirements of this section and of Section 3 of the Act and shall be permitted to operate as a viatical settlement broker, as defined in Section 2K of the Act, if that person is licensed as a resident or nonresident insurance producer with a life insurance line of authority pursuant to [cite state producer licensing laws] for at least one year. Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the producer shall notify the department that he or she is acting as a viatical settlement broker on a form or in a manner that may be prescribed by the department, and shall pay any applicable fees to be determined by the department. The notification shall include an acknowledgment by the producer that he or she will operate as a viatical settlement broker in accordance with the Act and this regulation.

[Section 4. Appointments

A. A viatical investment agent shall not act as an agent of a viatical settlement provider unless the investment agent becomes an appointed agent of that provider.

B. To appoint an investment agent as its agent, the appointing provider shall file, in a format approved by the insurance commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first contact with an investor on behalf of the provider.

C. Upon receipt of the notice of appointment, the insurance commissioner shall verify within a reasonable time not to exceed thirty (30) days that the investment agent is determined to be eligible for appointment. If the investment agent is determined to be ineligible for appointment, the insurance commissioner shall notify the provider within five (5) days of its determination.

D. A provider shall pay an appointment fee, in the amount and method of payment set forth in [the appropriate state law or regulation], for each investment agent appointed by the provider.

E. A provider shall remit, in a manner prescribed by the insurance commissioner, a renewal fee in the amount set forth in [insert the appropriate state law or regulation].]

Section 5. Standards for Evaluation of Reasonable Payments for Terminally or Chronically Ill Insureds

Alternative I

[In order to assure that viators receive a reasonable return for viaticating an insurance policy, the return for viaticating a policy shall be no less than the following payouts for insureds who are terminally or chronically ill:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	[80%]
At least 6 but less than 12 months	[70%]
At least 12 but less than 18 months	[65%]
At least 18 but less than 25 months	[60%]
Twenty- five months or more	Viator must receive at least the greater of the cash surrender value or accelerated death benefit in the policy

Drafting Note: The cash surrender value or accelerated death benefit is that which would actually be available to the seller at the time of the transaction.

Except where the cash surrender value is paid, the percentage may be reduced by [5%] for viaticating a policy written by an insurer rated less than the highest [4] categories by A.M. Best, or a comparable rating by another rating agency.

Alternative II

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the viatical settlement contract shall not provide a payment to the viator for a terminally or chronically ill insured that is unreasonable or unjust. In determining whether a payment is unreasonable or unjust, the commissioner's consideration shall include, but not be limited to, the following factors:

A. The face amount being purchased;

B. Any policy loan in effect on the policy being purchased;

C. The life expectancy of the insured at the time of purchase;

D. The age of the insured at the time of purchase;

E. The future premiums that must be paid to minimally keep this policy in force;

F. The cash surrender value or accelerated death benefit available from the policy;

G. An allocation of internal costs relating directly to the acquisition of this policy;

H. The payment of any commission, fee and any other expense paid to a viatical settlement broker or any other external party;

I. Any future interest payments for any borrowing of the funds needed to purchase this policy;

J. The applicable rating at the time of purchase of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups;

K. The prevailing discount rates in the viatical settlement market in [insert state], or if insufficient data is available for [insert state], the prevailing rates nationally or in other states that maintain this data;

L. Whether the policy is within the contestable period; and

M. Other charges not explicitly noted in the above list.

Section 6. Reporting Requirement

A. On or before March 1 of each calendar year, the licensed viatical settlement provider shall submit the following related to the licensee's activities for the previous calendar year:

(1) A report of the viatical settlement transactions in all states and territories, which shall be submitted on Form VSP 001;

(2) A report of the viatical settlement transactions related to [state] viators, which shall be submitted on Form VSP 002;

(3) A report of the individual mortality of [state] insureds, which shall be submitted on Form VSP 003; and

(4) A certification of the information contained in the reports, which shall be submitted on Form VSPB 001 and shall be filed with the reports.

B. On or before March 1 of each calendar year, the licensed viatical settlement broker shall submit the following related to the licensee's activities for the previous calendar year:

(1) A report of the viatical settlement transactions in all states and territories, which shall be submitted on Form VSB 001; and

(2) A report of the viatical settlement transactions related to [state] viators, which shall be submitted on Form VSB 002;

(3) A certification of the information contained in the reports, which shall be submitted on Form VSPB 001 and shall be filed with the reports.

C. The following material is incorporated by reference:

(1) Form VSP 001, "Viatical Settlement Provider Report-All States and Territories";

(2) Form VSP 002, "Viatical Settlement Provider Report-[State] Insureds Only";

(3) Form VSP 003, "Individual Mortality Report-[State] Insureds Only";

(4) Form VSB 001, "Viatical Settlement Broker Report-All States and Territories"; and

(5) Form VSB 002, "Viatical Settlement Broker Report-[State] Insureds Only";

(6) Form VSPB 001, "Viatical Settlement Provider/Broker Certification Form."

Section 7. General Rules

A. With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

B. Payment of the proceeds of a viatical settlement pursuant to [insert citation for Section 9E of Viatical Settlements Model Act] shall be by means of wire transfer to an account designated by the viator or by certified check or cashier's check.

C. Payment of the proceeds to the viator pursuant to a viatical settlement shall be made in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds not disclosed or described in the viatical settlement contract by the viatical settlement provider or escrow agent is not permissible without written consent of the viator.

D. A viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] shall not discriminate in the making or soliciting of viatical settlements as provided by [insert reference to state law prohibiting discrimination], or discriminate between viators with dependents and without.

E. A viatical settlement provider or viatical settlement broker shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator, other than a viatical settlement broker, with respect to the viatical settlement.

F. A viatical settlement provider [or viatical settlement investment agent] shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

G. If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions;

(1) A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

(2) A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either;

(a) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

(b) Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and

(3) A provision that apportions the premiums to be paid by the viatical settlement provider and the viator, provided that the contract provides premium payment terms and nonforfeiture options no less favorable, on a proportional basis, than those included in the policy.

H. In all cases where the insured is a minor child, disclosures to and permission of a parent or legal guardian satisfy the requirements of [insert reference to the Viatical Settlements Model Act] and this regulation.

Section 8. Prohibited Practices

A. A viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] shall obtain from a person that is provided with patient identifying information a signed affirmation that the person or entity will not further divulge the information without procuring the express, written consent of the insured for the disclosure. Notwithstanding the foregoing, if a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] is served with a subpoena and, therefore, compelled to produce records containing patient identifying information, it shall notify the viator and the insured in writing at their last known addresses within five (5) business days after receiving notice of the subpoena.

B. A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

C. A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

Section 9. Insurance Company Practices

A. Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from a viatical settlement provider or a viatical settlement broker within thirty (30) calendar days of the date a request is received, subject to the following conditions:

(1) A current authorization consistent with applicable law, signed by the policy owner or certificate holder, accompanies the request;

(2) In the case of an individual policy or group insurance coverage where details with respect to the certificate holder's coverage are maintained by the insurer, submission of a form substantially similar to Appendix B, which has been completed by the viatical settlement provider or the viatical settlement broker in accordance with the instructions on the form.

B. Nothing in this section shall prohibit a life insurance company and a viatical settlement provider or a viatical settlement broker from using another verification of coverage form that has been mutually agreed upon in writing in advance of submission of the request.

C. A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this section in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

D. The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policy owner or certificate holder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

E. A life insurance company shall not require the viator or insured to sign any request for change in a policy or a group certificate from a viatical settlement provider that is the owner or assignee of the insured's insurance coverage, unless the viator or insured has ownership, assignment or irrevocable beneficiary rights under the policy. In such a situation, the viatical settlement provider shall provide timely notice to the insured that a settlement transaction on the policy has occurred. Timely notice shall be provided within fifteen (15) calendar days of the change in a policy or group certificate.

Section 10. Effective Date

A. This regulation is effective [insert date]. A viatical settlement provider, viatical settlement broker or [viatical settlement investment agent] transacting business in this state may continue to do so pending approval of the provider, broker or [investment agent's] application for a license as long as the application is filed with the commissioner by [insert date].

B. Providers, brokers or [investment agents] that have applied to the commissioner for a license by no later than the effective date of this regulation and that are using forms subject to [insert statute requiring filing and approval of forms] may continue to use forms in use prior to licensure for up to ninety (90) days following the effective date of this regulation.

APPENDIX A

Questions to Ask

- Is the principal and return on my investment guaranteed?
- How is the return on my investment calculated?
- When is the principal and return on my investment paid?
- What fees or other cost am I required to pay?
- Will I ever be required to pay the premiums on the insurance policy?
- What happens if the insured outlives me?

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts about viatical settlements before you invest. This pamphlet provides some of that information, but it's only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable investment for you.

Always Check with Your State

- Your state may have a list of viatical settlement providers and brokers licensed to do business in the state. Make sure yours are on the list.
- Ask for a copy of regulations related to viatical settlements for your financial advisors to review.

Selling a Life Insurance Policy?

If you're interested in selling your life insurance policy, contact your state insurance department *before* you make a decision.

STATE INSURANCE DEPARTMENT

Primary Business Address
Your Address Line 2
Your Address Line 3
Phone: 555-555-5555 Fax: 555-555-5555
Email: xyz@microsoft.com
Website

State Insurance Department

Viatical Settlements

Buying Viaticals as Investments

Before You Decide

Viatical settlements allow life insurance policyholders to sell their policies to investors for an immediate cash benefit. In return, the buyer of the viatical settlement becomes the new owner of the life insurance policy, pays future premiums and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

If you are asked to put your money into this type of investment, it is critical that you understand the risks involved, know how your investment will be used and know what the likely return will be. Contact your state insurance department if you need more information.

Be an Informed Investor

- A viatical settlement is not a liquid investment. You can't "cash in" your principal if you change your mind. There is no return on your investment until the insured dies and the death benefit is paid.
- There is no guaranteed annual rate of return. The rate of return depends on when the insured dies and no one can perfectly predict a person's life expectancy. You should find out the life expectancy of the insured and how that determination was made. Remember that individuals who sell their policies in a viatical settlement may not have a life-threatening illness. They may be selling the policy because they can't afford it or no longer need it.

Need to pick an appropriate graphic

- You are investing in a life insurance policy and premiums must be paid until the insured dies. Find out who is responsible for paying the premiums. Could *you* ever be responsible for paying the premiums? For example, if the insured lives longer than expected, will you have to pay the premiums? If so, this could decrease your rate of return.

Watch for These Special Risks

- **Group Insurance:** The main risk under an employer provided group policy is that the employer or the insurance company could terminate the group policy. If that happens, the insured may have the right to change to an individual policy but the premium will usually be higher. You will want to ask if there are any special rules about changing from the group policy and who will be responsible for paying any additional premiums.
- **Incontestable Clause:** Insurance companies may refuse to pay death claims for policies less than two years old. In the first two years, the death benefit could be denied for various reasons including suicide or false medical information.
- **Term Insurance:** Term life insurance is issued for a certain number of years. An insurance company won't pay the death benefit if the insured outlives the term of the policy. Find out if it is possible to change the policy to a whole life policy.
- **Retirement Funds:** If you will be using money from retirement funds such as a 401(k), IRA, Keogh, or another qualified retirement plan, check with your tax advisor first to make sure you won't lose any tax advantages.

MO-698-10

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of viatical settlement providers and brokers that are licensed to do business in the state. Contact them to make sure yours are on the list.

Always Check with Your State

Contact your state insurance or securities departments to learn about the issues and risks of viatical settlements *if*:

- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy *and* your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy *and* immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state insurance department *before* you make a decision.

STATE INSURANCE DEPARTMENT

Primary Business Address
Your Address Line 2
Your Address Line 3
Phone: 555-555-5555 Fax: 555-555-5555
Email: xyz@microsoft.com
Website

State Insurance Department

Selling Your Life Insurance Policy

Understanding Viatical Settlements

Viatical Settlements Model Regulation

What is a Viatical Settlement?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (*viator*) of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the viatical settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Need to pick an appropriate graphic

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.

2. Find out if your life insurance policy has an *accelerated death benefit.* An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.
- Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?

Model Regulation Service—July 2004

MO-698-11

APPENDIX B

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO: _____NAIC #_____
Name of Insurance Company

POLICY NUMBER: _____

SUBMITTED FROM: _____
Name of Viatical Settlement Broker/Provider

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____TITLE:_____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or social security number	*	
Insured's name	*	
Insured's date of birth	*	
Second insured's name (if applicable)	*	
Second insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

_____ _____
Signature of policy owner **Date signed**

Form VOC

IS THE POLICY IN FORCE? _____YES _____NO

IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

*_____**TERM** _____**WHOLE LIFE** _____**UNIVERSAL LIFE** _____**VARIABLE LIFE**

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy		
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?		
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)		
Date of last cost of insurance deduction		

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

_____ _____

Signature Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____(date).

Insurance company: _____NAIC #_____

Printed name: _____Title: _____

Telephone number: _____Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- o Absolute Assignment/Change of Ownership/Viatical Assignment
- o Change of Beneficiary
- o Release of Irrevocable Beneficiary (if applicable)
- o Waiver of Premium Claim Form
- o Disability Waiver of Premium Approval Letter
- o Release of Assignment
- o Change of Death Benefit Option Form (if UL)
- o Allocation Change Form (if Variable)
- o Annual Report
- o Current In Force Illustration

APPENDIX C

Viatical Settlement Provider Report

Viatical Settlement Provider's Name _____

All States and Territories

Calendar year **200__**

	1	2	3	4	5	6	7	8			1	2	3	4	5	6	7	8	
States	Are you doing business in this state? (Y/N)	Total number of policies reviewed for consideration	Total number of policies where an offer was made	Total number of policies where an offer was not made	Total number of policies purchased	Aggregate total net death benefit	Aggregate amount paid to viators	Secondary market transactions		States	Are you doing business in this state? (Y/N)	Total number of policies reviewed for consideration	Total number of policies where an offer was made	Total number of policies where an offer was not made	Total number of policies purchased	Aggregate total net death benefit	Aggregate amount paid to viators	Secondary market transactions	
								pur	sold									pur	sold
Alabama										New Jersey									
Alaska										New Mexico									
Arizona										New York									
Arkansas										North Carolina									
California										North Dakota									
Colorado										Ohio									
Connecticut										Oklahoma									
Delaware										Oregon									
Dist. of Columbia										Pennsylvania									
Florida										Rhode Island									
Georgia										South Carolina									
Hawaii										South Dakota									
Idaho										Tennessee									
Illinois										Texas									
Indiana										Utah									
Iowa										Vermont									
Kansas										Virginia									
Kentucky										Washington									
Louisiana										West Virginia									
Maine										Wisconsin									
Maryland										Wyoming									
Massachusetts										American Samoa									
Michigan										Guam									
Minnesota										Puerto Rico									
Mississippi										U.S Virgin Islands									
Missouri										Canada									
Montana																			
Nebraska										TOTALS									
Nevada																			
New Hampshire																			

VSP 001

Initials of preparer: _____

Viatical Settlement Provider Report—All States and Territories Instructions

NOTE: This form must be accompanied by Viatical Settlement Provider/Broker Certification Form.

1. Indicate (Y or N); have you done business in this state during the calendar year being reported.

2. For that state or territory, indicate the total number of policies reviewed for consideration for that state or territory.

3. For that state or territory, indicate the total number of policies where an offer was made.

4. For that state or territory, indicate the total number of policies where an offer was refused.

5. For that state or territory, indicate the total number of policies purchased.

6. List the total aggregate net death benefit of the policies viaticated in that state or territory.

7. List the total aggregate amount paid to viators in that state or territory.

8. List the total number of policies purchased and/or sold in the secondary market for that state or territory.

VSP 001 Instructions Initials of preparer: _____

Viatical Settlement Broker's Name _____

Calendar year 200__

Viatical Settlement Broker Report

All States and Territories

States	1 Are you doing business in this state? (Y/N)	2 Total number of policies reviewed for consideration	3 Total number of policies represented for viatication	4 Total number of policies where representation was refused	5 Total number of policies sold to a provider	6 Aggregate net death benefit viaticated	7 Aggregate net amount paid to viators
Alabama							
Alaska							
Arizona							
Arkansas							
California							
Colorado							
Connecticut							
Delaware							
Dist. of Columbia							
Florida							
Georgia							
Hawaii							
Idaho							
Illinois							
Indiana							
Iowa							
Kansas							
Kentucky							
Louisiana							
Maine							
Maryland							
Massachusetts							
Michigan							
Minnesota							
Mississippi							
Missouri							
Montana							
Nebraska							
Nevada							
New Hampshire							
New Jersey							
New Mexico							
New York							
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Rhode Island							
South Carolina							
South Dakota							
Tennessee							
Texas							
Utah							
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin							
Wyoming							
American Samoa							
Guam							
Puerto Rico							
U.S. Virgin Islands							
Canada							
Totals							

Initials of preparer: _____

VSB 001

Viatical Settlement Broker Reporting—All States and Territories Instructions

NOTE: This form must be accompanied by "Viatical Settlement Provider/Broker Certification Form."

1. Indicate (Y or N) to all the states and territories where you are currently doing business.
2. Indicate the total number of policies you reviewed for consideration for that state or territory.
3. Indicate the total number of policies you represented for viatication in that state or territory.
4. Indicate the total number of policies you refused to represent for that state or territory.
5. Total number of policies sold to a provider.
6. List the total aggregate net amount of the policies you transacted for viatication in that state or territory.
7. Regarding transaction where you functioned as a broker, list the total aggregate net amount paid to viators in that state or territory.

VSB 001 Instructions Initials of preparer: _____

Viatical Settlement Provider's Name _____

Calendar year 200__

Viatical Settlement Provider Report

[State] Transactions Only

1	2	3	4	5	6	7	8	9	10	11
Viatical settlement provider settlement number	Contract date purchased	Total net death benefit ($)	Age of insured at time of contract	Life expectancy at time of contract.	Net amount paid to viator ($)	Policy type: I or G	Funding: F, P, I, T or RPT	Source of policy: B, D, SM, P or O	Commission amount ($)	Name of source of policy

VSP 002

Initials of preparer: _____

Viatical Settlement Provider Report [State] Insureds Only Instructions

NOTE: This form must be accompanied by Viatical Settlement Provider/Broker Certification Form.

1. List the settlement number, case number or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date the viatical settlement contract was purchased by the provider during the current calendar year, whether or not the insured is still alive at the end of the calendar year.

3. List the net amount (in dollars) being viaticated.

4. List the age (in years) of the person insured by the policy being viaticated, at the time of the viatical settlement contract.

5. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract.

6. List the net amount (in dollars) paid to the viator.

7. Identify whether the policy was an individual policy (I) or a group policy (G).

8. List the type of funding for the transaction: "F" for a licensed financial institution (policies collateralized), "P" for private (purchaser) funding, "I" for internal funding, "T" for trust, and "RPT" for related provider trust.

9. Indicate the purchase source of the policy. Use "B" for viatical settlement broker, "D" for direct from the viator, "I" for insurance agent/producer, "SM" for a secondary market or viatical settlement provider, "P" for private (purchaser) funding or "O" for other.

10. List the amount of commissions (in dollars) paid to viator source involved in the transaction whether that be a viatical settlement broker, an insurance producer or other licensed entity authorized to be viator source.

11. List the name of the source of the viatical settlement transaction. If it is a broker, producer or other licensee, name that person; if it is direct, from a relative, from the corporation of the insured or any other entity that could possibly reveal the insured, designate by writing "Direct," "Relative," "Corporation," or other nondesignating word.

VSP 002 Instructions Initials of preparer: _____

Viatical Settlement Broker's Name

Viatical Settlement Broker Report

[State] Insureds Only

Calendar year 200___

1	2	3	4	5	6
Viatical settlement provider's settlement number	Contract date sold to viatical settlement provider	Total net death benefit ($)	Net amount paid to viator ($)	Commission amount ($)	Viatical settlement provider's name

Initials of preparer: _____

VSB 002

Viatical Settlement Broker Report—[State] Insureds Only Instructions

***NOTE*: This form must be accompanied by "Viatical Settlement Provider/Broker Certification Form."**

1. List the settlement number, case number, or unique identifying number used by the Viatical Settlement Provider to identify the specific viatical settlement transaction.

2. List the date sold of the viatical settlement contract to the Viatical Settlement Provider.

3. List the total net death benefit.

4. List the net amount (in dollars) paid to the viator.

5. List the amount of commissions (in dollars) paid to all viatical settlement brokers involved in the transaction.

6. List the name of the Viatical Settlement Provider involved in the viatical settlement transaction.

VSB 002 Instructions Initials of preparer: _____

Calendar year 200___

Individual Mortality Report

[State] Insureds Only

Viatical Settlement Provider's Name

1	2	3	4	5	6	7	8	9	10
Viatical settlement provider's settlement number	Contract date	Age of insured at time of contract	Life expectancy at time of contract	Net amount paid to viator	Date of death	Total premiums paid to maintain policy	Death benefit collected	Number of months between date of contract and date of death	Number of months between life expectancy at contract date and date of death (+ / -)

Completed by Viatical Settlement Providers

Initials of preparer: _____

VSP 003

Individual Mortality Report—[State] Insureds Only Instructions

NOTE: This form must be accompanied by the Viatical Settlement Provider/Broker Certification Form.

1. List the settlement number, case number, or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date of the viatical settlement contract.

3. List the age of the insured at the time of the contract.

4. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract. For first to die policies, use the shortest life expectancy of the two lives. For second to die policies, use the longest life expectancy of the two lives.

5. List the "Net" amount paid to the viator.

6. Indicate the insured's date of death. For first to die policies, use the date of the first insured's death. For second to die policies, use the date of the last insured's death.

7. List the total amount of premiums (in dollars) required to be paid to the insurer to maintain the policy from the date of viatication to the date of death.

8. List the total death benefit collected from the insurer.

9. List the number of months between the date of contract and the insured's date of death.

10. List the number of months between the life expectancy of the insured at the time of contract and the insured's date of death. This should be noted as a plus (+) figure if the insured died after the estimated life expectancy or a minus (-) if the insured died prior to the estimated life expectancy.

VSP 003 Instructions Initials of preparer:_____

Viatical Settlement Provider/Broker Certification Form

This section should be completed by viatical settlement providers.

Please check all forms submitted:

- ☐ Viatical Settlement Provider Reporting Form - All States and Territories (VSP 001)
- ☐ Viatical Settlement Provider Reporting Form - [State] Viators Only (VSP 002)
- ☐ Individual Mortality Report - [State] Insureds Only (VSP 003)

I hereby certify that the information contained in the reports indicated above is true and accurate. I acknowledge that providing false and misleading information in the reports, or failing to divulge a fact material thereto, is sufficient grounds for administrative action by the commissioner and potentially, applicable criminal penalties.

_____ Date: ____/____/____
Signature of individual that prepared reports

_____
Print or type name

_____ Date: ____/____/____
Signature of Authorized Representative

_____
Print or type name

This section should be completed by viatical settlement brokers.

Please check all forms submitted:

- ☐ Viatical Settlement Broker Reporting Form - [All States and Territories] (VSB 001)
- ☐ Viatical Settlement Provider Reporting Form - [State] Viators Only (VSB 002)

I hereby certify that the information contained in the reports indicated above is true and accurate. I acknowledge that providing false and misleading information in the reports, or failing to divulge a fact material thereto, is sufficient grounds for administrative action by the commissioner and potentially, applicable criminal penalties.

_____ Date: ____/____/____
Signature of individual that prepared reports

_____
Print or type name

_____ Date: ____/____/____
Signature of Authorized Representative

_____
Print or type name

VSPB 001

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1994 Proc. 2nd Quarter 13, 39, 53, 550, 572-574 (adopted).
1999 Proc. 1st Quarter 8, 9, 506-507, 510, 511-518 (amended and reprinted).
1999 Proc. 3rd Quarter 25, 26, 746, 749, 750-758 (amended to add three appendices).
2003 Proc. 4th Quarter 267-269 (model amended by working group).
2004 Proc. 1st Quarter 329, 337-384 (model further amended and adopted by parent committee).
2004 Proc. 2nd Quarter 49-50 (adopted by Plenary).
2013 Proc. 2nd Quarter 113, 127-129, 346 (adopted Guideline Amendments).

VIATICAL SETTLEMENTS MODEL REGULATION

The NAIC amended this model during the 2013 Summer National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2013 3rd Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Authority

This regulation is adopted by the commissioner pursuant to the authority in Section [insert reference to state statute equivalent to Section 15 of the Viatical Settlements Model Act].

Drafting Note: States considering adoption of this version of the regulation should be sure the corresponding elements contained in the current Viatical Settlements Model Act have been put in place.

Section 2. Definitions

In addition to the definitions in Section [insert reference to equivalent to Section 2 of the Viatical Settlements Model Act], the following definitions apply to this regulation:

A. "Insured" means the person covered under the policy being considered for viatication.

B. "Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider considering medical records and appropriate experiential data.

C. "Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

D. "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

Section 3. License Requirements

A. (1) (a) An applicant for a viatical settlement broker's license or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity shall pass the Viatical Settlements Brokers Examination designated by the department.

(b) An applicant or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity who holds or has held a life insurance producer's license for more than one year and is in good standing with the insurance department shall be exempt from the life insurance portion of the examination.

(2) (a) No existing viatical settlement broker's license shall be renewed or reissued until the licensee or individual authorized to act as a viatical settlement broker under a license issued to a legal entity has passed the Viatical Settlement Brokers Examination.

(b) A viatical settlement broker or an individual authorized to act as a viatical settlement broker under a license issued to a legal entity who holds or has held a life insurance producer's license for more than one year and is in good standing with the insurance department shall be exempt from the life insurance portion of the examination.

Drafting Note: Paragraphs (1)(b) and (2)(b) are intended to exempt life insurance producers in good standing with the department from taking the life insurance portion of the examination. They would be subject to all other licensing requirements in Section 3. Individuals licensed only with a limited lines license associated with life insurance are not exempt from the examination procedure.

(3) A passing score for the Viatical Settlements Brokers Examination shall be a minimum score of seventy percent (70%).

(4) If the individual passes the Viatical Settlement Brokers Examination that is administered by another state that is a participant in the Viatical Settlement Brokers Examination process, then the individual has satisfied the testing requirements of this state.

B. In addition to the information required in Section [insert reference to state law equivalent to Section 3 of the Viatical Settlements Model Act], the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] complies with the requirements of Section [insert reference to state law equivalent to Section 3 of Viatical Settlements Model Act].

Drafting Note: Throughout this document text related to investments in viatical settlements is in brackets. It should be considered for inclusion in states where securities regulators do not regulate the investment side of the transaction or adapted for inclusion in the securities code.

C. The application shall be accompanied by a fee of $[insert amount]. The license may be renewed yearly by payment of $[insert amount] and a current copy of a letter of good standing obtained from the filing officer of the applicant's state of domicile. If a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] fails to pay the renewal fee within the time prescribed, or a viatical settlement provider or broker fails to submit the reports required in Section 6 of this regulation, the nonpayment or failure to submit the required reports shall result in lapse of the license. If a viatical settlement provider has, at the time of renewal, viatical settlements where the insured has not died, it shall do one of the following:

Drafting Note: States should consider whether they intend to seek a certification from the secretary of state of the domicile that the corporation is in good standing, or whether they intend to seek assurance from the domicile insurance department before non-resident licensing. The wording should be adjusted to reflect the procedures the state wishes to follow. If the state of residence of the applicant does not license viatical settlement providers or brokers, a state should consider what type of documentation to require.

Drafting Note: States should consider using a license renewal period that matches license renewals for insurance producers.

(1) Renew or maintain its current license status until the earlier of the following events:

(a) The date the viatical settlement provider properly assigns, sells or otherwise transfers the viatical settlements where the insured has not died; or

(b) The date that the last insured covered by viatical settlement transaction has died.

(2) Appoint, in writing, either the viatical settlement provider that entered into the viatical settlement, the broker who received commissions from the viatical settlement, if applicable, or any other viatical settlement provider or broker licensed in this state to make all inquiries to the viator, or the viator's designee, regarding health status of the insured or any other matters.

Drafting Note: If fees are covered in state law or a comprehensive fee regulation, delete reference to fees in Subsection C.

D. (1) An individual licensed as a viatical settlement broker or authorized to act under a license issued to a licensed entity as a viatical settlement broker shall complete [insert number] hours of department-approved continuing education during each continuing education biennium.

(2) The required continuing education hours shall include a minimum of:

(a) [Insert number] hours in life insurance;

(b) [Insert number] hours in viaticals; and

(c) [Insert hours] hours in ethics.

(3) The same hours may be credited towards the individual's continuing education requirements for the viatical settlement broker license and the applicable producer license, if any.

(4) Each continuing education biennium shall begin on [insert time frame to begin] and end two (2) years later.

Drafting Note: States should insert numbers in Subsection D consistent with those required for insurance producers.

(5) The license of an individual who fails to comply with this continuing education requirement and who has not been granted an extension of time to comply in accordance with Section [insert citation for continuing education laws] shall terminate and shall be promptly surrendered to the commissioner without demand.

E. (1) A viatical settlement broker or viatical settlement provider shall file with the commissioner, and thereafter for as long as the license remains in effect shall keep in force, evidence of financial responsibility in the sum of not less than $[insert number] per occurrence, and the sum of $[insert number] in the aggregate, for all occurrences within one year. This evidence shall be in the form of an errors and omissions insurance policy issued in accordance with the [cite state law for financial responsibility], a bond issued by an authorized corporate surety, a deposit, or any combination of these evidences of financial responsibility. The policy, bond, deposit or combination thereof shall not be terminated without thirty (30) days prior written notice to the licensee and the commissioner.

(2) The commissioner may also accept as evidence of financial responsibility proof that a financial instrument in accordance with the requirements in Paragraph (1) has been filed with the commissioner of any other state where the viatical settlement broker or viatical settlement provider is licensed as a viatical settlement broker or viatical settlement provider.

F. The license issued to a viatical settlement provider, viatical settlement broker or [viatical settlement investment agent] shall be a limited license that allows it to operate only within the scope of its license.

[G. An individual licensed as a viatical settlement investment agent shall be licensed by the appropriate regulatory agencies to engage in the business of securities in this state.]

Drafting Note: A state should identify which securities license will be required in the state and insert it in Subsection G.

H. A person shall be deemed to meet the licensing requirements of this section and of Section 3 of the Act and shall be permitted to operate as a viatical settlement broker, as defined in Section 2K of the Act, if that person is licensed as a resident or nonresident insurance producer with a life insurance line of authority pursuant to [cite state producer licensing laws] for at least one year. Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the producer shall notify the department that he or she is acting as a viatical settlement broker on a form or in a manner that may be prescribed by the department, and shall pay any applicable fees to be determined by the department. The notification shall include an acknowledgment by the producer that he or she will operate as a viatical settlement broker in accordance with the Act and this regulation.

[Section 4. Appointments

A. A viatical investment agent shall not act as an agent of a viatical settlement provider unless the investment agent becomes an appointed agent of that provider.

B. To appoint an investment agent as its agent, the appointing provider shall file, in a format approved by the

insurance commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first contact with an investor on behalf of the provider.

C. Upon receipt of the notice of appointment, the insurance commissioner shall verify within a reasonable time not to exceed thirty (30) days that the investment agent is determined to be eligible for appointment. If the investment agent is determined to be ineligible for appointment, the insurance commissioner shall notify the provider within five (5) days of its determination.

D. A provider shall pay an appointment fee, in the amount and method of payment set forth in [the appropriate state law or regulation], for each investment agent appointed by the provider.

E. A provider shall remit, in a manner prescribed by the insurance commissioner, a renewal fee in the amount set forth in [insert the appropriate state law or regulation].]

Section 5. Standards for Evaluation of Reasonable Payments for Terminally or Chronically Ill Insureds

Alternative I

[In order to assure that viators receive a reasonable return for viaticating an insurance policy, the return for viaticating a policy shall be no less than the following payouts for insureds who are terminally or chronically ill:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	[80%]
At least 6 but less than 12 months	[70%]
At least 12 but less than 18 months	[65%]
At least 18 but less than 25 months	[60%]
Twenty- five months or more	Viator must receive at least the greater of the cash surrender value or accelerated death benefit in the policy

Drafting Note: The cash surrender value or accelerated death benefit is that which would actually be available to the seller at the time of the transaction.

Except where the cash surrender value is paid, the percentage may be reduced by [5%] for viaticating a policy written by an insurer rated less than the highest [4] categories by A.M. Best, or a comparable rating by another rating agency.

Alternative II

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the viatical settlement contract shall not provide a payment to the viator for a terminally or chronically ill insured that is unreasonable or unjust. In determining whether a payment is unreasonable or unjust, the commissioner's consideration shall include, but not be limited to, the following factors:

A. The face amount being purchased;

B. Any policy loan in effect on the policy being purchased;

C. The life expectancy of the insured at the time of purchase;

D. The age of the insured at the time of purchase;

E. The future premiums that must be paid to minimally keep this policy in force;

F. The cash surrender value or accelerated death benefit available from the policy;

G. An allocation of internal costs relating directly to the acquisition of this policy;

H. The payment of any commission, fee and any other expense paid to a viatical settlement broker or any other

external party;

I. Any future interest payments for any borrowing of the funds needed to purchase this policy;

J. The applicable rating at the time of purchase of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups;

K. The prevailing discount rates in the viatical settlement market in [insert state], or if insufficient data is available for [insert state], the prevailing rates nationally or in other states that maintain this data;

L. Whether the policy is within the contestable period; and

M. Other charges not explicitly noted in the above list.

Section 6. Reporting Requirement

On or before March 1 of each calendar year, the licensed viatical settlement provider shall submit the following related to the licensee's activities for the previous calendar year:

A. A report of the viatical settlement transactions related to [state] viators, which shall be submitted on Form VSP 001;

B. A report of the individual mortality of [state] insureds, which shall be submitted on Form VSP 002; and

C. A certification of the information contained in the reports, which shall be submitted on Form VSP 003 and shall be filed with the reports.

Section 7. General Rules

A. With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

B. Payment of the proceeds of a viatical settlement pursuant to [insert citation for Section 9E of Viatical Settlements Model Act] shall be by means of wire transfer to an account designated by the viator or by certified check or cashier's check.

C. Payment of the proceeds to the viator pursuant to a viatical settlement shall be made in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds not disclosed or described in the viatical settlement contract by the viatical settlement provider or escrow agent is not permissible without written consent of the viator.

D. A viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] shall not discriminate in the making or soliciting of viatical settlements as provided by [insert reference to state law prohibiting discrimination], or discriminate between viators with dependents and without.

E. A viatical settlement provider or viatical settlement broker shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator, other than a viatical settlement broker, with respect to the viatical settlement.

F. A viatical settlement provider [or viatical settlement investment agent] shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

G. If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions;

(1) A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

(2) A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either;

(a) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

(b) Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and

(3) A provision that apportions the premiums to be paid by the viatical settlement provider and the viator, provided that the contract provides premium payment terms and nonforfeiture options no less favorable, on a proportional basis, than those included in the policy.

H. In all cases where the insured is a minor child, disclosures to and permission of a parent or legal guardian satisfy the requirements of [insert reference to the Viatical Settlements Model Act] and this regulation.

I. No later than the time the application for the viatical settlement contract is signed by all parties, a viatical settlement provider or viatical settlement broker shall provide the viator information describing the process of a viatical settlement. At a minimum, the informational brochure in Appendix A shall be used unless another form is developed or approved by the commissioner.

Section 8. Prohibited Practices

A. A viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] shall obtain from a person that is provided with patient identifying information a signed affirmation that the person or entity will not further divulge the information without procuring the express, written consent of the insured for the disclosure. Notwithstanding the foregoing, if a viatical settlement provider, viatical settlement broker [or viatical settlement investment agent] is served with a subpoena and, therefore, compelled to produce records containing patient identifying information, it shall notify the viator and the insured in writing at their last known addresses within five (5) business days after receiving notice of the subpoena.

B. A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

C. A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

Section 9. Insurance Company Practices

A. Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from the viatical settlement provider or the viatical settlement broker within thirty (30) calendar days of the date a request is received, subject to the following conditions:

(1) A current authorization consistent with applicable law, signed by the policy owner or certificate holder, accompanies the request;

(2) In the case of an individual policy or group insurance coverage where details with respect to the certificate holder's coverage are maintained by the insurer, submission of a form substantially similar to Appendix B, which has been completed by the viatical settlement provider or the viatical settlement broker in accordance with the instructions on the form.

B. Nothing in this section shall prohibit a life insurance company and a viatical settlement provider or a viatical settlement broker from using another verification of coverage form that has been mutually agreed upon in

writing in advance of submission of the request.

C. Nothing in this section shall limit a policy owner's right to request information, consistent with applicable law, before or after completion of the viatical settlement contract about the policy from a life insurance company at any time.

D. A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this section in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

E. The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policy owner or certificate holder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

F. A life insurance company shall not require the viator or insured to sign any request for change in a policy or a group certificate from a viatical settlement provider that is the owner or assignee of the insured's insurance coverage, unless the viator or insured has ownership, assignment or irrevocable beneficiary rights under the policy. In such a situation, the viatical settlement provider shall provide timely notice to the insured that a settlement transaction on the policy has occurred. Timely notice shall be provided within fifteen (15) calendar days of the change in a policy or group certificate.

G. The format for the company report is demonstrated in Appendix B, i.e., Verification of Coverage.

Section 10. Effective Date

A. This regulation is effective [insert date]. A viatical settlement provider, viatical settlement broker or [viatical settlement investment agent] transacting business in this state may continue to do so pending approval of the provider, broker or [investment agent's] application for a license as long as the application is filed with the commissioner by [insert date].

B. Providers, brokers or [investment agents] that have applied to the commissioner for a license by no later than the effective date of this regulation and that are using forms subject to [insert statute requiring filing and approval of forms] may continue to use forms in use prior to licensure for up to ninety (90) days following the effective date of this regulation.

APPENDIX A

Selling Your Life Insurance Policy:
Life and Viatical Settlements

Important Terms to Know
*The **viator** is the policy owner.*
*The **provider** buys the policy.*
*The **broker** finds providers to make offers on the policy.*

What is a Life Settlement?

A life settlement (also known as a viatical settlement) is the sale of a life insurance policy by you, the policy owner, to a life settlement provider. The **provider** buys your life insurance policy for cash. Once you sign a contract to sell your policy, the provider asks the life insurance company to transfer ownership of the policy from you to the new owner. You will then be known as the "**viator**." The new owner then pays future premiums and collects the death benefit when the insured person dies.

You may choose to use the services of a life settlement broker to help you sell your insurance policy. The **broker** works for you and not for the provider or for the insurance company. You can expect the broker to search the market and find providers to make offers to buy your policy.

Your Rights and Responsibilities.

State laws protect you if you sell a life insurance policy.

- All providers and brokers must be licensed by your state insurance department. The insurance department also must approve all life settlement contract forms.
- Providers and brokers must give you certain information before you sign a life settlement contract. This information includes the amount your beneficiary would have received when you die, and the amount the broker will be paid.
- The amount a provider pays you for your policy must be greater than either the cash surrender value of the policy or, if available, the accelerated death benefit.

- The money paid for your policy will be put in an escrow account, and held by an independent third party while the life settlement is finalized.
- You have the right to change your mind about the settlement for a short period of time after you sign the contract. Be sure you understand how to cancel the sale.

Before You Sign a Contract, Be Sure You Can Answer These Questions.

Talk with your insurance agent and company and your other advisors such as an attorney, accountant or financial planner.

- How long have you had your policy? State law generally requires that you must have owned the life insurance policy for a certain period of time before you can sell it to a provider. Ask your broker if your policy qualifies.
- Can you get cash from your policy without selling it? Ask about the cash value of your policy. Find out if you can get a policy loan.
- If the insured person is ill, can you get accelerated death benefits under your policy?
- Can your beneficiaries still receive any life insurance benefit after you sell the policy?
- How much money will you get from the sale? When and how will you receive the money?
- How much is the broker's compensation?
- How many providers did the broker contact? How many offers were received?

Important Things to Know Before You Sell Your Policy.

- Creditors may claim some or all of the money you receive.
- The money you receive from the sale may be taxable.
- Once you receive the money, you may not be eligible for public assistance benefits such as food

stamps or Medicaid.

- You may have to pay back loans you've taken against the insurance policy.
- If your policy is issued through an employer plan or other group policy, you may need permission from the employer or group to sell your policy.
- The provider can ask about the insured person's health from time to time. The provider must give notice explaining who will get personal information.
- If you give inaccurate information to a provider when selling your policy, you could be accused of fraud and the sale of your policy could be cancelled.

Always Check With Your State Insurance Department.

- To be sure the provider and broker are licensed to do business in the state.
- If someone asks you to buy a new life insurance policy and to immediately sell it for cash.
- If you are asked to buy a new life insurance policy and the insurance agent or some other person offers to pay the premiums for you.

APPENDIX B

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO: _____NAIC #_____
Name of Insurance Company

POLICY NUMBER: _____

SUBMITTED FROM: _____
Name of Viatical Settlement Broker/Provider

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____TITLE:_____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or social security number	*	
Insured's name	*	
Insured's date of birth	*	
Second insured's name (if applicable)	*	
Second insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

_____ _____
Signature of policy owner **Date signed**

Form VOC

IS THE POLICY IN FORCE? _____YES _____NO
IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

***_____TERM _____WHOLE LIFE _____UNIVERSAL LIFE _____VARIABLE LIFE**

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy		
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?		
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)		
Date of last cost of insurance deduction		

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

_____ _____

Signature Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____(date).

Insurance company: _____NAIC #_____

Printed name: _____Title: _____

Telephone number: _____Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- o Absolute Assignment/Change of Ownership/Viatical Assignment
- o Change of Beneficiary
- o Release of Irrevocable Beneficiary (if applicable)
- o Waiver of Premium Claim Form
- o Disability Waiver of Premium Approval Letter
- o Release of Assignment
- o Change of Death Benefit Option Form (if UL)
- o Allocation Change Form (if Variable)
- o Annual Report
- o Current In Force Illustration

APPENDIX C

_____
Viatical Settlement Provider's Name

Viatical Settlement Provider Report
[State] Transactions Only

Calendar year **20___**

1	2	3	4	5	6	7	8	9	10	11
Viatical settlement provider settlement number	Contract date purchased	Total net death benefit ($)	Age of insured at time of contract	Life expectancy at time of contract.	Net amount paid to viator ($)	Policy type: I or G	Funding: F, P, I, T or RPT	Source of policy: B, D, SM, P or O	Commission amount ($)	Name of source of policy

Initials of Preparer: _____

VSP 001

Viatical Settlement Provider Report [State] Insureds Only Instructions

1. List the settlement number, case number or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date the viatical settlement contract was purchased by the provider during the current calendar year, whether or not the insured is still alive at the end of the calendar year.

3. List the net amount (in dollars) being viaticated.

4. List the age (in years) of the person insured by the policy being viaticated, at the time of the viatical settlement contract.

5. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract.

6. List the net amount (in dollars) paid to the viator.

7. Identify whether the policy was an individual policy (I) or a group policy (G).

8. List the type of funding for the transaction: "F" for a licensed financial institution (policies collateralized), "P" for private (purchaser) funding, "I" for internal funding, "T" for trust, and "RPT" for related provider trust.

9. Indicate the purchase source of the policy. Use "B" for viatical settlement broker, "D" for direct from the viator, "I" for insurance agent/producer, "SM" for a secondary market or viatical settlement provider, "P" for private (purchaser) funding or "O" for other.

10. List the amount of commissions (in dollars) paid to viator source involved in the transaction whether that be a viatical settlement broker, an insurance producer or other licensed entity authorized to be viator source.

11. List the name of the source of the viatical settlement transaction. If it is a broker, producer or other licensee, name that person; if it is direct, from a relative, from the corporation of the insured or any other entity that could possibly reveal the insured, designate by writing "Direct," "Relative," "Corporation," or other nondesignating word.

VSP 001 Instructions Initials of preparer: _____

_____ **Individual Mortality Report** Calendar year

Viatical Settlement Provider's Name *[State] Insureds Only* **20___**

1	2	3	4	5	6	7	8	9	10
Viatical settlement provider's settlement number	Contract date	Age of insured at time of contract	Life expectancy at time of contract	Net amount paid to viator	Date of death	Total premiums paid to maintain policy	Death benefit collected	Number of months between date of contract and date of death	Number of months between life expectancy at contract date and date of death (+ / -)

Completed by Viatical Settlement Providers Initials of preparer: _____

VSP 002

Individual Mortality Report—[State] Insureds Only Instructions

1. List the settlement number, case number, or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date of the viatical settlement contract.

3. List the age of the insured at the time of the contract.

4. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract. For first to die policies, use the shortest life expectancy of the two lives. For second to die policies, use the longest life expectancy of the two lives.

5. List the "Net" amount paid to the viator.

6. Indicate the insured's date of death. For first to die policies, use the date of the first insured's death. For second to die policies, use the date of the last insured's death.

7. List the total amount of premiums (in dollars) required to be paid to the insurer to maintain the policy from the date of viatication to the date of death.

8. List the total death benefit collected from the insurer.

9. List the number of months between the date of contract and the insured's date of death.

10. List the number of months between the life expectancy of the insured at the time of contract and the insured's date of death. This should be noted as a plus (+) figure if the insured died after the estimated life expectancy or a minus (-) if the insured died prior to the estimated life expectancy.

VSP 002 Instructions Initials of preparer:_____

Viatical Settlement Provider Certification Form

This section should be completed by viatical settlement providers.

Please check all forms submitted:

☐ Viatical Settlement Provider Reporting Form - [State] Viators Only (VSP 001)

☐ Individual Mortality Report - [State] Insureds Only (VSP 002)

I hereby certify that the information contained in the reports indicated above is true and accurate. I acknowledge that providing false and misleading information in the reports, or failing to divulge a fact material thereto, is sufficient grounds for administrative action by the commissioner and potentially, applicable criminal penalties.

_____ Date: ____/____/____
Signature of individual that prepared reports

_____
Print or type name

_____ Date: ____/____/____
Signature of Authorized Representative

_____
Print or type name

VSP 003

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1994 Proc. 2nd Quarter 13, 39, 53, 550, 572-574 (adopted).
1999 Proc. 1st Quarter 8, 9, 506-507, 510, 511-518 (amended and reprinted).
1999 Proc. 3rd Quarter 25, 26, 746, 749, 750-758 (amended to add three appendices).
2003 Proc. 4th Quarter 267-269 (model amended by working group).
2004 Proc. 1st Quarter 329, 337-384 (model further amended and adopted by parent committee).
2004 Proc. 2nd Quarter 49-50 (adopted by Plenary).
2013 Proc. 2nd Quarter 113, 127-129, 346 (adopted Guideline Amendments).

VIATICAL SETTLEMENTS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VIATICAL SETTLEMENTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 31.300 to 31.449 (2002/2012) (portions of model).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE R. 054.00.69 (1998); DIRECTIVE 1-2009 (2009).
California			CAL. CODE REGS. tit. 10, §§ 2548 (2007/2014); BULLETIN 2012-2 (2012).
Colorado			3 COLO. CODE REGS. 702-2:2-1-11 (2012).
Connecticut			CONN. AGENCIES REGS. §§ 38a-465-2 to 38a-465-10 (1998/2013).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		

VIATICAL SETTLEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. §§ 431C-31 to 431C-34 (2012).
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana			760 IND. ADMIN. CODE 1-61-1 to 1-61-12 (1999/2005).
Iowa			IOWA ADMIN. CODE R. 191-48.1 to 191-48.14 (2002/2012); 191-50.110 to 191-50.113 (2000/2007) (investments in viatical settlements); BULLETIN 2011-5 (2011).
Kansas	NO CURRENT ACTIVITY		
Kentucky			806 KY. ADMIN. REGS. 9:310 (2001/2009); 806 KY. ADMIN. REGS. 15:050 (2001/2009).
Louisiana			LA. ADMIN. CODE tit. 37, §§ XIII.3901 to XIII.3919 (Regulation 58) (1995/2009).
Maine			02-031 ME. CODE R. 931(2000); 02-032 ME. CODE R. § 539 (2007).
Maryland			MD. CODE REGS. 31.09.11.01 to 31.09.11.02 (2007).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		

VIATICAL SETTLEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Mississippi			19 CODE MISS. R. Pt. 2, R. 15.01 to 15.14 (2012).
Missouri	NO CURRENT ACTIVITY		
Montana	MONT. ADMIN. R. 6.6.8501 to 6.6.8512 (2000/2006) (portions of model).		
Nebraska			210 NEB. ADMIN. CODE § 76 (2002).
Nevada			NEV. ADMIN. CODE 688C.010 to 688C.120 (2006); BULLETIN 2006-007 (2006); BULLETIN 2011-011 (2011).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. ADMIN. CODE §§ 11:4-35.1 to 11:4-35.18 (2001).
New Mexico			N.M. CODE R. §§ 13.9.15.1 to 13.9.15.20 (2000).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 380.1 to 380.10 (Regulation 148) (1994/2003); §§ 381.1 to 381.3 (2010/2011); GEN. COUNSEL OPIN. 11-6-2006 (2006).
North Carolina			11 N.C. ADMIN. CODE §§ 12.1710 to 12.1720 (2002).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO ADMIN. CODE 3901-9-01 to 3901-9-04 (2010).
Oklahoma			OKLA. ADMIN. CODE §§ 365:25-11-1 to 365:25-11-11 (1999/2009); BULLETIN 11-1-2008 (2008); BULLETIN 4-9-2009 (2009).

VIATICAL SETTLEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon			OR. ADMIN.R. 836-014-0200 to 836-014-0330 (1996/2006).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. COMP. R. & REGS. 0780-1-71-.01 to 0780-1-71-.11 (2003).
Texas			28 TEX. ADMIN. CODE §§ 3.1701 to 3.1760 (2013); BULLETIN B-0028-08 (2008); BULLETIN B-0036-11 (2011).
Utah			UTAH ADMIN. CODE r. 590-222-1 to 590-222-17 (2003/2013).
Vermont			VT. CODE R. 95-4 (1996).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			14 VA. ADMIN. CODE §§ 5-71-10 to 5-71-100 (1997/2003).
Washington			WASH. ADMIN. CODE 284-97-010 to 284-97-925 (1995/2013).
West Virginia			W. VA. CODE R. §§ 114-80-1 to 114-80-12 (2008/2009).
Wisconsin			WIS. ADMIN. CODE INS. § 2.18 (2012).
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2013

VIATICAL SETTLEMENTS MODEL REGULATION (#698)

1. Description of the Project, Issues Addressed, etc.

The guideline revisions to the *Viatical Settlements Model Regulation* (#698) were made to update the model for consistency with the 2007 revisions to the *Viatical Settlements Model Act* (#697). Specifically, the guideline revisions eliminate several reports that are no longer required as a result of the 2007 revisions to Model #697. The guideline revisions add a specific provision requiring viatical settlement providers and brokers to provide information about viatical settlements to a viator, and provide that, at a minimum, unless another form is developed or approved by the commissioner, the viatical settlement provider or broker must provide the consumer with a copy of the Viatical Settlement Informational Brochure in Appendix A to satisfy this requirement. The guideline revisions also clarify the policy owner's right to receive information about the insurance policy from the insurer either before or after completion of the viatical settlement contract. The guideline revisions also update the Viatical Settlement Informational Brochure in Appendix A.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Viatical Settlements (A) Working Group was responsible for drafting the guideline revisions. The members of the Working Group were: Iowa, Chair; New Hampshire, Vice Chair; Florida; Georgia; Kansas; Louisiana; Nebraska; and Tennessee.

3. Project Authorized by What Charge and Date First Given to the Group.

The Viatical Settlements (A) Working Group was given an existing Life Insurance and Annuities (A) Committee charge in 2011 to review and consider revisions to the *Viatical Settlements Model Regulation* (#698) for consistency with the 2007 revisions made to the *Viatical Settlements Model Act* (#697), including reviewing and considering revisions to or replacement of, as appropriate, the Informational Brochure in Appendix A. *Important*

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The guideline revisions were drafted by the Viatical Settlements (A) Working Group, which developed four drafts of the proposed guideline revisions to Model #698 prior to its adoption. The Working Group discussed the drafts and the comments received on the drafts at in-person meetings during the 2012 Spring National Meeting, 2012 Summer National Meeting and 2012 Fall National Meeting. The Working Group also held conference calls Sept. 18, Nov. 7 and Dec. 18, 2012, during which the drafts and comments received on the drafts were discussed. The guideline revisions were adopted by the Working Group during the Dec. 18, 2012, conference call and adopted by the Life Insurance and Annuities (A) Committee at the 2013 Spring National Meeting. All drafts and comments were posted on the Working Group's Web page. Numerous interested parties participated in the drafting process, including consumer representatives and industry representatives.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The Regulatory Framework (B) Task Force discussed the drafts and comments received on them during in-person meetings during the 2012 Spring National Meeting, 2012 Summer National Meeting and 2012 Fall National Meeting. The Working Group also held conference calls Sept. 18, Nov. 7 and Dec. 18, 2012, during which the drafts and comments received on the drafts were discussed. The guideline revisions were adopted by the Working Group during the Dec. 18, 2012, conference call and adopted by the Life Insurance and Annuities (A) Committee at the 2013 Spring National Meeting. All drafts and comments were posted on the Working Group's Web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

There were no significant issues or items of controversy. However, there were some issues raised and resolved by the Working Group related to the guideline revisions clarifying the timeframe within which an insurer must provide a verification of coverage (VOC) and who may request the VOC. The Working Group decided to add a new provision that affirms that a policy owner has the right to request information about the policy at any time both before and after completion of the viatical settlement contract. In addition, the section in Model #698 related to the requirements for requesting a VOC was amended to specify that the parties involved in the initial viatical settlement transaction may request a VOC from the insurer and the insurer must respond to the request within 30 days under specified circumstances.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2004

VIATICAL SETTLEMENTS MODEL REGULATION (# 698)

1. Description of the Project, Issues Addressed, etc.

The viatical settlement industry has changed a great deal over the ten years since development of the initial model act by the NAIC. Revisions to the Viatical Settlements Model Act were prepared in 1998 and 2001 to reflect the new business model. The latest amendments broadened the scope of the model to cover sales of life insurance policies by those who were not terminally or chronically ill. The model regulation has been revised to match the scope of the model act.

2. Name of Group Responsible for Drafting the Model and States Participating

This model was developed by the Viatical Settlements Working Group, chaired by Lester Dunlap of Louisiana. Members of the working group are: Michael Bownes, Alabama; Rich Robleto, Florida; Bill McAndrew, Illinois; Roger Strauss, Iowa; Marlyn Burch, Kansas; Brian Staples, Kentucky; Paul Hanson, Minnesota; Anne Marie Narcini, New Jersey; Dennis Stapleton, Ohio; Dalora Schafer, Oklahoma; Carl Lundberg/David Ball, Oregon; Gwen Fuller, South Carolina; Maliaka EssamelDin, Tennessee; and Bob Wright, Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

Revisions to the Viatical Settlements Model Act were adopted in March 2001. As soon as those changes were adopted, the working group began work on revisions to the regulation to bring it into line with the amendments to the model act. The 2001 charge was: "Revise the Viatical Settlements Model Regulation to coordinate with the revised model act, including requirements regarding sales of the policies of healthy individuals and investor protections, to be completed by the Winter National Meeting."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open to comments and participation by all interested parties. Representatives from the life insurance industry, the viatical settlement industry and financial investors participated fully in the discussion. Comments were received on each draft of the model and considered by the working group in open meetings. Consumer representatives were also welcome and participated to a limited degree.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Copies of every draft were posted on the NAIC website and ample time provided for comments on each draft. Comment letters were posted on the NAIC website. NAIC staff also maintains a list of interested parties, who received notice of each conference call and copies of drafts and comments by e-mail. After the working group adopted the model, a hearing was held at the A Committee.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

A number of issues were raised that required extensive discussion to resolve.

(1) Licensing issues related to brokers and providers: Several interested parties suggested that any licensed life insurance agent should be allowed to serve as a viatical settlement broker without additional licensing. The working group did not agree with this reasoning because of concerns about the conflict of interest that could arise when a person got a commission for selling a policy to an individual and another commission for viaticating the policy. In addition, the working group added educational and testing requirements for viatical brokers to be sure they were knowledgeable about the business they were undertaking. The A Committee decided to amend the model to allow any licensed life insurance producer to serve as a viatical settlement broker without additional licensing, with a requirement that the producer notify the department and agree to comply with the requirements in the model.

(2) Standards for evaluation of reasonable payments: This issue has been controversial since the first model regulation was adopted in 1994. The model includes minimum payouts for those who are terminally or chronically ill. Segments of the viatical industry have urged the deletion of this section with the argument that it reduces the availability of offers by requiring a minimum payment. At the time of the last revision, an alternative was added to require "reasonable" payments, and this was revised to list specific factors for measuring reasonableness. Just before adoption of the model, the group voted to request a charge to develop guidelines with more detail to assist in administration.

(3) Requests for information: The viatical industry and the life insurance industry have been in conflict for many years in regard to the requests made by viatical providers and brokers for information in the possession of the insurer. During the last revision of the regulation, the two sets of interests sat down together and drafted a verification of coverage form. The use of the form has not helped the situation as much as hoped. Providers ask for more than is on the form and insurers note that some information is not available. The working group totally revamped the form to require significantly less information and to require that viatical settlement providers and brokers fill out some of the form prior to submitting it to the insurer. The working group decided that a provider should not be prepared to make an offer or express interest in a life insurance contract without gathering at least some basic information.

7. Any Other Important Information (e.g., amending an accreditation standard).

Congress has expressed interest in uniformity of state laws and has held hearings on the issue. Updates on state activity are requested frequently.

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

Whereas, the standard policy as set forth in Section [insert applicable section] is not intended to cover loss or damage caused by nuclear reaction, or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy; and

Whereas, it is desirable in the public interest that written notice of such intention be given to persons insured under such a standard policy;

Now therefore, be it enacted, that

Insurers issuing the standard policy pursuant to Section [insert applicable section] are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy; provided, however, that nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1959 Proc. I 115, 116 (adopted).

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

What are the state pages?

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How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

STATE PAGE KEY:

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PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-1509 (1960).		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. INS. CODE § 2079 (1959); § 6019 (1959).
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. GEN. STAT. § 38a-308 (1977/1980).		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	GA. CODE ANN. § 33-32-1(b) (1960).		
Guam	NO CURRENT ACTIVITY		

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	HAW. REV. STAT. § 431:10-210(6) (1987).		
Idaho	IDAHO CODE ANN. § 41-2401(2) (1961/1978).		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA CODE § 515.139 (1961).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. REV. STAT. ANN. § 22:1311(G) (1960/1985).		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	MASS. GEN. LAWS ANN. ch. 175, § 99A (1962).		
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. § 65A.05 (1967).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. REV. STAT. § 44-501.01 (1959).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. § 407:23 (1959).		
New Jersey	N.J. STAT. ANN. § 17:36-5.28 (1959).		

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. INS. LAW § 3405 (1984).		
North Carolina	N.C. GEN. STAT. § 58-44-25 (1963).		
North Dakota	N.D. CENT. CODE §§ 26.1-39-07 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	OKLA. STAT. tit. 36, § 4806 (1961).		
Oregon	OR. REV. STAT. §§ 742.244 (1959).		
Pennsylvania	40 PA. STAT. ANN. § 636 (1961).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS § 27-5-3.1 (1961).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-2102 (1986).		
Washington	NO CURRENT ACTIVITY		

INSURANCE STATUTE ATOMIC ENERGY EXCLUSION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE § 33-17-11 (1959).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

NATIONWIDE INLAND MARINE DEFINITION

Table of Contents

Section 1. Purpose

The purpose of this instrument is to describe the kinds of risks and coverages which may be classified or identified under state insurance laws as marine, inland marine or transportation insurance, but does not include all of the kinds of risks and coverages which may be written, classified or identified under marine, inland marine or transportation insuring powers, nor shall it be construed to mean that the kinds of risks and coverages are solely marine, inland marine or transportation insurance in all instances.

This instrument shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.

Section 2. Applicability

Marine or transportation policies may cover under the following conditions:

A. Imports

Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

An import, as a proper subject, or marine or transportation insurance, shall be deemed to maintain its character as such, so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when the property has been:

(1) Sold and delivered by the importer, factor or consignee; or

(2) Removed from place of storage and placed on sale as part of importer's stock in trade at a point of sale-distribution; or

(3) Delivered for manufacture, processing or change in form to premises of the importer or of another used for any such purposes.

B. Exports

Exports may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this ruling respecting domestic shipments shall apply. However, this provision shall not apply to long established methods of insuring certain commodities (e.g., cotton).

C. Domestic Shipments

(1) Domestic shipments on consignment, for sale or distribution, exhibit, trial, approval or auction, while in transit, while in the custody of others and while being returned, provided that in no event shall the policy cover on premises owned, leased or operated by the consignor.

(2) Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, provided that the shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser.

D. Bridges, Tunnels and Other Instrumentalities of Transportation and Communication (excluding buildings, their improvements and betterments, furniture and furnishings, fixed contents and supplies held in storage)

The foregoing includes:

(1) Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto;

(2) Piers, wharves, docks, slips, dry docks and marine railways;

(3) Pipelines, including on-line propulsion, regulating and other equipment appurtenant to the pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants;

(4) Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges;

(5) Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus;

(6) Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.

E. Personal Property Floater Risk covering individuals and/or generally

(1) Personal Effects Floater Policies;

(2) The Personal Property Floater;

(3) Government Service Floaters;

(4) Personal Fur Floaters;

(5) Personal Jewelry Floaters;

(6) Wedding Present Floaters for not exceeding ninety (90) days after the date of the wedding;

(7) Silverware Floaters;

(8) Fine Arts Floaters covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit;

(9) Stamp and Coin Floaters;

(10) Musical Instrument Floaters (Radios, televisions, record players and combinations thereof are not deemed musical instruments);

(11) Mobile Articles, Machinery and Equipment Floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use) covering identified property of a mobile or floating nature pertaining to or usual to a household. The policies shall not cover furniture and fixtures not customarily used away from premises where the property is usually kept;

(12) Installment Sales and Leased Property Policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or lease, but excluding motor vehicles designed for highway use. The policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest; and

(13) Live Animal Floaters.

F. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation

(1) Radium Floaters;

(2) Physician's and Surgeons' Instrument Floaters. The policies may include coverage of furniture, fixtures and tenant Assured's interest in improvements and betterments of buildings located in that portion of the premises occupied by the assured in the practice of his or her profession;

(3) Pattern and Die Floaters;

(4) Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes;

(5) Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records;

(6) Salesmen's Samples Floaters;

(7) Exhibition Policies on property while on exhibition and in transit to or from exhibitions;

(8) Live Animal Floaters;

(9) Builders Risks or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. The policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.

Coverage shall be limited to Builders Risks or Installation Risks where perils in addition to Fire and Extended Coverage are to be insured.

If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.

(10) Mobile Articles, Machinery and Equipment Floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use), covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into custody or control of parties who intend to use such property for which it was manufactured or created. The policies shall not cover furniture and fixtures not customarily used away from premises where the property is usually kept.

(11) Property in transit to or from and in the custody of bailees (not owned, controlled or operated by the bailor). The policies shall not cover bailee's property at his or her premises.

(12) Installment Sales and Leased Property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. The policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This section is not intended to include machinery and equipment under certain "lease-back" contracts.

(13) Garment Contractors Floaters.

(14) Furriers or Fur Storers Customers Policies (i.e., policies under which certificates or receipts are issued by furriers or fur storers) covering specified articles the property of customers.

(15) Accounts Receivable Policies, Valuable Papers and Records Policies.

(16) Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

(a) The merchandise is specifically identifiable as encumbered to the bank or lending institution;

(b) The dealer's right to sell or otherwise dispose of the merchandise is conditioned upon its being released from encumbrance by the bank or lending institution;

(c) That the policies cover in transit and do not extend beyond the termination of the dealer's interest.

These policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

(17) Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.

(18) Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.

(19) Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically by the owner under Inland Marine Policies including:

(a) Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(b) Camera Dealers Policies, covering property consisting principally of cameras and their accessories.

(c) Furriers Dealers Policies, covering property consisting principally of furs and fur garments.

(d) Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefore; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.

(e) Stamp and Coin Dealers covering property of philatelic and numismatic nature.

(f) Jewelers Block Policies.

(g) Fine Arts Dealers.

Policies may include coverage of money in locked safes or vaults on the assured's premises. The policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds' interest in improvements of buildings.

Drafting Note: This would allow the same limited "money coverage" privilege currently available under Jewelers Block policies to be granted under other block or dealers policies.

(20) Wool Growers Floaters.

(21) Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.

(22) Difference in Conditions Coverage excluding fire and extended coverage perils.

(23) Electronic Data Processing policies.

Drafting Note: Items 22 and 23 authorize these coverages as Inland Marine to meet market demand for such protection.

Section 3. Exceptions

Unless otherwise permitted, nothing in the foregoing shall be construed to permit marine or transportation policies to cover:

A. Storage of assured's merchandise, except as hereinbefore provided.

B. Merchandise in course of manufacture, the property of and on the premises of the manufacturer.

C. Furniture and fixtures and improvements and betterments to buildings.

D. Monies or securities in safes, vaults, safety deposit vaults, bank or assured's premises, except while in the course of transportation.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1933 Proc. 121-127 (adopted).
1953 Proc. II 555-560, 561-572 (amended and reprinted).
1977 Proc. I 26, 28, 666, 667-671 (amended and reprinted).

NATIONWIDE INLAND MARINE DEFINITION

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NATIONWIDE INLAND MARINE DEFINITION

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-011-.01 (1978/2008) (adopted by reference).		
Alaska			ALASKA STAT. § 21.12.090 (1966).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-602 (1969/1986).		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. CODE REGS. tit. 10, §§ 2320 to 2322 (1954).		
Colorado	3 COLO. CODE REGS. § 702-5:5-1-6 (2012).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	18 DEL. CODE REGS. § 2101 (1979/2003).		
District of Columbia	NO CURRENT ACTIVITY		

NATIONWIDE INLAND MARINE DEFINITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69O-167.020 to 69O-167.024 (1980/1992).		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. § 41-505 (1961).
Illinois	ILL. ADMIN. CODE tit 50, §§ 101.10 to 101.40 (1958/1984).		
Indiana	BULLETIN 35A (1978) (adopted by reference).		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. ADMIN. REGS. § 40-3-22 (1967/2006).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	MD. CODE REGS. 31.08.06.01 to 31.08.06.02 (1953/1968).		MD. CODE ANN., INS. § 1-101 (1963/2014).
Massachusetts	211 MASS. CODE REGS. 10.00 to 10.05(1964).		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		

NATIONWIDE INLAND MARINE DEFINITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. CODE REGS. ANN. tit. 20, § 500-1.200 (1964/1979).		
Montana	MONT. CODE ANN. §§ 33-1-221 to 33-1-229 (1981).		
Nebraska	NEB. ADMIN. R. & REGS. tit. 210, ch. 17, §§ 001 to 004 (2004).		
Nevada			NEV. ADMIN. CODE § 681A.050 (1972/2010).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	11 N.C. ADMIN. CODE 10.0307 (1978/1986) (adopted by reference).		
Northern Marianas	NO CURRENT ACTIVITY		
North Dakota	BULLETIN 82-5 (1982) (adopted by reference).		
Ohio	OHIO ADMIN. CODE 3901-1-23 (1978/2007) (adopted by reference).		
Oklahoma	OKLA. ADMIN. CODE § 365:15-1-6 (1981).		
Oregon			OR. REV. STAT. § 731.174 (1967).
Pennsylvania	31 PA. CODE §§ 91.1 to 91.8 (1982).		
Puerto Rico	26 LAWS OF P.R. § 405 (1977).		
Rhode Island			27 R.I. GEN. LAWS ANN. §§ 27-6-2 to 27-6-53 (2002).

NATIONWIDE INLAND MARINE DEFINITION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS §§ 58-9-6 to 58-9-10 (1966).
Tennessee	NO CURRENT ACTIVITY		
Texas	TEX. ADMIN. CODE §§ 5.5001 to 5.5005 (1984/1998).		
Utah			UTAH CODE ANN. § 31A-1-301 (84) (1987/2014).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. ADMIN. CODE 284-20-030 to 284-20-050 (1956/1998).		
West Virginia			W. VA. CODE § 33-1-10(d) (1982).
Wisconsin			WIS. ADMIN. CODE INS. § 6.75 (1982).
Wyoming	NO CURRENT ACTIVITY		

MODEL RISK RETENTION ACT

Table of Contents

Section 1. Purpose

The purpose of this Act is to regulate the formation and/or operation of risk retention groups and purchasing groups in this State formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 ("RRA 1986"), to the extent permitted by such law.

Section 2. Definitions

As used in this Act

A. "Commissioner" [director, superintendent] means the insurance commissioner [director, superintendent] of [insert name of state] or the commissioner, director or superintendent of insurance in any other state;

B. "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by

(1) Any person who performs that work; or

(2) Any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

Drafting Note: The definition of "completed operations liability" is taken from the definition in the Product Liability Risk Retention Act of 1981 (Product Liability RRA 1981) Section 2(a)(1). A purpose of RRA 1986 was to expand the permissible coverage offered by risk retention groups from product liability and completed operations to general liability insurance, as further defined in RRA 1986. Some risk retention groups that were chartered under the Product Liability RRA 1981 are "grandfathered" by RRA 1986 to the extent that they can continue to provide product liability and completed operations coverage if they meet the criteria established by RRA 1986. The definitions relating to product liability and completed operations coverage, therefore, are relevant to any such groups which may continue to so operate.

C. "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means

(1) For a corporation, the state in which the purchasing group is incorporated; and

(2) For an unincorporated entity, the state of its principal place of business;

D. "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able

(1) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(2) To pay other obligations in the normal course of business;

Drafting Note: The definition of "hazardous financial condition" stipulates that a regulator, in looking at the financial condition of a risk retention group, can base his conclusions on reasonable expectations of future performance. In determining the present or reasonably anticipated financial condition of a risk retention group, the commissioner may utilize all relevant financial tests, ratios and other factors used in determining the financial condition of authorized insurers, including an analysis of actuarial soundness of rates charged.

E. "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;

Drafting Note: Definition taken from RRA 1986 Section 2(a)(1).

F. "Liability"

(1) Means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of

(a) Any business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations; or

(b) Any activity of any state or local government, or any agency or political subdivision thereof; and

Drafting Note: A state may specify acceptable means for managing the liability of the state or its local governments, or any agency or political subdivision thereof, by including or excluding insurance coverage obtained from an admitted insurance company, an excess lines company, a risk retention group, or any other source; or through a broker, agent, purchasing group, or any other person. Similarly, a state may specify acceptable means of demonstrating financial responsibility as a condition for obtaining a license or permit to undertake specified activities pursuant to Section 6(d), RRA 1986.

(2) Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.);

G. "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in Subsection F;

H. "Plan of operation" or "feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum;

(1) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

(2) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;

(3) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(4) Pro forma financial statements and projections;

(5) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(6) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

(7) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

(8) Such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state;

I. "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

Drafting Note: The definition of "product liability" is identical to that contained in Product Liability RRA 1981, Section 2(a)(3), for a "grandfathered" risk retention group. See Drafting Note following Subsection 2B of this Act.

J. "Purchasing group" means any group which

(1) Has as one of its purposes the purchase of liability insurance on a group basis;

(2) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in Paragraph (3);

(3) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(4) Is domiciled in any state;

Drafting Note: The Product Liability RRA 1981 contained a very loose definition of "purchasing group." RRA 1986 offers a more restrictive definition of those groups that can qualify as "purchasing groups." A purchasing group must only offer liability insurance to its group members, and the insurance must cover their similar or related liability exposure. Further, the group members must have businesses or activities that are similar or related with respect to the liability to which group members are exposed. Finally, the purchasing group must be domiciled in one of the states of the United States, i.e., it cannot be domiciled offshore.

K. "Risk retention group" means any corporation or other limited liability association:

(1) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(2) Which is organized for the primary purpose of conducting the activity described under Paragraph (1);

(3) Which

(a) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(b) Before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986);

(4) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(5) Which

(a) Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(b) Has as its sole owner an organization which has as

(i) Its members only persons who comprise the membership of the risk retention group; and

(ii) Its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(6) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

(7) Whose activities do not include the provision of insurance other than

(a) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(b) Reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that the group or member meets the requirement described in Paragraph 6 from membership in the risk retention group which provides such reinsurance; and

(8) The name of which includes the phrase "Risk Retention Group;"

Drafting Note: RRA 1986 changes the definition of "risk retention group" by further restricting the permissible membership and its activities. A risk retention group must be chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of one of the fifty states unless it qualifies under the "grandfather" provision of Subsection K(3)(b). In that event, it may only continue to provide product liability or completed operation coverage.

Each of the members of the group must have an "ownership interest" in the group. In addition, all owners must be provided insurance by the group. One purpose of this requirement is to prevent participation by third parties which may not be interested in the specific insurance problems of group members but merely may be interested in making a profit. The single exception to this requirement is when the sole member and sole owner of the organization is an entity consisting of persons, each of whom is a member of the risk retention group and is provided insurance by the group.

The members "who are also the owners" are required to be engaged in businesses or activities "similar or related with respect to the liability to which they are exposed by virtue of any related, similar, or common business, trade, product, services, premises or operation." This restriction is for the purpose of requiring substantial identity among the members (who are also the owners and insureds) in regard to the nature of the risks faced.

A risk retention group may not provide insurance other than liability insurance. Further, it can only provide reinsurance to another risk retention group if all of that group's members would qualify for membership in the risk retention group offering the reinsurance. This provision was designed to restrict a risk retention group to only reinsuring its own risks or the similar risks of similarly situated businesses. For example, a risk retention group whose membership consists of grocery store owners, could not reinsure a risk retention group whose membership consists of hazardous waste transporters.

The risk retention group must be chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of one of the fifty states unless it qualifies under the "grandfather" provision of Subsection K(3)(b).

L. "State" means any state of the United States or the District of Columbia.

Section 3. Risk Retention Groups Chartered in this State

A. (1) A risk retention group shall, pursuant to the provisions of Section [insert appropriate reference to Insurance Law], be chartered and licensed to write only liability insurance pursuant to this Act and, except as provided elsewhere in this Act, must comply with all of the laws, rules, regulations and requirements applicable to insurers chartered and licensed in this state and with Section 4 of this Act to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

(2) Notwithstanding any other provision to the contrary, all risk retention groups chartered in this state shall file with the department and the National Association of Insurance Commissioners (NAIC), an annual statement in a form prescribed by the NAIC and in diskette form, if required by the Commissioner and completed in accordance with its instructions and the NAIC Accounting Practices and Procedures Manual.

B. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the insurance commissioner of this state a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of the plan or study is approved by the commissioner.

C. At the time of filing its application for charter, the risk retention group shall provide to the commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the commissioner shall forward the information to the National Association of Insurance Commissioners. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of Section 4 or any other sections of this Act.

D. Governance Standards For Risk Retention Groups - Within a year of the effective date of this Act, existing risk retention groups shall be in compliance with the following Governance Standards. New risk retention groups shall be in compliance with the standards at the time of licensure.

(1) Board of Directors. The "board of directors" or "board" as used in this section, means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions. "Director" as used in this section, means a natural person designated in the articles of the risk retention group, or designated, elected or appointed by any other manner, name or title to act as a director.

(a) Independent Directors. The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors/subscribers advisory committee under these standards; and, to the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

(i) No director qualifies as "independent" unless the board of directors affirmatively determines that the director has no "material relationship" with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director and/or employee of such an owner and insured, unless some other position of such officer, director and/or employee constitutes a "material relationship"), as contemplated by Section 3901(a)(4)(E)(ii) of the Liability Risk Retention Act, is considered to be "independent."

(b) "Material relationship" of a person with the risk retention group includes, but is not limited to:

(ii) The receipt in any one 12-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group's gross written premium for such 12-month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a 12-month period. Such person or immediate family member of such person is not independent until one year after his/her compensation from the risk retention group falls below the threshold.

(iii) A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment or auditing relationship.

(iv) A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

(2) Service Provider Contracts. The term of any material service provider contract with the risk retention group shall not exceed five (5) years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to five percent (5%) of the risk retention group's annual gross written premium or two percent (2%) of its surplus, whichever is greater.

(a) For purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims and/or the preparation of financial statements. Any reference to 'lawyers' in the prior sentences does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are 'material' as referenced in Section (1)(B) above.

(b) No service provider contract meeting the definition of "material relationship" contained in Section (1)(B) shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such period.

Drafting note: For the sake of clarity, the domestic Commissioner's authority is included in this subpart. Some states may prefer the Commissioner's authority as included in this subpart be enacted in Section 11 "Administrative and Procedural Authority Regarding Risk Retention Groups and Purchasing Groups."

(3) Written Policy. The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to:

(a) Assure that all owner/insureds of the risk retention group receive evidence of ownership interest;

(b) Develop a set of governance standards applicable to the risk retention group;

(c) Oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements;

(d) Review and approve the amount to be paid for all material service providers; and

(e) Review and approve, at least annually:

(i) Risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(ii) The officers' and service providers' performance in light of those goals the and objectives; and,

(iii) The continued engagement of the officers and material service providers.

(4) Audit Committee The risk retention group shall have an audit committee composed of at least three independent board members as defined in Section (1). A non-independent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

(a) The audit committee shall have a written charter that defines the committee's purpose, which, at a minimum, must be to:

(i) Assist board oversight of (1) the integrity of the financial statements, (2) the compliance with legal and regulatory requirements, and (3) the qualifications, independence and performance of the independent auditor and actuary;

(ii) Discuss the annual audited financial statements and quarterly financial statements with management;

(iii) Discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor;

(iv) Discuss policies with respect to risk assessment and risk management;

(v) Meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(vi) Review with the independent auditor any audit problems or difficulties and management's response;

(vii) Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(viii) Require the external auditor to rotate the lead (or coordinating) audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five (5) consecutive fiscal years; and

(ix) Report regularly to the board of directors.

(b) The domestic regulator may waive the requirement to establish an audit committee composed of independent board members if the risk retention group is able to demonstrate to the domestic regulator that it is impracticable to do so and the risk retention group's board of directors itself is otherwise able to accomplish the purposes of an audit committee, as described in Section (4)(a).

Drafting Note: As an alternative to subsection four "Audit Committee", the state may substitute the NAIC audit provisions applicable to traditional insurers.

Drafting Note: As an alternative to Section 4(b), the state may substitute "If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee."

(5) Governance Standards The board of directors shall adopt and disclose governance standards, where "disclose" means making such information available through electronic (e.g., posting such information on the risk retention group's website) or other means, and providing such information to members/insureds upon request, which shall include:

(a) A process by which the directors are elected by the owner/insureds;

(b) Director qualification standards;

(c) Director responsibilities;

(d) Director access to management and, as necessary and appropriate, independent advisors;

(e) Director compensation;

(f) Director orientation and continuing education;

(g) The policies and procedures that are followed for management succession; and

(h) The policies and procedures that are followed for annual performance evaluation of the board.

(6) Business Conduct and Ethics The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which should include the following topics:

(a) Conflicts of interest;

(b) Matters covered under the corporate opportunities doctrine under the state of domicile;

(c) Confidentiality;

(d) Fair dealing;

(e) Protection and proper use of risk retention group assets;

(f) Compliance with all applicable laws, rules and regulations; and

(g) Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

(7) Reporting Non-Compliance The captive manager, president or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if either becomes aware of any material non-compliance with any of these governance standards.

Drafting Note: RRA 1986 allows for the chartering state to apply the full range of its insurance laws to a risk retention group wishing to charter in that state, except for requiring participation in the guaranty fund. The language of this section is derived from Product Liability RRA 1981 Section 3(a)(1) (which was not amended by RRA 1986 as it relates to this issue). The function of the office of the National Association of Insurance Commissioners shall be solely to provide administrative services for its member states and territories. Although RRA 1986 specifically requires that the phrase "Risk Retention Group" be included in the name, the chartering state is not precluded from prohibiting the use of deceptive or misleading words, designations or phrases in the name. Further, a state may require a risk retention group it charters and licenses to locate books and records or administrative functions within that state to the same extent it imposes those requirements on its domestic insurers.

Section 4. Risk Retention Groups Not Chartered in this State

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

Drafting Note: RRA of 1986 exempts a risk retention group from any state law regarding its operation in a state in which it is not domiciled except those laws referred to in RRA 1986. The state of domicile, however, retains under that section the full authority to regulate the formation and operation of the group.

However, if a risk retention group fails to qualify under the definitional requirement of RRA 1986, it will not benefit from this exemption from state law. The commissioner, therefore, would be authorized to apply any of the laws that may be preempted by RRA 1986 because the group will not qualify for the preemption.

A. Notice of Operations and Designation of Commissioner as Agent.

(1) Before offering insurance in this state, a risk retention group shall submit to the commissioner on a form prescribed by the NAIC:

(a) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and such other information, including information on its membership, as the commissioner of this state may require to verify that the risk retention group is qualified under Section 2K of this Act;

Drafting Note: The commissioner may need to take appropriate action in order to preserve the confidentiality of any proprietary or other confidential information, such as lists identifying the specific members of the group and their location.

(b) A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

(i) Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(ii) Was offered before that date by any risk retention group which had been chartered and operating for not less than three (3) years before that date; and

(2) The risk retention group shall submit a copy of any material revision to its plan of operation or feasibility study required by Section 3B of this Act within 30 days of the date of the approval of such revision by the commissioner of its chartering state, or if no such approval is required, within 30 days of filing.

Drafting Note: The plan of operations or feasibility study required under this provision is that submitted to and accepted by the chartering state.

(3) The risk retention group shall submit a statement of registration, for which a filing fee shall be determined by the commissioner, which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

B. Financial Condition. Any risk retention group doing business in this state shall submit to the commissioner:

(1) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners);

(2) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(3) Upon request by the commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

(4) Such information as may be required to verify its continuing qualification as a risk retention group under Section 2K.

Drafting Note: RRA 1986 also added the opportunity for a state to require that a risk retention group submit a notice of operations and financial condition. The purpose of this provision is to require a risk retention group to give the commissioner of any state in which it intends to operate adequate notice of its intended activity and financial condition so that the commissioner can take appropriate action if the possibility of a potential insolvency or commercial abuse exists.

C. Taxation.

(1) Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state, and shall report to the commissioner the net premiums written for risks resident or located within this state. The risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

(2) To the extent licensed agents or brokers are utilized pursuant to Section 12 of this Act, they shall report to the commissioner the premiums for direct business for risks resident or located within this state which the licensees have placed with or on behalf of a risk retention group not chartered in this state.

(3) To the extent that insurance agents or brokers are utilized pursuant to Section 12 of this Act, each agent or broker shall keep a complete and separate record of all policies procured from each risk retention group, which record shall be open to examination by the commissioner, as provided in [insert appropriate reference to Insurance Law]. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

(a) The limit of liability;

(b) The time period covered;

(c) The effective date;

(d) The name of the risk retention group which issued the policy;

(e) The gross premium charged; and

(f) The amount of return premiums, if any.

Drafting Note: RRA 1986 does not specify which premium tax rate will be applied. The NAIC has recommended applying the rate for foreign admitted insurers; some states, however, may apply the surplus lines rate.

D. Compliance with Unfair Claims Settlement Practices Law. Any risk retention group, its agents and representatives shall comply with the Unfair Claims Settlement Practices Act of this state, [insert section of the Insurance Code].

Drafting Note: The provisions regarding the liability of risk retention groups to state taxation, compliance with the unfair claims settlement practices law, and registration and designation of the commissioner as agent for purpose of service of process were included in the Product Liability RRA 1981 and continued in RRA 1986.

E. Deceptive, False, or Fraudulent Practices. Any risk retention group shall comply with the laws of this state, [insert sections of the Insurance Code], regarding deceptive, false or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

Drafting Note: The provision regarding compliance with state laws regarding deceptive, false or fraudulent practices was added by RRA 1986. The chartering state retains all of its authority to deal with an unfair trade practice under all its laws generally, including its insurance law. However, the 1986 Act preempts those portions of non-chartering states' Unfair Trade Practices Acts contained in their insurance laws that relate to methods of competition and acts or practices that are unfair, if such methods, acts or practices are not also deceptive. Nonetheless, state antitrust and state unfair practice laws which apply to commerce generally are applicable and are not preempted by the federal law.

F. Examination Regarding Financial Condition. Any risk retention group must submit to an examination by the commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

Drafting Note: A provision regarding submission to examination by the nondomiciliary state was included in the Product Liability RRA 1981. However, it was modified to eliminate the requirement that the commissioner had "reason to believe" the risk retention group was in a financially impaired condition. This deletion gives the commissioner greater latitude in requiring the group to submit to an examination.

G. Notice to Purchasers. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in ten (10) point type the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Drafting Note: A provision regarding the notice to purchasers concerning the limitation of regulatory oversight of risk retention groups and the lack of insolvency guaranty fund protection was added by RRA 1986. The purpose is to allow the states to require minimal disclosure to consumers.

H. Prohibited Acts Regarding Solicitation or Sale. The following acts by a risk retention group are hereby prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

Drafting Note: The provision regarding the prohibition of solicitation or sale of insurance by the risk retention group to any person who is not eligible for membership or by a group that is in hazardous financial condition or financially impaired was included in RRA 1986 for the purpose of enhancing state regulatory authority. These provisions have not been included in state insurance codes due to the limitation on the coverages permissibly offered under the Product Liability RRA 1981. This provision is not intended to limit those acts against which a commissioner can take action but rather to expand those acts by identifying acts that would not have been violations of the law prior to the passage of RRA 1986.

I. Prohibition on Ownership by an Insurance Company. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

Drafting Note: The prohibition on ownership by an insurance company of a risk retention group was added by RRA 1986 for the purpose of limiting the involvement of fully regulated insurance companies in risk retention groups. The states should also amend the appropriate licensing law applying to authorized insurers to include a similar prohibition. The Congress believed that this was a method to avoid the possibility that fully regulated companies would choose the Risk Retention Act as a vehicle to avoid full regulation.

J. Prohibited Coverage. The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

Drafting Note: The provision regarding prohibited coverages was added by RRA 1986 for the purpose of enabling a state to regulate the coverages that could be offered within its borders. The Congress believed that this was a matter of public policy to be determined by each state.

K. Delinquency Proceedings. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under Section 4F of this Act.

L. Penalties. A risk retention group that violates any provision of this Act will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally.

M. Operation Prior to Enactment of this Act. In addition to complying with the requirements of this section, any risk retention group operating in this state prior to enactment of this Act shall, within thirty (30) days after the effective date of this Act, comply with the provision of Subsection A(1) of this section.

Drafting Note: A risk retention group which qualifies under the grandfather provision contained in Section 2K(3)(b) is exempt from Subsection M above, so long as it only offers product liability or completed operations coverage.

Section 5. Compulsory Associations

A. No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by a risk retention group.

B. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

C. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by the state guaranty fund subject to [insert appropriate reference to Insurance Law].

D. (OPTIONAL) Notwithstanding [insert appropriate references to JUA provisions], the commissioner may require or exempt a risk retention group from participation in any mechanism established or authorized under the law of this state for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism, and such risk retention group shall submit sufficient information to the commissioner to enable the commissioner to apportion on a nondiscriminatory basis the risk retention group's proportionate share of such losses and expenses.

Drafting Note: Product Liability RRA Section 3(a)(2) specifically exempts risk retention groups from participation in the state guaranty fund. Section 3(a)(1)(C) of RRA 1986 permits a state to require that a risk retention group participate in JUAs or similar mechanisms on a nondiscriminatory basis. In making such a determination, each state should take into account the different considerations which are applicable to JUAs and to assignments under assigned risk plans, respectively, as well as to the impact on the financial condition of risk retention groups.

Section 6. Countersignatures not Required

A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned as otherwise provided in Section [insert reference] of the Insurance Code.

Drafting Note: Product Liability RRA Section 3(a)(3) preempts the states from requiring policies to be countersigned by resident agent or brokers. This section is optional depending on states' existing countersignature laws.

Section 7. Purchasing Groups—Exemption from Certain Laws

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

A. Prohibit the establishment of a purchasing group;

B. Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

C. Prohibit a purchasing group or its members from purchasing insurance on a group basis described in Subsection B of this section;

D. Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

E. Require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

F. Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

G. Otherwise discriminate against a purchasing group or any of its members; or

H. Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

Drafting Note: RRA 1986 establishes that the scope of the exemption from state law for risk retention groups is greater than that for purchasing groups. RRA 1986 in Section 3 states that a risk retention group is exempt from the laws of non-chartering states and then specifies those powers which are retained by those states. In regard to purchasing groups, however, Section 4 of RRA 1986 specifically lists those laws from which a purchasing group is exempt and which are in the nature of prohibiting or otherwise discriminating against purchasing groups. Therefore, a state can apply all other provisions of its laws to purchasing groups and persons dealing with purchasing groups. As noted in regard to risk retention groups, if a purchasing group does not meet any of the criteria specified to define it as a purchasing group, it does not benefit from any federal preemption of state law and all state laws apply.

Section 8. Notice and Registration Requirements of Purchasing Groups

A. A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the commissioner which shall, on forms prescribed by the NAIC:

(1) Identify the state in which the group is domiciled;

(2) Identify all other states in which the group intends to do business;

(3) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(4) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

(5) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(6) Identify the principal place of business of the group; and

(7) Provide such other information as may be required by the commissioner to verify that the purchasing group is qualified under Section 2J of this Act.

B. A purchasing group shall, within ten (10) days, notify the commissioner of any changes in any of the items set forth in Subsection A of this section.

Drafting Note: The notice provisions regarding purchasing groups are designed to require that purchasing groups provide adequate information to the commissioner so that an evaluation can be made as to whether a purchasing group is (a) bona fide and (b) is likely to operate in a manner and to purchase insurance coverage that is consistent with the laws of the state.

C. The purchasing group shall register with and designate the commissioner (or other appropriate authority) as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be determined by the commissioner, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Products Liability Risk Retention Act of 1981, and:

(1) Which in any state of the United States

(a) Was domiciled before April 1, 1986; and

(b) Is domiciled on and after October 27, 1986;

(2) Which

(a) Before October 27, 1986 purchased insurance from an insurance carrier licensed in any state; and

(b) Since October 27, 1986 purchased its insurance from an insurance carrier licensed in any state; or

(3) Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

D. Each purchasing group that is required to give notice pursuant to Subsection A of this section shall also furnish such information as may be required by the commissioner to:

(1) Verify that the entity qualifies as a purchasing group;

(2) Determine where the purchasing group is located; and

(3) Determine appropriate tax treatment.

E. Any purchasing group which was doing business in this state prior to the enactment of this Act shall, within thirty (30) days after the effective date of this Act, furnish notice to the commissioner pursuant to the provisions of Subsection A of this section and furnish such information as may be required pursuant to Subsections B and C of this section.

Drafting Note: The provision regarding registering with and designating the commissioner as legal agent is designed to allow the commissioner to take prompt legal action against the purchasing group by facilitating proper legal service of process. The purchasing groups "grandfathered" out of this registration requirement are only those that were prior to April 1986, and continue to be, domiciled in one of the United States, that purchase insurance only from U.S. carriers, that qualified as a purchasing group under the Product Liability Risk Retention Act of 1981, and that do not currently purchase insurance other than that authorized under the Product Liability RRA 1981.

Section 9. Restrictions on Insurance Purchased by Purchasing Groups

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

Drafting Note: Although Section 4(f) of RRA was one of the most significant provisions dealing with regulation of insurance purchased by purchasing groups, the term "located" was not defined in the federal act.

B. A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of the group which have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state, and that the risk retention group or insurer may not be subject to all insurance laws and regulations of this state.

Drafting Note: This provision, with respect to non-admitted insurers, applies only if a state requires this notice to policyholders in the state with respect to other insurers not covered by insurance insolvency guaranty funds.

C. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

D. Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Drafting Note: A state may prescribe limitations with respect to aggregate limits to all purchases of group insurance, as long as such limitations are not applied in a manner which discriminates against purchasing groups.

Section 10. Purchasing Group Taxation

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups shall be:

A. Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

B. Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

Drafting Note: The term "insurance source" refers to admitted, licensed and authorized carriers on the one hand and non-admitted, surplus line carriers on the others. The enacting states may wish to include applicable taxing provisions of its Code.

Section 11. Administrative and Procedural Authority Regarding Risk Retention Groups and Purchasing Groups

The commissioner is authorized to make use of any of the powers established under the Insurance Code of this state to enforce the laws of this state not specifically preempted by the Risk Retention Act of 1986 including the commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the commissioner can rely on the procedural laws of this state. The injunctive authority of the commissioner, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

Drafting Note: This provision regarding the administrative and procedural authority retained by the states under Sections 3(f) and 4(g) of RRA 1986 is designed to permit the commissioner to investigate for potential hazardous financial condition or market conduct abuses and to take appropriate action where necessary. It clarifies that no federal preemption takes place regarding the procedural and administrative authority of the commissioner.

However, RRA 1986 requires that any injunction sought by the commissioner must be obtained from a court of competent jurisdiction. See RRA 1986 Section 3(a)(1)(G), Section 3(e), and Section 3(f). However, this restriction on the injunctive authority of the commissioner does not carry over to any action that the commissioner may take under its state administrative procedural law regarding purchasing groups. Section 4 of RRA 1986, which addresses the limited preemption from state law provided to purchasing groups, does not refer to any restriction on the commissioner's injunctive authority. More specifically, the "savings clause" regarding state authority, RRA Section 4(g), makes no mention of such requirement.

Section 12. Duty of Agents or Brokers to Obtain License

A. Risk retention groups.

(1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state from a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Section [insert appropriate reference to Insurance Law].

B. Purchasing groups.

(1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Section [insert appropriate reference to Insurance Law].

(2) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance coverage in this state for any member of a purchasing group under a purchasing group's policy unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with Section [insert appropriate reference to Insurance Law].

(3) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless such person, firm, association or corporation is licensed as a surplus lines agent or excess line broker in accordance with [insert appropriate reference to Insurance Law].

Drafting Note: The RRA (1986) does not preempt state law with respect to licensing and regulation of agents and brokers, with the exception of the elimination of the residence requirement and of countersignature laws, as provided in Subsection C of this section, and Sections 6 and 7H of this Act.

C. For purposes of acting as an agent or broker for a risk retention group or purchasing group pursuant to Subsections A and B of this section, the requirement of residence in this state shall not apply.

D. Every person, firm, association or corporation licensed pursuant to the provisions of [insert appropriate references to Insurance Law], on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by Subsection G of Section 4 of this Act in the case of a risk retention group and Subsection C of Section 9 of this Act in the case of a purchasing group.

Section 13. Binding Effect of Orders Issued in U.S. District Court

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states or in any territory or possession of the United States) upon a finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the courts of the state.

Section 14. Rules and Regulations

The commissioner may establish and from time to time amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of the Act.

Section 15. Severability

If any clause, sentence, paragraph, section or part of this act or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgement shall not affect, impair or invalidate the remainder of this act, and the application thereof to other persons or circumstance, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgement shall have been rendered and to the person or circumstances involved.

Section 16. Effective Date

This Act will be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1983 Proc. I 6, 35, 789-790, 795, 799-805 (adopted).
1987 Proc. I 11, 20, 744, 857-865 (amended and reprinted).
1987 Proc. II 15, 24, 774-775, 776-788 (amended).
1991 Proc. II 25, 58, 976, 992-1003 (amended and reprinted)
2011 Proc. 3rd Quarter Vol. I 114, 119, 132-134, 339 (amended).

MODEL RISK RETENTION ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL RISK RETENTION ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-31A-1 to 27-31A-15 (1993/2015).		BULLETIN 4-6-2009 (2009).
Alaska			ALASKA STAT. § 21.09.290 (1995); § 21.96.090 (1995/2010); ALASKA ADMIN. CODE tit. 3, §§ 24.010 to 24.590 (1989/2008); BULLETIN 95-04 (1995).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-2401 to 20-2414 (1987/2016).		
Arkansas	ARK. CODE ANN. §§ 23-94-204 to 23-94-215 (2017/2019).		
California	CAL. INS. CODE §§ 125 to 140 (1991/2013).		
Colorado	COLO. CODE REGS. § 702-2:2-1-8 (Regulation 2-1-8) (1991/2017).		
Connecticut	CONN. GEN. STAT. §§ 38a-250 to 38a-266 (1987/2016).		

MODEL RISK RETENTION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	DEL. CODE ANN. tit. 18, §§ 8001 to 8014 (1991/2015).		
District of Columbia	D.C. CODE §§ 31-4101 to 31-4112 (1993/2004); 26-A D.C. MUN. REGS. § 3775 (2017).		
Florida		FLA. STAT. §§ 627.941 to 627.955 (1987/2003).	
Georgia		GA. CODE ANN. §§ 33-40-1 to 33-40-21 (1987/1992).	GA. COMP. R. & REGS. 120-2-63 (1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431K-1 to 431K-13 (1987/2016).		
Idaho		IDAHO CODE ANN. §§ 41-4801 to 41-4816 (1987/2005).	
Illinois	215 ILL. COMP. STAT. 5/123B-1 to 5/123B-14 (1987/2016).		
Indiana		IND. CODE §§ 27-7-10-1 to 27-7-10-34 (1988/2003).	
Iowa		IOWA CODE §§ 515E.1 to 515E.14 (1988/2018).	
Kansas		KAN. STAT. ANN. §§ 40-4101 to 40-4120 (1986/1992).	
Kentucky	KY. REV. STAT. §§ 304.45-010 to 304.45-150 (1986/2017).		
Louisiana		LA. REV. STAT. ANN. §§ 22:481 to 22:498 (1987/2009).	DIRECTIVE Nos. 75 and 78 (1987).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 6091 to 6104 (1987/2010); 02-031-165 ME. CODE R. §§ 1 to 7 (2014).		
Maryland	MD. CODE ANN., INS. §§ 25-101 to 25-111 (1987/2018).		

MODEL RISK RETENTION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts		MASS. GEN. LAWS ch. 176L, §§ 1 to 14 (1993).	
Michigan		500 MICH. COMP. LAWS. §§ 1801 to 1839 (1989).	
Minnesota		MINN. STAT. §§ 60E.01 to 60E.14 (1987/1993).	
Mississippi		MISS. CODE ANN. §§ 83-55-1 to 83-55-29 (1988/1999).	
Missouri		MO. REV. STAT. §§ 375.1080 to 375.1105 (1991/1992).	MO. CODE REGS. ANN. tit. 20, § 200-8.100 (1989/2003).
Montana	MONT. CODE ANN. §§ 33-11-101 to 33-11-125 (1987/2019).		
Nebraska	NEB. REV. STAT. §§ 44-4401 to 44-4423 (1987/2016).		
Nevada	NEV. REV. STAT. §§ 694C.392 (2015); §§ 695E.010 to 695E.220 (1987/2013).		BULLETIN 2014-008 (2014).
New Hampshire		N.H. REV. STAT. ANN. §§ 405-A:1 to 405-A:13 (1988/1992).	
New Jersey		N.J. REV. STAT. §§ 17:47A-1 to 17:47A-11 (1993).	N.J. ADMIN. CODE §§ 11:2-36.1 to 11:2-36.8 (1993/2009).
New Mexico		N.M. STAT. ANN. §§ 59A-55-1 to 59A-55-26 (1988/1999).	
New York		N.Y. INS. LAW §§ 5901 to 5913 (1988/1990).	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 301.0 to 301.9 (Regulation 134) (1988).
North Carolina	N.C. GEN. STAT. §§ 58-22-1 to 58-22-70 (1986/2015).		
North Dakota		N.D. CENT. CODE §§ 26.1-46-01 to 26.1-46-13 (1987/2001).	
Northern Marianas	NO CURRENT ACTIVITY		

MODEL RISK RETENTION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio		OHIO REV. CODE ANN. §§ 3960.01 to 3960.13 (1989).	
Oklahoma	OKLA. STAT. tit. 36, §§ 6451 to 6468 (1987/2021).		
Oregon		OR. REV. STAT. §§ 735.300 to 735.365 (1987/2003).	OR. ADMIN. R. 836-28-005 to 836-28-0045 (1988/2005).
Pennsylvania		40 PA. CONS. STAT. §§ 991.1501 to 991.1516 (1993).	
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		R.I. GEN. LAWS §§ 27-46-1 to 27-46-15 (1991/2002).	
South Carolina	S.C. CODE ANN. §§ 38-87-10 to 38-87-140 (1988/2016).		
South Dakota	S.D. CODIFIED LAWS §§ 58-6A-1 to 58-6A-24 (1987/2016).		
Tennessee	TENN. CODE ANN. §§ 56-45-101 to 56-45-114 (2016).		
Texas			TEX. INS. CODE ANN. §§ 2201.001 to 2201.259 (2005); 28 TEX. ADMIN. CODE §§ 13.301 to 13.313 (1991/2008).
Utah	UTAH CODE ANN. §§ 31A-15-201 to 31A-15-214 (1992/2016).		
Vermont	VT. STAT. ANN. tit. 8, §§ 6050 to 6061 (1992/2015).		VT. STAT. ANN. tit. 8, §§ 6070 to 6075 (1994) (managing general agents and reinsurance intermediaries for RRGs).

MODEL RISK RETENTION ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia		VA. CODE ANN. §§ 38.2-5100 to 38.2-5115 (1987/1995).	
Washington		WASH. REV. CODE ANN. §§ 48.92.010 to 48.92.140 (1987/1993).	WASH. ADMIN. CODE 284-92-010 to 284-92-510 (1993).
West Virginia		W. VA. CODE §§ 33-32-1 to 33-32-23 (1987/2003).	
Wisconsin			WIS. STAT. § 601.41 (6) (1988) (authority to promulgate regulations); § 601.72(2m) (1988) (registration); §§ 618.41(7m) (2017); 628.02 (2012) (agents); § 628.48 (1988) (marketing).
Wyoming		WYO. STAT. ANN. §§ 26-36-101 to 26-36-116 (1987/1991).	44-15 WYO. CODE R. §§ 1 to 7 (1988/2016).

PROJECT HISTORY - 2011

MODEL RISK RETENTION ACT (#705)

1. Description of the Project, Issues Addressed, etc.

A request to amend the *Model Risk Retention Act (#705)* was adopted by the Executive (EX) Committee at the 2010 Fall National Meeting. The request was developed based upon the the Risk Retention (C) Working Group's consideration of developing corporate governance standards to respond to accreditation and corporate governance issues. The corporate governance standards were adopted by the Property and Casualty (C) Committee in June 2007 and referred to the Financial Condition (E) Committee for consideration to include the standards in the Property/Casualty Annual Statement Instructions. The Risk Retention (E) Task Force found that the Annual Statement Instructions were not the proper place for this guidance, but instead, should be incorporated into a model law or regulation so that a state insurance department could compel the RRG to comply with these requirements.

2. Name of Group Responsible for Drafting the Model and States Participating

The Risk Retention Handbook and Model Law Amendment Subgroup of the Risk Retention (C) Working Group drafted most of the changes to the Act. Members of the Subgroup include: California (Chair), Delaware, District of Columbia, Florida, Hawaii, Louisiana, Mississippi, Missouri, Nevada, New York, Oklahoma, South Carolina, Utah, Vermont and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

A request to amend the *Model Risk Retention Act (#705)* was adopted by the Executive (EX) Committee at the 2010 Fall National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Risk Retention Handbook and Model Law Amendment Subgroup made most of the edits to the Act. All conference calls were open to interested parties who participated in the development of the amendments throughout the process. Interested parties participating via conference call and written comments include: Vermont Captive Insurance Association, OMS National Insurance Company, National Risk Retention Association, New Home Warranty Insurance Company Risk Retention Group, RAA and NAMIC.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Risk Retention Handbook and Model Law Amendment Subgroup held six conference calls discussing the edits to the Model Act. The Subgroup held one formal written comment period and heard from numerous interested parties on the conference calls. The Risk Retention (C) Working Group held two separate 30-day comment periods and sent comments back to the Subgroup for review. No comments were received during the second comment period. A further clarification on the Act was requested during a Sept. 16 conference call of the Property and Casualty Insurance (C) Committee. This technical change was made during an Oct. 3 conference call of the Risk Retention (C) Working Group.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was discussion on when risk retention groups would need to comply with the corporate governance provisions within the Act. Some parties wanted six months, but it was decided that one year would be the most reasonable requirement. It was also decided that new risk retention groups need to be in compliance with the standards at the time of licensure.

A paragraph on enforcement stating that the "risk retention group's domestic regulator may take appropriate regulatory action against any director or officer of the risk retention group or its captive manager, pursuant to its laws and regulations, if the risk retention group or captive manager violates these governance standards" was included within the original corporate governance standards. It was decided that this paragraph should be deleted because states already have full authority to enforce compliance with applicable laws and regulations.

Discussion was held whether to delete a section requiring the captive manager, president, or chief executive officer of the risk retention group to notify the domestic regulator in writing of any material non-compliance. Ultimately, the group decided to leave the section in.

Several drafting notes were added to the Act for the sake of clarity. There was general agreement among all parties to include the notes.

As stated above, a change to the Act that did not involve the corporate governance standards was made during an Oct. 3 conference call of the Risk Retention (C) Working Group. The Model previously read that that a risk retention group must submit a copy of a revision to its plan of operation to a non-chartering state at the same time that the revision is submitted to the commissioner of the chartering state. A change was made to require that a revision be submitted after the chartering state has approved the revision. All parties agreed that this change made sense because the nondomestic state should not be burdened with proposed plans that are not approved.

7. Any Other Important Information (e.g., amending an accreditation standard).

The revisions to the Act were made in order to incorporate corporate governance standards into the Act with the expectation that they will be accreditation standards. The Property and Casualty Insurance (C) Committee and the Risk Retention (C) Working Group recommend that the Financial Regulation Standards and Accreditation (F) Committee consider the corporate governance standards within the Act as an accreditation standard.

MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION

Table of Contents

[Insert statement of authority to issue this regulation]

Section 1. Introduction

The purpose of this regulation is to prescribe rules to prevent abuses in connection with the sale of property-liability insurance in this state pursuant to mass marketing plans, while preserving for consumers the potential benefits of this form of marketing.

Section 2. Definitions

As used in this regulation:

A. "Mass marketing plan" means a method of selling property-liability insurance wherein (i) such insurance is offered to employees of particular employers or to members of particular associations or organizations or to persons grouped in other ways and (ii) the employer, association or organization, if any, has agreed to or otherwise affiliated itself with the sale of such insurance to its employees or members; and

B. "Property-liability insurance" means insurance to which Sections [insert applicable section] of the Insurance Law applies.

Drafting Note: The term "property-liability insurance" may not be appropriate in every state. It may be necessary, for instance, to make it "property casualty insurance" or to add a specific reference to automobile insurance.

Section 3. Applicability

This regulation shall be applicable only to insurance policies issued or renewed in this state after [insert date], and is in addition to, and not in substitution for, other applicable requirements of the insurance law and department regulations. The requirements of this regulation are not applicable to methods of marketing other than mass marketing plans.

Section 4. Fictitious Arrangement Prohibited

No insurer shall, without the approval of the commissioner, sell insurance pursuant to a mass marketing plan to members of any association or organization formed principally for the purpose of obtaining such insurance.

Section 5. Premium Rates

Premium rates under a mass marketing plan shall comply with the standards in the insurance law, including the standards that rates not be excessive, inadequate or unfairly discriminatory. Rates shall not be deemed to be unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates shall not be deemed to be unfairly discriminatory if they are averaged broadly among persons insured under a mass marketing plan.

Section 6. Statistics

An insurer selling insurance pursuant to mass marketing plans shall maintain separate statistics as to loss and expense experience pertinent thereto.

Section 7. Producers

No person shall act as an insurance agent or an insurance broker in connection with a mass marketing plan for any kind of insurance unless such person is duly licensed under Section [insert applicable section] of the Insurance Law as an agent or broker for such kind of insurance.

Section 8. Compulsory Participation Prohibited

No insurer shall sell insurance pursuant to a mass marketing plan if it is a condition of employment or of membership in an association, organization or other group that any employee or member purchase insurance pursuant to such plan, or if any employee or member shall be subject to any penalty by reason of his non-participation.

Section 9. Tie-in Sales Prohibited

No insurer shall sell insurance pursuant to a mass marketing plan if (i) the purchase of insurance available under such plan is contingent upon the purchase of any other insurance, product or service; or (ii) the purchase or price of any other insurance, product or service is contingent upon the purchase of insurance available under such plan. This provision shall not be deemed to prohibit the reasonable requirement of safety devices, such as heat detectors, lightning rods, theft prevention equipment and the like.

Section 10. Disclosure Required

Every insurer, agent or broker selling insurance pursuant to a mass marketing plan shall, prior to sale, make full and fair disclosure to prospective insureds of all features of such plan, whether favorable or unfavorable, including but not limited to premium rates, benefits, duration of coverage, policyholder services, conversion privileges available, and the financial interests in the plan, if any, of the sponsoring employer, association, organization or the group.

Section 11. Underwriting Standards

No insurer shall use underwriting standards for individual risk selection in a mass marketing plan which are, on the whole, more restrictive than the standards used by such insurer for individual risk selection in the sale of the same kind of insurance in this state other than pursuant to mass marketing plans. In the event the insurer does not sell such kind of insurance in this state other than pursuant to mass marketing plans, its underwriting standards for individual risk selection in such plans shall, on the whole, be no more restrictive than the standards used by its principal affiliate, if any, for individual risk selection in the sale of such kind of insurance in this state other than pursuant to mass marketing plans.

Section 12. Cancellation and Nonrenewal

A. For purposes of Sections [insert applicable section] and [insert applicable section] of the Insurance Law, limiting the cancellation and nonrenewal of insurance policies, the failure of an employer, association, organization or other group to remit premiums when due for any reason (including, but not limited to, interruption or termination of employment or membership) shall not be regarded as "nonpayment of premium" by any insured under any such plan providing for remittance of premium by such employer, association, organization or other group, unless such insured shall have been given written notice of such failure to remit and shall not himself have paid such premium by the later of (i) twenty days after such notice or (ii) the due date of such premium remittance under the mass marketing plan.

B. All mass marketing plans shall provide that upon termination of employment or membership or upon the discontinuance of the mass marketing plan, the insured employee or member may maintain his policy in force for sixty (60) days in the same amount, upon payment of the premium applicable to the class of risk to which he belongs on an individual basis. The option to maintain the insurance in force shall be exercised within thirty (30) days following the date of termination. Any notice of cancellation or nonrenewal of any policy of an employee or member insured under a mass marketing plan shall be accompanied by a notice to the employee or member that, at his request, the insurer will afford the employer, association, organization or other group a reasonable opportunity to consult with the insurer and to present facts in opposition to cancellation or nonrenewal.

Section 13. Compulsory Facilities

An insurer, agent or broker selling insurance pursuant to a mass marketing plan shall, with respect to any employees or members who apply for but are denied insurance under such plan, assist such persons in obtaining insurance through any other appropriate voluntary or mandatory insurance plan, such as the [assigned risk plan] or the [FAIR Plan].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1972 Proc. I 15, 58, 59-60 (adopted).

THE MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION

What are the state pages?

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THE MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	3 COLO. CODE REGS. § 702-5:5-1-1 (2012).		
Connecticut			CONN. GEN. STAT. §§ 38a-802 to 38a-810 (1971/1984) (personal lines property and casualty insurance).
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		

THE MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii			HAW. REV. STAT. §§ 431:12-101 to 431:12-116 (1988) (motor vehicle insurance).
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2931 to 2940 (1973/1989).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE §§ 11:2-12.1 to 11:2-12.15 (1974/1996).		
New Mexico	NO CURRENT ACTIVITY		

THE MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 13.1 to 13.13 (Regulation 58) (1971).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	OR. ADMIN. R. §§ 836-042-0300 to 836-042-0322 (1983/2005).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. RULE XXXIX (1974).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-24-45.1 (1966/2014).
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE R. §§ 114-9-1 to 114-9-5 (1972).		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION, AND DISCLOSURE MODEL ACT

Table of Contents

PREAMBLE: The purpose of this Act shall be to regulate declinations, cancellations and refusals to renew certain policies of automobile insurance and to require specific reasons for such actions.

Section 1. Scope

This Act shall apply to applications for and to automobile insurance policies delivered, issued for delivery or renewed in this state after the effective date of this Act. This Act shall not apply to:

A. Policies of automobile insurance issued under the [insert state] Automobile Insurance Plan; or

B. A policy insuring more than four (4) motor vehicles; or

C. A policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards.

Drafting Note: Automobile policies issued under a state Automobile Insurance Plan (AIP) or other residual market mechanism are excluded from this Act because of the special underwriting considerations and regulatory treatment afforded such policies under state law. While the application of many of the substantive principles of this Act to such policies would be desirable and should be encouraged, the mechanism for implementing these principles should be the plan of operation of the AIP or residual market mechanism, not a state law governing automobile insurance declinations and terminations in the voluntary market.

Section 2. Definitions

A. "Automobile insurance policy" means a policy delivered or issued for delivery in this state, insuring a natural person as named insured, or one or more related individuals resident of the same household, and under which the insured vehicles therein designated are of the following types only:

(1) A four-wheel private passenger motor vehicle that is not used as a public or livery conveyance for passengers, nor rented to others; or

(2) Any other four-wheel motor vehicle with a load capacity of 1500 pounds or less that is not rated by the insurer as a commercial motor vehicle whether or not used in the occupation, profession or business of the insured.

B. "Declination" means either the refusal of an insurer to issue an automobile insurance policy upon receipt of a written nonbinding application or written request for coverage from its agent or an applicant, or the refusal of an agent or broker to transmit to an insurer a written nonbinding application or written request for coverage received from an applicant. For the purposes of this Act, the offering of insurance coverage with a company within an insurance group that is different from the company requested on the nonbinding application or written request for coverage, or the offering of policy coverage or rates substantially less favorable than requested in the nonbinding application or written request for coverage, shall be considered a declination.

C. "Nonpayment of premium" means the failure of the named insured to discharge an obligation in connection with the payment of premiums on policies of automobile insurance subject to this Act, whether the payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit.

D. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. For the purposes of this Act, any policy written for a period or term of less than six (6) months or any policy with no fixed expiration date shall be considered as if written for a policy period or term of six (6) months.

E. "Termination" means either a cancellation or nonrenewal of automobile insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in Subsection A. An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a termination.

Drafting Note: Depending on whether the term "insurer" is normally understood to mean an individual licensed company or an affiliated group of companies, states may wish to add the following sentence in order to permit certain transfers of policyholders between companies in the same group without requiring a formal notice of nonrenewal accompanied by an offer to issue a substantially similar policy in another company in the group: "For purposes of this Act, the transfer of a policyholder between companies within the same insurance group shall be considered a termination only if the transfer results in policy coverage or rates substantially less favorable to the insured."

Section 3. Notifications and Reasons for a Declination or Termination

A. (1) Except as provided in Paragraph (2) of this subsection, upon declining an application or written request for an automobile insurance policy subject to this Act, the insurer, agent or broker making the declination shall either provide the insurance applicant with the specific reasons in writing for the declination at the time of the declination or advise the applicant in writing that specific written reasons for the declination will be provided within twenty-one (21) days of the timely receipt by the insurer, agent or broker making the declination of the applicant's written request for the reasons. An applicant's written request shall be timely under this subsection if received within ninety (90) days of the date of that notice to the applicant.

(2) In the event of a declination by an insurer of a risk submitted by an agent or broker on behalf of the applicant, the insurer shall provide the agent or broker with specific written reasons for the declination. In the event the agent or broker is unable to effect insurance for the applicant through an admitted insurer other than a residual market mechanism, the agent or broker shall submit specific written reasons to the applicant for all such declinations.

(3) No agent or broker, or an insurer not represented by an agent or broker, shall refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker or insurer.

B. No insurer shall cancel an automobile insurance policy unless a written notice of cancellation is mailed or delivered to the last known mailing address of the named insured as shown in the records of the insurer at least twenty (20) days prior to the effective date of cancellation, except that when cancellation is for nonpayment of premium, notice shall be mailed or delivered to the named insured at the last known mailing address as shown in the records of the insurer at least ten (10) days prior to the effective date of cancellation. Such notice shall be accompanied by a written explanation of the specific reasons for the cancellation.

C. No insurer shall refuse to renew an automobile insurance policy unless at least thirty (30) days before the end of a policy period, as described in Section 2D of this Act, the insurer shall deliver or mail to the named insured, at the last known mailing address of the named insured as shown in the records of the insurer, written notice of the insurer's intention not to renew the policy upon expiration of the current policy period. The notice of intention not to renew shall include or be accompanied by a written explanation of the insurer's specific reason or reasons for the nonrenewal. No notice of intention not to renew shall be required where the named insured is given written notice of the insurer's willingness to renew the policy by the mailing or delivering of a renewal notice, bill, certificate or policy. If notice as required by this subsection is not provided, coverage shall be deemed to be renewed under the same terms and conditions for the ensuing policy period, for which the appropriate premium shall be payable, and subject to the provisions of Section 4 of this Act, until the named insured has accepted replacement coverage with another insurer or until the named insured has agreed to the nonrenewal.

D. Proof of mailing a notice of cancellation or a notice of an intention not to renew, or business records of the notice of the insurer's willingness to renew, shall be retained for a period of one year by the insurer or agent or broker giving notice.

Section 4. Permissible Cancellation

A. No notice of cancellation of a policy of automobile insurance shall be effective unless it is based upon at least one of the following reasons:

(1) Nonpayment of premium;

(2) Fraud or material misrepresentation made by or with the knowledge of an insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy;

(3) The failure of the named insured, or any operator who resides in the same household or customarily operates an automobile insured under the policy, to make available upon written request from the insurer the insured's driving experience record for the preceding thirty-six (36) months;

(4) The named insured or an operator who resides in the same household or customarily operates an automobile insured under the policy has within the policy term or, if the policy is a renewal, during its term or the 180 days immediately preceding its effective date:

(a) Had his or her driver's license suspended or revoked; or

(b) Has been convicted of or forfeited bail for any action arising out of or in connection with the operation of a motor vehicle, conviction for which is a ground for suspension or revocation of license.

Drafting Note: Insurers should not be required to provide coverage for an operator whose driver's license has been suspended or revoked during the policy term or within six (6) months immediately preceding the effective date of the policy. In some states, insurers are permitted to offer a named driver exclusion which excludes coverage when the insured vehicle is operated by the problem driver but keeps the coverage in effect for other drivers in the household. As a matter of public policy, other states prohibit the use of named driver exclusions, and still other states require the exclusion to be offered whenever an insurer's decision is based on the driving record of some, but not all, of the drivers in a household. The drafting of this permitted reason for cancellation should be consistent with the individual state's policy position concerning named driver exclusions.

(5) The insured motor vehicle is:

(a) So mechanically defective that its operation might endanger public safety;

(b) Used in carrying passengers for hire or compensation; however, the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation;

(c) Used in the transportation of flammables or explosives or for an illegal purpose;

(d) An authorized emergency vehicle; or

(e) Altered by an insured during the policy period so as to substantially increase the risk;

(6) The named insured moves to a state where the insurer is not licensed to do business;

(7) Failure to pay dues or fees where payment of dues or fees is a prerequisite to obtaining or continuing automobile insurance coverage;

(8) A determination by the commissioner of insurance that the continuation of the policy would place the insurer in violation of the law or would be hazardous to the interests of policyholders, creditors or the public.

B. This section shall not apply to a policy of automobile insurance that has been in effect less than sixty (60) days at the time notice of cancellation is mailed or delivered by the insurer unless the policy has been renewed.

Section 5. Terminations/Declinations: Prohibited Reasons

The declination of an application for, or the termination of, a policy of automobile insurance subject to this Act by an insurer, agent or broker is prohibited if the declination or termination is:

A. Based upon the race, religion, nationality or ethnic group of the applicant or named insured;

B. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to an insurer, agent or broker that limits its market to one lawful occupation or profession or to several related lawful occupations or professions;

C. Based upon the principal location of the insured motor vehicle unless the decision is for a business purpose that is not a mere pretext for unfair discrimination;

D. Based upon the age, sex or marital status of an applicant or an insured, except that this subsection shall not prohibit rating differentials based on age, sex or marital status;

E. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism; or

F. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

Drafting Note: While insurers shall not decline an application or terminate a policy simply because of a previous adverse underwriting decision by another insurer, insurers should not be prohibited from inquiring as to the existence of any previous adverse underwriting decision so long as they also inquire as to the reasons given for these decisions. An insurer may decline an application or terminate a policy based on further information as to the reasons for the previous declination, termination or placement in a residual market mechanism.

Section 6. Enforcement Provisions

A. Complaint and Hearing. Upon a complaint of a person filed within ninety (90) days of a violation of this Act, the commissioner shall determine whether the complaint is reasonably founded. If the commissioner determines that the complaint is reasonably founded, or if the commissioner otherwise has reason to believe that an insurer, agent or broker has engaged in practices that violate this Act and that a proceeding in respect thereto would be in the public interest, the commissioner shall set a date for a public hearing to determine whether a violation of this Act has in fact occurred. The hearing shall be held upon no less than ten (10) days' notice to the person charged and the complainant, if any. The notice shall set forth the specific grounds upon which the complaint is based. If a hearing is based upon a complaint, the hearing shall be set no later than thirty (30) days from the date the complaint was filed. The hearing shall take place before a hearing examiner who shall make a record of the evidence and set forth findings and conclusions.

Once a prima facie violation of this Act has been established, the person charged in the complaint shall have the burden of showing that the termination was based on a reason not prohibited by this Act. The findings of fact determined by the hearing examiner shall be reviewed by the commissioner who shall issue a final order. A petition for rehearing may be filed within thirty (30) days of the final order of the commissioner.

B. Sanctions. If the commissioner determines in a final order that:

(1) An insurer has violated Sections 4 or 5 of this Act, the commissioner may require the insurer to:

(a) Accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics;

(b) Reinstate insurance coverage to the end of the policy period; or

(c) Continue insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics.

(2) A person has violated any provisions of this Act, the commissioner may:

(a) Issue a cease and desist order to restrain the person from engaging in practices that violate this Act;

(b) Assess a penalty against the person of up to $500 for each violation of this Act; or

(c) Assess a penalty against the person of up to $5,000 for each willful and knowing violation of this Act.

C. Judicial Review. Any person aggrieved by a determination or order of the commissioner under this Act may seek judicial review in the [insert applicable court] Court. Failure of the commissioner to act upon a complaint under this Act within thirty (30) days of the filing of the complaint shall constitute a determination that the complaint was not reasonably founded.

Section 7. Immunity

A. There shall be no liability on the part of and no cause of action shall arise against:

(1) The commissioner of insurance;

(2) An insurer or its authorized representatives, agents or employees;

(3) A licensed insurance agent or broker; or

(4) Any person furnishing information to an insurer as to reasons for a termination or declination, for any communication giving notice of or specifying the reasons for a declination or termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a declination or termination under this Act.

B. Subsection A above shall not apply to statements made in bad faith with malice in fact.

Section 8. Effective Date

This Act shall take effect on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 908, 918-924 (adopted).

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

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NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-23-20 to 27-23-28 (1971).
Alaska			ALASKA STAT. §§ 21.36.210 to 21.36.310 (1970/1987).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. §§ 20-1631 to 20-1634 (1972/1987).
Arkansas			ARK. CODE ANN. §§ 23-89-301 to 23-89-308 (1969).
California			CAL. INS. CODE §§ 660 to 669 (1968/2013).
Colorado			COLO. REV. STAT. §§ 10-4-601 to 10-4-609 (1969/2013); BULLETIN B-5.29 (#2) (2012).
Connecticut			CONN. GEN. STAT. §§ 38a-342 to 38a-346 (1969/1990); BULLETIN PC-66 (2009).
Delaware			DEL. CODE ANN. tit. 18, §§ 3903 to 3920 (1959).

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. CODE § 31-2409 (1982/2001); D.C. MUN. REGS., tit. 26-A, §§ 300 to 399 (1985).
Florida			FLA. STAT. §§ 627.728 to 627.7286 (1982/2014).
Georgia			GA. CODE ANN. §§ 33-24-44 to 33-24-45 (1960/2014); GA. COMP. R. & REGS. 120-2-53-.01 to 120-2-53-.06 (1997).
Guam			GUAM CODE ANN., tit. 16 §§ 21104 to 21105 (1988).
Hawaii			HAW. REV. STAT. §§ 431:10C-111 to 431:10C-113 (1988/2004).
Idaho			IDAHO CODE ANN. §§ 41-2506 to 41-2512 (1969).
Illinois			215 ILL. COMP. STAT. 5/143.10 to 5/143.20 (1937); 5/143.24 (1979/1982).
Indiana			IND. CODE §§ 27-7-6-1 to 27-7-6-12 (1969/1985).
Iowa			IOWA CODE §§ 515D.1 to 515D.12 (1970).
Kansas			KAN. STAT. ANN. §§ 40-276 to 40-278 (1968/1984).
Kentucky			KY. REV. STAT. ANN. § 304.20-040 (1980/1986).
Louisiana			LA. REV. STAT. ANN. § 22:1266 (2009/2010).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 2911 to 2924 (1973/1983).

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Maryland			MD. CODE ANN., INS. §§ 27-601 to 27-614 (1971/2009); MD. CODE REGS. 31.08.03.01 to 31.08.03.10 (1979/2005).
Massachusetts			MASS. GEN. LAWS ch. 175, § 113D (1933); § 113F (1971/1983); MASS. CODE REGS. 97.01 to 97.07 (2009).
Michigan			MICH. COMP. LAWS §§ 500.2101 to 500.2131 (1981).
Minnesota			MINN. STAT. §§ 65B.14 to 65B.21 (1967/1984).
Mississippi			MISS. CODE ANN. §§ 83-11-1 to 83-11-21 (1970).
Missouri			MO. REV. STAT. §§ 379.110 to 379.123 (1974); MO. ADMIN. R. tit. 20, § 500-2.300 (1975/2005).
Montana			MONT. CODE ANN. §§ 33-23-201 to 33-23-217 (1967/2003).
Nebraska			NEB. REV. STAT. §§ 44-514 to 44-523 (1979) BULLETIN cb-111 (2006).
Nevada			NEV. REV. STAT. §§ 687B.310 to 687B.400 (1971).
New Hampshire			N.H. REV. STAT. ANN. §§ 417-A:1 to 417-A:10 (1969/2014); N.H. CODE ADMIN. R. ANN. INS. 1401.01 to 1401.03 (1982/1992).
New Jersey			N.J. STAT. ANN. §§ 17:29C-1 to 17:29C-13 (1968/2003); N.J. ADMIN. CODE §§ 11:3-8.1 to 11:3-8.14 (1983/2012).

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. INS. LAW § 3425 (1984/2004).
North Carolina			N.C. GEN. STAT. § 20-279.22 (1953).
North Dakota	N.D. CENT. CODE §§ 26.1-40-01 to 26.1-40-12 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3937.30 to 3937.39 (1969/2013).
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. §§ 742.560 to 742.572 (1971/1975).
Pennsylvania			40 PA. STAT. ANN. §§ 991.2001 to 991.2013 (1998).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			230 R.I. CODE R. 20-05-2.1 to 20-05-2.13 (2006).
South Carolina			S.C. CODE ANN. §§ 38-77-30 to 38-77-120 (1988).
South Dakota			S.D. CODIFIED LAWS §§ 58-11-45 to 58-11-55 (1968/2004).
Tennessee			TENN. CODE ANN. §§ 56-7-1301 to 56-7-1305 (1968/1981).
Texas			28 TEX. ADMIN. CODE §§ 5.7001 to 5.7018 (1976/1983).

NAIC AUTOMOBILE INSURANCE DECLINATION, TERMINATION AND DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah			UTAH CODE ANN. § 31A-21-303 (1986/2010).
Vermont			VT. STAT. ANN. tit. 8, §§ 4222 to 4229 (1972/1977).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-2208 to 38.2-2213 (1986/2015).
Washington			WASH. REV. CODE ANN. §§ 48.18.291 to 48.18.297 (1985).
West Virginia			W. VA. CODE §§ 33-6A-1 to 36-6A-5 (1967/2009); §§ 33-6B-1 to 33-6B-7 (1989); W. VA. CODE R. §§ 114-3-1 to 114-3-5 (2005).
Wisconsin			WIS. STAT. ANN. § 631.36 (1975/2013); § 632.35 (1975/1979).
Wyoming	NO CURRENT ACTIVITY		

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

Table of Contents

Section 1. Title

This Act shall be known as the Property and Casualty Actuarial Opinion Law.

Section 2. Actuarial Opinion of Reserves and Supporting Documentation

This section shall become operative at the end of the first full calendar year following the year of enactment.

A. Statement of Actuarial Opinion

Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an Appointed Actuary entitled "Statement of Actuarial Opinion." This opinion shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions.

B. Actuarial Opinion Summary

(1) Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an Actuarial Opinion Summary, written by the company's Appointed Actuary. This Actuarial Opinion Summary shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the Actuarial Opinion required in Subsection A.

(2) A company licensed but not domiciled in this state shall provide the Actuarial Opinion Summary upon request.

C. Actuarial Report and Workpapers

(1) An Actuarial Report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each Actuarial Opinion.

(2) If the insurance company fails to provide a supporting Actuarial Report and/or workpapers at the request of the commissioner or the commissioner determines that the supporting Actuarial Report or workpapers provided by the insurance company is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting Actuarial Report or workpapers.

Drafting Note: Even though the regulator as part of an exam or target exam usually has the authority to do this; this section reinforces the authority of the commissioner. The commissioner can also fine or require the company to have the workpapers redone with proper documentation.

D. The Appointed Actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the Appointed Actuary.

Section 3. Confidentiality

A. The Statement of Actuarial Opinion shall be provided with the Annual Statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document.

B. (1) Documents, materials or other information in the possession or control of the Department of Insurance that are considered an Actuarial Report, workpapers or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the Actuarial Report, workpapers or Actuarial Opinion Summary, shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(2) This provision shall not be construed to limit the commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents, nor shall this section be construed to limit the commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

C. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection B.

D. In order to assist in the performance of the commissioner's duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [Optional provision] May enter into agreements governing sharing and use of information consistent with Subsections B to D.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D.

Section 4. Effective Date

This Act shall take effect [insert date].

Chronological Summary of Actions (All references are to the Proceedings of the NAIC).

2003 Proc. 2nd Quarter 323, 347-348, 349-351 (adopted by parent committee).
2003 Proc. 3rd Quarter 14 (adopted by Plenary).

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-149-.01 to 482-1-149-.10 (2009).		ALA. CODE § 27-3-26.1 (1993/1994).
Alaska			ALASKA STAT. § 21.09.207 (2006).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-697 to 20-697.01 (2009).		
Arkansas	ARK. CODE ANN. §§ 23-63-1901 to 23-63-1905 (2009).		
California			BULLETIN 91-11 (1991).
Colorado			3 COLO. CODE REGS. 702-1:1-1-1 (2012).
Connecticut			CONN. AGENCIES REGS. §§ 38a-53-1 to 38a-53-4 (1993/2010).
Delaware	DEL. CODE ANN. tit. 18, §§ 1131 to 1133 (2015).		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. ADMIN. CODE ANN. r. 69O-170.031 (1992/2003).

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia			GA. CODE ANN. § 33-3-21.2 (1989).
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:3-304 to 431:3-304.5 (2010/2011).		HAW. CODE R. §§ 16-169-10 to 16-169-13 (2012).
Idaho	IDAHO ADMIN. CODE r. 18.01.56.000 to 18.01.56.022 (2006).		
Illinois	215 ILL. COMP. STAT. 5/136 (1997/2009).		
Indiana			IND. CODE § 27-1-20-21.3 (1990/2000).
Iowa	IOWA CODE §§ 515H.1 to 515H.3 (2007).		
Kansas	KAN. STAT. ANN. §§ 40-223H to 40-223J (2008).		
Kentucky			KY. REV. STAT. § 304.3-242 (1992).
Louisiana			LA. ADMIN. CODE tit. 37, Pt.XIII, §§701 to 709 (Regulation 39) (1992/1999).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 991 to 994 (2007/2009).		
Maryland	MD. CODE REGS. §§ 31.05.12.01 to 31.05.12.04 (2010).		BULLETIN 2010-3 (2010).
Massachusetts	MASS. GEN. LAWS ch. 175 § 227 (2015).		
Michigan	MICH. COMP. LAWS § 500.814a (2010).		
Minnesota	MINN. STAT. §§ 60A.1295 to 60A.1296 (2013).		
Mississippi	MISS. CODE ANN. §§ 83-5-501 to 83-5-505 (2009/2012).		

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-1.105 (2010).		
Montana	MONT. CODE ANN. §§ 33-1-1401 to 33-1-1403 (2009).		
Nebraska	NEB. REV. STAT. §§ 44-7901 to 44-7903 (2005).		
Nevada	NEV. ADMIN. CODE 681B.250 to 681B.290 (2010).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 2402.01 to 2402.07 (2010).		
New Jersey			N.J. ADMIN. CODE §§ 11:1-21.1 to 11:1-21.6 (1986/2014).
New Mexico	N.M. CODE R. §§ 13.2.9 (2010/2012).		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, § 111.2 (2017); CIRCULAR LETTER 2005-22 (2009).
North Carolina			N.C. GEN. STAT. ANN. §§ 58-10-150 to 58-10-175 (2007); DIRECTIVE 90-11 (1990).
North Dakota	N.D. ADMIN. CODE 45-03-19.1-01 (2010).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3903.77 (2009).		
Oklahoma	OKLA. STAT. tit. 36, §§ 1125 to 1126 (2006/2012).		
Oregon	OR. ADMIN. R. 836-011-0015 (2010).		OR. REV. STAT. § 731.312 (1993/2001).
Pennsylvania			NOTICE 2005-11 (2005).
Puerto Rico	P.R. REGS. O.C.S. 7993 (2011).		

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS § 27-12.3 (2008)		
South Carolina			S.C. CODE ANN. § 38-9-225 (2009).
South Dakota			S.D. CODIFIED LAWS § 58-26-13.1 (1992/1997).
Tennessee	TENN. CODE ANN. §§ 56-1-419 to 56-1-420 (2010).		
Texas	28 TEX. ADMIN. CODE § 7.9 (2006).		TEX. INS. CODE ANN. § 802.002 (2003).
Utah	UTAH ADMIN. CODE R590-264 (2012).		
Vermont			VT. STAT. ANN. tit. 8, § 3577 (1992/210).
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-1315.1 (2006/2014).		
Washington	WASH. REV. CODE § 48.05.383 (2006); § 48.05.385 (2006); § 42.56.403 (2006).		WASH. ADMIN. CODE § 284-07-060 (1993/2014).
West Virginia	W. VA. CODE R. §§ 114-41A-1 to 114-41A-3 (2010).		
Wisconsin			WIS. ADMIN. CODE § 50.30 (1993).
Wyoming	WYO. STAT. ANN. §§ 26-6-401 to 26-6-403 (2007).		

PROJECT HISTORY - 2003

PROPERTY AND CASUALTY ACTUARIAL OPINION MODEL LAW (#745)

1. Project Description

A property and casualty insurer's Annual Financial Statement is required to be filed with an insurance department on March 1. The insurer is also required to submit an Actuarial Opinion on loss and loss adjustment expense reserves. The Actuarial Opinion is a public document. A detailed Actuarial Report including all work papers supporting the Actuarial Opinion is then required to be available for examination by May 1.

The model law was created to require insurers to annually submit to regulators an "Actuarial Opinion Summary" of the Actuarial Report, and to provide confidential treatment to the Summary and to the Report. The summary must provide information on the opining actuary's point estimate and/or range of reasonable estimates and include additional information as required by the Annual Statement Instructions. The summary is due shortly after the time the Actuarial Opinion and Financial Statement are filed so regulators can detect companies in need of further investigation in a more timely manner.

2. Group Responsible for Drafting Model and States Participating

The Actuarial Opinions Instruction Working Group of the Casualty Actuarial (C) Task Force was responsible for drafting the model. Richard Marcks of Connecticut chaired the working group. The following states were members: California, Connecticut, Illinois; Ohio, Pennsylvania, and Texas, The concept of the Actuarial Opinion Summary Model Law was first proposed to the Actuarial Opinion Instructions Working Group by Texas in May of 2002.

3. Charge Authorizing Project

The Casualty Actuarial Task Force was charged in 2003 to re-appoint an Actuarial Opinion Instructions Working Group to consider, among other issues, the development of a model law to address confidential disclosure to regulators of an "Actuarial Opinion Summary" of the Actuarial Report. The summary was to include such items as point estimate and/or range of reasonable reserve estimates.

4. General Description of Drafting Process

The Standard Valuation Law contains the requirement that valuation of reserve liabilities for life insurers be provided in the Actuarial Opinion submitted with the Life Annual Statement. The Actuarial Opinions Instructions Working Group used this law as a basis for developing a similar requirement for property and casualty reserves. Annual Statement instructions for the P/C Actuarial Opinion were drafted to provide guidance to actuaries and companies as to the information that should be included in the Summary.

Throughout the drafting process input was solicited from all interested parties, including the American Academy of Actuaries and representatives from the insurance industry. To ensure that all aspects of confidentiality were considered, the group sought assistance from the NAIC Information Sharing Working Group and obtained legal advice from insurance department attorneys, and the NAIC Legal Division. Working group meetings regarding development of the model law were open to all interested parties. All revised drafts of the model were posted on the NAIC Website and circulated for public comment.

5. Significant Issues Raised

The significant issues raised involved the specific requirement for disclosure of a point estimate and/or a range of reserve estimates; the reasonableness of the proposed due date for such information given the numerous financial information already requested; and whether regulatory authority could ensure confidentiality of the information under all circumstances, including federal requests for information. Whether indemnification for the opining actuary was appropriate and whether summary information should be released to the American Academy of Actuaries' Actuarial Board for Counseling and Discipline were also discussed.

MODEL REGULATION TO REQUIRE REPORTING OF STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES

Table of Contents

Section 1. Authority

This regulation is promulgated pursuant to sections [insert reference to sections authorizing the adoption of rules and regulations and the section in the statutes relating to statistical reporting] regarding the reporting of statistical data by insurance companies.

Section 2. Purpose

The purpose of this regulation is to set forth the manner of reporting data by insurers to statistical agents, to prescribe reports to be submitted by statistical agents to the commissioner, and to prescribe certain conduct in connection therewith. This regulation does not apply to data reported directly by insurers to the commissioner.

Section 3. Definitions

A. "NAIC *Statistical Handbook* or *Handbook*" is a publication of the National Association of Insurance Commissioners (NAIC) that explains insurance statistical data and provides reporting requirements and report formats to be regularly furnished by statistical agents.

B. "Statistical agent" is an entity that has been designated by the commissioner to collect statistics from insurers and provide reports developed from these statistics to the commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers.

C. "Statistical plan" is a statistical agent's system for collecting information from reporting insurers, including exposure, coverage, classification, territory, premium, loss and other information.

Section 4. Lines of Insurance

This regulation applies to all lines of insurance except life insurance, variable annuities, sickness and accident insurance, title insurance, reinsurance, ocean marine insurance and aviation insurance.

Drafting Note: The intent is to capture all P & C lines of insurance except those which fall outside of rating and statistical laws. This section should be adjusted to conform to other exceptions (i.e., assessment companies or the like) that individual states may have or may choose to make. Many states will find that the intent of this section can be accomplished by referencing specific P & C lines of insurance as defined by state law, rather than by using an exception-type statement.

Section 5. Examination of Statistical Agents

To be designated to collect statistics from insurers for purposes of fulfilling the statistical reporting requirements of this rule, an entity other than a licensed advisory organization shall be subject to the same examination provisions as licensed advisory organizations.

Drafting Note: The laws of many states do not recognize "statistical agents." In these states, statistical collection is one of the authorized activities for advisory organizations. The laws in most such states provide that the commissioner may utilize an advisory organization "or other agencies" for the collection of statistics. These laws customarily stipulate that advisory organizations may be examined and may also stipulate that they must file statistical plans. Therefore, the purpose of this and the following section is to ensure that statistical agents that are not licensed advisory organizations will also be subject to examination and be required to file statistical plans.

Section 6. Filing of Statistical Plans by Statistical Agents

Every statistical agent shall file with the commissioner every statistical plan and every modification that it proposes to use to collect statistics to meet the requirements of this regulation. Such statistical plan filings shall be deemed to meet the requirements of this rule unless disapproved by the commissioner within thirty (30) days after filing.

Drafting Note: Some state's rating laws already contain provisions for the filing of statistical plans.

Section 7. Statistical Plans and Reporting by Insurers

Every insurance company licensed in this state shall report its insurance statistical experience for lines of insurance covered by this regulation to a statistical agent designated by the commissioner. This data shall be submitted in accordance with statistical plans approved in accordance with Section 6 of this rule.

Drafting Note: States that choose to collect raw statistical data directly from insurers will need to amend this section. It is suggested that states choosing to have significant and lasting exceptions to the *Statistical Handbook* place these exceptions in the regulation at this point or in the next section. This section provides requirements for insurers; the next section provides requirements for statistical agents.

Section 8. Statistical Agents' Compliance with the *Statistical Handbook*

For every line of insurance that it collects statistics in this state, every statistical agent shall, at a minimum, collect statistics and file reports and compilations in the form and detail provided in the NAIC *Statistical Handbook*, edition date [insert edition date], unless otherwise specified by the commissioner.

Drafting Note: Adoption of this regulation in a state will establish the *Statistical Handbook* as the standard for statistical reporting in that state.

Section 9. Multiple Statistical Agents for the Same Line of Insurance

For lines of insurance where more than one statistical agent has been designated and collects statistics in this state, the statistical agents shall, if so directed by the commissioner, arrange to file combined reports for all statistical agents collecting data for the affected lines of insurance. The statistical agents may make arrangements among themselves for the equitable sharing of the costs to produce combined reports.

Drafting Note: The state should first confirm which lines are combinable, and then decide if there are lines where the state would prefer to receive separate reports from multiple statistical agents. At this writing, the combinability of reports from different statistical agents has been verified for the personal lines only. Because combined reports are more meaningful to work with, it is expected that most states would want to operate in this fashion. It should be noted, however, that combined reports can only be provided as quickly as the slowest statistical agent provides its data to the statistical agent that is combining the data.

Section 10. Edit and Control Procedures for Statistical Agents

Statistical agents shall adopt edit and control procedures to screen and check data for reasonableness, apparent accuracy and completeness. These procedures shall, at a minimum, conform to the specifications provided in the NAIC *Statistical Handbook*, edition date [insert edition date], unless otherwise specified by the commissioner.

Drafting Note: The *Handbook's* data quality provisions are subdivided into private passenger auto, homeowners, workers' compensation and all other lines (primary commercial lines). A state may select to apply these requirements to some of these lines, but not to others. If so, exceptions should be stated for Sections 10 and 11 in this regulation.

Section 11. Insurer Edit and Audit Procedures

Insurers shall adopt edit and audit procedures to screen and check data required by this rule to be reported to see that such data meets the standards for reasonableness and accuracy provided in the NAIC *Statistical Handbook*, edition date [insert edition date], unless otherwise specified by the commissioner.

Section 12. Adoption of Changes to the *Statistical Handbook*

Revisions to the *Statistical Handbook* shall apply upon the commissioner's notification to insurers or statistical agents of the adoption of the revisions and their effective dates. Statistical agents shall notify insurers that report to them of any changes that affect data collection or the reporting activities of insurers.

Drafting Note: States that cannot adopt statistical reporting updates without recourse to a rulemaking process should omit this section. Such states, when they choose to adopt changes, would initiate a rulemaking proceeding to change the edition dates specified in various sections of this rule. States should also be aware of the lead time necessary for insurers and statistical agents to implement revised data reporting requirements.

Section 13. Disclosure of Complying and Non-Complying Insurers

Statistical reports shall each contain a listing of insurers whose data are included. In addition, if data from an insurer or insurers that had agreed to have data included are, in fact, not included, then a listing of these insurers shall also be made with the statistical report as specified in the NAIC *Statistical Handbook*. For any insurer that is listed as not included in a statistical report, the statistical agent shall, upon the request of the commissioner, provide reasons for the exclusion.

Section 14. Access to Data

The commissioner shall have access to all statistical data that have been collected by statistical agents for the purpose of fulfilling the requirements of this rule. Upon request by the commissioner, the statistical agent shall provide a copy of any report that it produces from data that the commissioner has required to be collected.

Section 15. Disclosure of Data

When data submitted to the insurance department by a statistical agent identify individual insurers, appear likely to identify individual claimants or insureds, or are asserted by the statistical agent or a reporting insurer to be subject to protection from disclosure, such data shall not be publicly disclosed unless, prior to such disclosure:

A. The department notifies the statistical agent and any insurer which has asserted the data to be subject to protection from disclosure of the request for disclosure;

B. The department then provides a thirty (30) day period for any insurer that reported data to the statistical agent to assert that its data are trade secret or are otherwise protected from disclosure. The thirty (30) day period shall run from the time that the statistical agent receives notification from the department.

C. The department then provides insurers which have asserted their data to be trade secret or otherwise protected from disclosure with the opportunity to support their positions, which shall be governed by the [insert reference to the applicable administrative procedures and/or other statutes], and

D. After the applicable adjudicative process is complete, there is a final decision that the data are not a trade secret and are not otherwise subject to protection from disclosure.

Drafting Note: These provisions were drafted based on a review of state and federal trade secret and open records/freedom of information laws and prior NAIC policy determinations on trade secret protection. Essentially, the provisions give insurers the opportunity under applicable law to attempt to prevent disclosure to competitors of data asserted to be trade secrets, and to protect data from disclosure that is otherwise subject to restrictions on disclosure because of privacy laws or other protections.

The NAIC *Statistical Handbook* and NAIC *Market Conduct Examiners Handbook* both alert regulators to the need to permit insurers the opportunity to attempt to protect their trade secret data from being disclosed to competitors. Providing the submitter of data to a governmental agency the opportunity to argue against disclosure is consistent with the federal Freedom of Information Act, corresponding Executive Order 12,600 and federal and state laws protecting trade secrets.

This section should be modified to reflect the appropriate rules of administrative, civil and appellate procedures of the state. The intent is that any disclosure of submitted data will not occur until the insurer has had the available opportunities under state law to seek judicial and/or administrative review.

Section 16. Exemption

Upon application by a statistical agent or an individual insurer, the commissioner may allow the submission of a report or statistical data at a specified later date if the submission of the report or data on the date required by this regulation would create a substantial hardship on the statistical agent or insurer.

In considering whether to grant such an exemption, the commissioner shall consider whether the delay is necessitated by an unusual or a one-time situation, or whether the delay is necessitated by a situation that is likely to reoccur. When the delay is necessitated by a situation that is likely to reoccur, the commissioner may condition the granting of an exemption on whether the insurer or statistical agent has a plan of action to address the situation in the future.

Section 17. Lines of Insurance without a Statistical Agent

Any licensed insurer writing any line of insurance not exempted in Section 4 of this regulation that finds or believes to have found that it is writing a line or type of insurance for which no statistical agent will accept data shall notify the commissioner of this fact as soon as practicable.

Section 18. Penalty

Failure to file the information required under this regulation in accordance with a statistical plan adopted by the commissioner shall result in a penalty of $[insert amount].

Drafting Note: In many states, the penalty provisions of the laws authorizing this rule may also provide penalties. In these cases, this section may be unnecessary.

Section 19. Separability

If any provision of this regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the regulation, and the application of the provision to persons or circumstances, other than those to which it is held invalid, shall not be affected.

Section 20. Effective Date

This regulation shall become effective on [insert date].

Drafting Note: Many of the reporting requirements and data quality checks contained in this regulation and in the *Statistical Handbook* will already be in place owing to prior regulations or requirements of the Insurance Department that have been stated less formally. As such, a relatively short lead-time (i.e., 3 months) will customarily be reasonable for most parts of this regulation. However, when a state has not required the same data quality checking or statistical elements as the *Handbook*, and chooses to newly adopt these additional elements by adoption of this regulation, then a lead-time of at least 12 months until the beginning of a calendar year is suggested. Greater lead times (i.e., 18 months or more) are suggested when the state is among the very first to adopt a new data element that is not being collected in other states by all statistical agents.

Chronological Summary of Actions (all references to the Proceedings of the NAIC).

1997 Proc. 2nd Quarter 1049, 1074-1077 (model adopted by task force).
1997 Proc. 4th Quarter 25-26, 27-28, 971-972 (adopted).
2004 Proc. 1st Quarter Vol. I 670, 745, 748-754 (amended and reprinted, adopted by parent committee).
2004 Proc. 2nd Quarter Vol. I 50 (adopted by Plenary).

This model replaces an earlier document on the same subject.

1988 Proc. II 5, 13-14, 693, 718-719, 724-729 (adopted).
1990 Proc. I 6, 29-30, 698, 799, 806-807 (amended).
1991 Proc. I 9, 18, 823, 846, 857-862 (amended and reprinted).

MODEL REGULATION TO REQUIRE REPORTING OF STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION TO REQUIRE REPORTING OF STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-235 (1986/1989) (authority to adopt regulation).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	3 COLO. CODE REGS. § 702-5:5-1-9 (2012).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. ADMIN. CODE ANN. r. 69O-171.003 to 69O-171.010 (1983/2008).

MODEL REGULATION TO REQUIRE REPORTING OF STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/1204 (1986) (authority to adopt regulation).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. §§ 374.400 to 374.455 (1978/1979); § 379.895 (1987).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE § 52 (1990/1994).		
Nevada	NEV. ADMIN. CODE §§ 686B.300 to 686B.395 (1989/1991).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 801.01 to 801.17 (1988/1999).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas			
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		

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South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. § 56-1-103 (1987) (authority to adopt).
Texas	NO CURRENT ACTIVITY		
Utah			UTAH ADMIN. CODE r. 590-225-1 to 590-225-16 (2003/2014).
Vermont	VT. ADMIN. CODE 4-3-12 (1989).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-1919 (1987/2003) (authority to adopt); ADMIN. LETTER 1988-3 (1988).
Washington	WASH. ADMIN. CODE 284-24B-010 to 284-24B-110 (2006).		WASH. ADMIN. CODE 284-07-010 (1987).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2004

MODEL REGULATION TO REQUIRE REPORTING OF STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES (#751)

1. Description of the Project, Issues Addressed, etc.

The Model Regulation to Require Reporting of Statistical Data was amended to establish the NAIC *Statistical Handbook of Data Available to Insurance Regulators* (Handbook) as the standard for statistical reporting of property and casualty data in states. By adopting the model, a state also adopts the Handbook's data quality standards and statistical report formats.

2. Name of Group Responsible for Drafting the Model and States Participating

Changes to the model regulation to designate the Handbook as the statistical data reporting standard were first drafted by the Statistical Handbook Working Group, chaired by Alan Wickman (NE) in 1997. Before they were considered for adoption, however, the working group needed to draft the new data quality standards for the Handbook. They also added Handbook chapters that prescribe formats for customized data requests including a special call format for catastrophe data and they updated the personal auto and the homeowners' chapters.

The model regulation changes and the revised Handbook chapters were moved up to the Statistical Information (C) Task Force at the 2002 Spring National Meeting. The task force deferred the adoption of the model regulation changes until additional changes to the Data Quality chapter and the other modified chapters of the Handbook were made. The task force adopted all the new and revised handbook chapters by December 2003. The model regulation changes were reviewed and adopted in the early part of 2004 and reported up the Property and Casualty (C) Committee at the 2004 Spring National Meeting.

Peg Ising (OH) chaired the task force throughout the handbook chapter revision effort and during the subsequent review of the model regulation. Rae Taylor (OR) became the task force chair in 2004. The following states were task force members throughout the handbook and model regulation revision process: California, the District of Columbia, Ohio, New Jersey, New York, Missouri, Oregon, and Texas. Other members of either the working group or the task force at some point during the revision period were Alaska, Florida, Illinois, Kansas, Kentucky, Pennsylvania, Puerto Rico, Virginia, Washington and West Virginia. Members that participated in the vote to adopt the model regulation amendments by include Ohio, Missouri, Oregon, New York, New Jersey, Pennsylvania and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

In 1996 the (Ex) Special Committee On Statistical Information initiated a project to study and recommend improvements to the system for collecting and disseminating statistical information relating to property/casualty insurance. The charge to this committee was to oversee the development of a strategic plan for the system that would encompass, but not be confined to the following areas:

a. types of data that should be collected;
b. timeliness of data;
c. methods of data collection and processing;
d. quality control;
e. access to information;
f. responsiveness of system to public and regulatory needs;
g. ownership and control structures of statistical agents; and
h. role of regulators and the NAIC.

In December 1996, the Special Committee adopted the NAIC *Statistical Strategic Plan* and charged the task force to update the Statistical Handbook according to its recommendations. A Statistical Handbook Working Group was designated to focus on these charges. The working group drafted revisions to the model regulation and the Handbook and developed formal procedures for making changes to Handbook. Upon completing these charges in 2002, the working group disbanded. The review and appropriate modifications to the Handbook and the model regulation are now standing charges to the Statistical Information (C) Task Force.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Changes to the model regulation itself were primarily technical in nature, drafted to make its provisions consistent with an enhanced Handbook. The goal was to enable any state that adopts the model regulation to rely on the Handbook for the collection of statistical data and the development of data calls that are informative and of good quality. Sections in the model regulation directly reference sections of the Handbook that were still being revised when the model regulation changes were made so action on the model regulation was deferred until after the drafting process for the Handbook chapters was complete.

Revising the Handbook was a considerably lengthy process, primarily due to the development of statistical data quality standards. A self-certification system that would enable statistical agents and companies to attest to the effectiveness of their data reporting systems was initially proposed but, after years of discussion, not adopted. A sampling and verification method for data quality assurance was developed, first, as a requirement for insurers, then—following a poll of states—as an option for states to consider in light of the potential costs associated with obtaining and reviewing the samples.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

From 1997 through 2002 the Statistical Handbook Working Group members worked diligently with statistical agent representatives, insurance company members, trade associations, funded consumer representatives and many other interested entities to revise the Handbook. In addition to the data quality standards, they also added handbook chapters that prescribe formats for customized data requests including catastrophe data calls and updated the personal auto and homeowners' insurance chapters. Dozens of drafts of the chapters were circulated for comment and volumes of comments were collected, discussed and incorporated into new drafts.

In March 2002, the working group sent its final recommendations for changes to the Handbook chapters and the model regulation to the renamed Statistical Information (C) Task Force. The task force implemented an aggressive review schedule that initially called for bi-weekly conference calls solely to review the proposed Handbook chapters. These intense deliberations continued over the next two years and resulted in major changes to the working group drafts. These final drafts were adopted at the 2003 Winter National Meeting. Minor changes were then made to the model regulation to reflect the new drafts of the Handbook chapters.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The significant issues raised throughout the handbook revision process related primarily to the cost of capturing new data elements, compiling new statistical reports and implementing new quality standards versus the benefit to regulators to have it. Several states and many consumer group representatives expressed the need to add data elements to that would provide more information to regulators, in greater detail, and to include model formats in the Handbook for states to use in developing new reports using these data.

As new statistical reports were proposed, the industry questioned whether all states would need or use the data and urged members to weigh the benefits of having the information against the significant costs to insurers and statistical agents to report it on a regular basis. Some states also expressed concerns about the need for the proposed new data and considered their own costs to store and review new reports. As a result, many compromises were made.

Some data reporting requirements were made optional so that states could chose to implement them if desired. Several proposals to collect new data elements, require new reporting formats or develop brand new statistical reports were considered good ideas that could be placed on hold until system changes necessary to accomplish them were more cost beneficial or until five or more states required insurers to start collecting it. Efforts to make special data call requirements more consistent among states reduce the industry costs to report these data to regulators. Once these issues were resolved, no significant issues were raised during the review and adoption of the model regulation changes.

7. **Any Other Important Information (e.g., amending an accreditation standard)**

None.

PROPERTY AND CASUALTY COMMERCIAL RATE AND POLICY FORM MODEL LAW (Condensed)

Drafting Note: This model law is not intended to be a stand-alone model. Its provisions are intended to replace comparable provisions in current state rate and policy form regulatory laws. Regulatory laws relating to definitions, rate and form standards, disapprovals, advisory organizations, etc. are to be preserved.

Table of Contents

Section 1. Scope of Act

This Act applies to all forms of casualty insurance, including fidelity, surety and guaranty bond, to all forms of fire, marine and inland marine insurance, and to any combination of any of the foregoing, on commercial risks or operations located in this state. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the commissioner, or as established by general custom of the business, as inland marine insurance. In determining whether new types of inland marine insurance fall under this exemption, the commissioner shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.

This Act shall not apply to:

A. Reinsurance, other than statutorily authorized joint reinsurance mechanisms to the extent stated in (insert specific state law);

B. Accident and health insurance;

C. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine insurance as determined by the commissioner;

D. Insurance of hulls of aircraft, including their accessories an equipment, or against liability arising out of the ownership, maintenance, or use of aircraft.

E. Insurance on personal risks.

F. Insurance

Drafting Note—Types of Insurance: Here should be listed (a) other kinds of insurance, if any, and (b) particular types of insurers, if any, to which this Act is not to apply in the state or jurisdiction adopting the Act.

Section 2. Competitive Market

A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues a ruling to that effect. Such a rule shall expire no later than one year after issue unless the commissioner renews the rule after hearings and a finding as to the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of competition exists, the commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers.

Section 3. Rate and Policy Form Filings

A. Section 3 shall not apply to:

(1) Financial Guaranty;

(2) Employment Practices Liability;

(3) Commercial Inland Marine that is not written according to manual rates or rating plans;

(4) Directors and Officers Liability;

(5) Boiler and Machinery;

(6) Nuclear Insurance Products; or

(7) Commercial Credit Insurance Products.

B. (1) Every insurer shall file with the commissioner every policy form, endorsement, and other contract language and related attachment rules, manual, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing that it proposes to use. The filing shall include underwriting rules to the extent necessary to determine the applicable rate. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by [insert section of state law]. The filing shall state the effective date, and shall indicate the character and extent of the coverage contemplated.

(2) Insurers utilizing the services of an advisory organization shall provide with their rate filing, at the request of the commissioner, a description of the rationale for such use, including its own information and method of utilization of the advisory organization's information.

(3) In a competitive market except as provided in Paragraph (4) of this subsection, the rates and supplementary rating information that will be used in this state shall be filed within thirty (30) days of the effective date. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least [insert number of days] before the effective date, all rates and supplementary rating information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

Drafting Note: Some states may wish to regulate workers' compensation rates under a file and use system based on a number of public policy considerations.

(4) In a competitive market, every insurer and advisory organizations shall file commercial policy forms, endorsements and other contract language and related attachment rules and for mortgage guaranty insurance and advisory organizations the rates and supplementary rating information [insert number of days] before the effective date. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates and policy forms require closer supervision because of the insurer's financial condition or unfairly discriminatory practices, the insurer shall file with the commissioner at least [insert number of days] before the effective date, all such rates and supplementary rating information and supporting information and policy forms as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

Drafting Note: The number of days inserted should be no more than thirty calendar days.

Drafting Note: Some states may wish to regulate workers' compensation forms and mortgage guaranty and advisory organization rates and forms under a prior approval system.

(5) An insurer may authorize an advisory organization to file policy forms, endorsements and other contract language and related attachment rules on its behalf.

(6) In a competitive market, Paragraphs (3) and (4) not withstanding, the commissioner may, after a hearing, determine that the filing for review of rates and supplementary and supporting information by insurers is not necessary for all or for portions of one or more commercial lines of insurance. In these cases, the commissioner instead may require, on a purely advisory or informational basis, the filing of rates and such other information as he or she needs to monitor competition and to provide consumer information. Any determination by the commissioner to waive filing requirements may be revoked at any time and the commissioner may order that rates in effect at the time of revocation shall be filed within a reasonable period of time as specified in the order.

C. (1) In a noncompetitive market, and for title insurance, subject to the exception specified in Subsection H of this section, commercial policy forms, endorsements and other contract language and related attachment rules, rates, supplementary rating information and supporting information shall be on file for a waiting period of thirty (30) days before it becomes effective, which period may be extended by the commissioner or the insurer or advisory organization for an additional period not to exceed thirty (30) days if written or electronic notice is given within the waiting period that additional time is needed for the consideration of the filing. Upon written or electronic application by the insurer, the commissioner may authorize a filing that has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this Act unless disapproved by the commissioner within the waiting period or any extension thereof. Failure of the insurer or advisory organization to provide the requested information within the waiting period or the extension thereof shall be deemed a request to withdraw the filing from further consideration. Failure of the commissioner to act within the waiting period or the extension thereof shall result in the filing being deemed to meet the requirements of the Act. Neither the insurer nor the commissioner may waive the timeliness requirements of the deemer provisions in this section.

(2) In a noncompetitive market, notwithstanding Paragraph (1), the commissioner may, subject to Section 2, determine that commercial policy forms, endorsements and other contract language and related attachment rules, rates, supplementary rating information and supporting information be filed in accordance with Subsection B(4) of this section.

D. (1) Every insurer and advisory organization making filings specified in Subsection B(4) and C(1) of this section shall file or incorporate by reference to material that has been filed with or approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or consist of a reference to:

(a) The experience or judgment of the insurer or information filed by the advisory organization on behalf of the insurer as permitted by [insert section of state law];

(b) Its interpretation of any statistical data it relies upon;

(c) The experience of other insurers or advisory organizations; or

(d) Any other relevant factors.

(2) When a filing is not accompanied by the information upon which the insurer supports the filing, the commissioner may require the insurer to furnish the information upon which it supports the filing.

(3) After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss, special assessment and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may use or supplement its experience with information filed with the commissioner by an advisory organization or statistical agent.

E. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this Act.

F. A filing and any supporting information shall be open to public inspection upon receipt of the filing.

G. Under such rules and regulations as may be adopted, the commissioner may, by written or electronic order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, for which the rates, rating systems or policy forms cannot practicably be filed before they are used. The commissioner may make such examination as deemed advisable to ascertain whether any rates affected by such order meet the standards set forth in [insert rates standards sections of state law] and any forms affected by the order meet the standards set forth in [insert form standards sections of state law].

H. A rate in excess of that provided by a filing otherwise applicable or a rate with respect to any individual or special risks whose size, classification, degree of exposure to loss, previous loss experience or other relevant factors call for the exercise of sound underwriting judgment in the promulgation of rates may be used on any specific risk and shall be exempt from filing. The commissioner may examine the books and records of the insurer to determine if a pattern or practice of business exists that would indicate that the insurer is avoiding the filing requirements of this Act by extensive use of this section to issue its policies.

I. Policy forms, endorsements and other contract language unique in character and designed for and used with regard to a particular risk shall be exempt from filing, except that the commissioner may by regulation or order make specific restrictions relating to this exemption. In making a determination, the commissioner shall consider whether the policy forms, endorsements and other contract language otherwise exempt would be likely to meet the requirements of [insert form standards sections of state law] and the extent to which it would be practical to file the forms prior to their use for specific risks.

J. The commissioner may, by regulation, allow commercial policy forms, endorsements and other contract language that is more expansive, and in no respect more restrictive, than that provided by a filing otherwise applicable, to be used without being filed prior to its use. Any such commercial policy forms, endorsements, and other contract language shall, by regulation, be filed within thirty (30) days of its effective date.

K. Policy forms, endorsements and other contract language that is identical to another insurers' filing in this state may be used and shall be filed within thirty (30) days of the effective date. The filing shall be accompanied by a certification that the policy form, endorsement and other contract language is identical to the referenced insurers filing. If the filing is not identical or is not accompanied by the certification, the provisions of the policy forms, endorsements and other contract language of the referenced insurers' filing is automatically incorporated.

L. No insurer shall make or issue a contract or policy except in accordance with the filings that are in effect for the insurer as provided in this Act.

M. A rate for a residual market in which insurers are mandated by law to participate shall not become effective until approved by the commissioner.

Section 4. Form Approval Requirements Applying to Multistate Commercial Risks

The commissioner shall adopt reasonable regulations to provide that this state's policy form requirements shall apply only to insurance written for individual commercial risks that are primarily located in this state.

A. In the development of practical requirements for insurers to use in determining whether a risk is primarily located in this state, the commissioner shall consider whether the headquarters of the risk is located in this state and whether contracts of insurance are purchased by officers or employees that are primarily located in this state. For purposes of this section, the location of the headquarters shall be primarily determined by the location where the officers and senior management are physically located.

B. The regulations shall provide that the requirements of [insert appropriate statutory references] shall not apply when in conflict with a policy written for a commercial risk primarily located in another state.

C. Regulations adopted pursuant to this section may not allow the alteration of mandatory coverage provisions in workers' compensation policies [or mandatory coverage provisions required by the state's automobile insurance law].

Section 5. Monitoring Competition

A. In determining whether or not a competitive market exists pursuant to Section 2, the commissioner shall hold a public hearing and issue a tentative report detailing the state of competition in for the following property or casualty lines of insurance [insert reference to applicable lines of insurance]. The report shall be based on relevant economic tests, including but not limited to those in Subsection C of this section. The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition. The report shall include a certification of whether or not competition exists in each form of insurance.

B. Not later than [insert date] and every other year thereafter, the commissioner shall issue a final report that shall include a final certification of whether or not competition exists in each form of insurance. The final report and certification shall be supported by substantial evidence.

C. All of the following may be considered by the commissioner for purposes of Subsections A and B:

(1) The extent to which the largest insurer groups control the insurance marketplace. A specific insurance market shall be considered competitive, from the standpoint of market concentration, so long as, measured by premium volume, the cumulative share of the market controlled by the four (4) largest insurer groups in the specific market does not exceed fifty percent (50%). If the fifty percent (50%) threshold is surpassed, other measures of concentration, such as the Herfindahl-Hirshman Concentration Index, should also be considered, on the basis of both premium volume and policy counts, in determining the extent to which market concentration may be limiting market competition;

(2) Whether the total number of companies writing the form of insurance in this state is sufficient to provide multiple options to the public;

(3) The extent to which insurer entries and exits, considered over several years, suggest the presence or lack of entry or exit barriers or both;

(4) The degree to which the insurance products offered to consumers are homogenous in nature and, thus, comparable;

(5) The availability of insurance coverage in all geographic areas. A review of changes in residual market shares, if applicable, may be used as an indication of availability;

(6) The overall rate level which is not excessive, inadequate or unfairly discriminatory;

(7) The profitability of each form of insurance over a period of several years;

(8) The level of knowledge of market participants and the extent to which comparative pricing information has been made readily available to consumers;

(9) The extent to which the market for each type of insurance is growing;

(10) The presence of conditions indicating reverse competition; and

(11) Any other factors the commissioner considers relevant.

D. The reports and certifications required under Subsections A and B shall be forwarded to the governor and all relevant members of the state legislature and shall be available to the public.

E. It is rebuttably presumed that competitive markets exist. However, if the commissioner certifies that a reasonable degree of competition does not exist with respect to a form of insurance on a statewide basis or any geographic areas, or that insurance is unavailable to a segment of the market who are, in good faith, entitled to obtain insurance through ordinary means, the commissioner shall take steps to enhance competition or availability where it does not exist. A plan for enhancing competition or availability adopted pursuant to this section shall be included in a final certification of noncompetition. The plan shall only relate to those geographic areas, classifications or kinds of risks where adequate competition has been certified not to exist. The plan may include methods designed to enhance competition or availability that the commissioner considers necessary, and may provide for the commissioner to do one or more of the following:

(1) Authorize, by order, joint underwriting activities in a manner specified in the commissioner's order; and

(2) Modify the rate approval process in a manner to increase competition or availability, while at the same time providing for reasonably timely rate approvals, including reverting to prior approval of all filings.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2001 Proc. 4th Quarter 6, 14-15, 78, 87-91 (adopted).

PROPERTY AND CASUALTY COMMERCIAL RATE AND POLICY FORM MODEL LAW (Condensed)

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American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. § 23-67-206 (1999); § 23-79-109 (1959/1999).
California	NO CURRENT ACTIVITY		
Colorado			3 COLO. CODE REGS. § 702-5:5-1-13 (2000/2006).
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia			D.C. CODE ANN. § 31-2701 (2007); § 31-2714 (2000/2004).

PROPERTY AND CASUALTY COMMERCIAL RATE AND POLICY FORM MODEL LAW
(Condensed)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			MEMORANDUM 2006-012 (2006).
Georgia			GA. COMP. R. & REGS. 120-2-77 (1999).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana			IND. CODE. §§ 27-1-22-2.5 to 27-1-22-4 (1999/2003).
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. §§ 40-955 (1997/1999).
Kentucky			KY. REV. STAT. § 304.11-020 (1970/2000).
Louisiana			LA. ADMIN. CODE 37:XIII.9001 to 37:XIII.9021 (Regulation 72) (2000) (form filing exemption).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2412-A (1999).
Maryland			MD. ANN. CODE INS. § 11-206 (1957/2000).
Massachusetts			MASS. GEN. LAWS ch. 175, §§ 224 to 225 (2004).
Michigan	NO CURRENT ACTIVITY		

PROPERTY AND CASUALTY COMMERCIAL RATE AND POLICY FORM MODEL LAW
(Condensed)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. § 379.321 (2018).
Montana	NO CURRENT ACTIVITY		
Nebraska			NEB. ADMIN. R. tit. 210 ch. 73 (2001).
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. REV. STAT. ANN. § 412 (1998).
New Jersey			N.J. ADMIN. CODE §§ 11:1-2.1 to 11:1-2.7 (2002/2014).
New Mexico			N.M. ADMIN. CODE § 13.8.2.26 (2002/2006).
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma			OKLA. STAT. tit. 36 § 997 (1999).
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS. §§ 27-65-1 to 27-65-2 (1999/2004).

PROPERTY AND CASUALTY COMMERCIAL RATE AND POLICY FORM MODEL LAW
(Condensed)

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina			S.C. CODE ANN. § 38-1-20 (1987/2003); § 38-61-25 (2000); S.C. INS. R. 69-64 (2003).
South Dakota			S.D. CODIFIED LAWS ANN. §§ 58-24-68 to 58-24-74 (2004).
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE § 38.2-1903.1 (2000/2005).
Washington			WASH. ADMIN. CODE 284-24-120 (1999/2008).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

CREDIT FOR REINSURANCE MODEL LAW

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Section 1. Purpose

The purpose of this Act is to protect the interest of insureds, claimants, ceding insurers, assuming insurers and the public generally. The legislature hereby declares its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the legislature hereby provides a mandate that upon the insolvency of a non-U.S. insurer or reinsurer that provides security to fund its U.S. obligations in accordance with this Act, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic U.S. insurance companies. The legislature declares that the matters contained in this Act are fundamental to the business of insurance in accordance with 15 U.S.C. §§ 1011-1012.

Section 2. Credit Allowed a Domestic Ceding Insurer

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of Subsections A, B, C, D, E, F or G of this section; provided further, that the commissioner may adopt by regulation pursuant to Section 5B specific additional requirements relating to or setting forth: (1) the valuation of assets or reserve credits; (2) the amount and forms of security supporting reinsurance arrangements described in Section 5B; and/or (3) the circumstances pursuant to which credit will be reduced or eliminated.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.

Credit shall be allowed under Subsections A, B or C of this section only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under Subsections C or D of this section only if the applicable requirements of Subsection H have been satisfied.

A. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

Drafting Note: A state that provides for licensing of reinsurance by line, for consistency should adopt an amended version of Subsection A requiring the assuming insurer to be "licensed to transact reinsurance in this state."

B. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

(1) File with the commissioner evidence of its submission to this state's jurisdiction;

(2) Submit to this state's authority to examine its books and records;

(3) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a U.S. branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(4) File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(5) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20,000,000 and its accreditation has not been denied by the commissioner within ninety (90) days after submission of its application.

Drafting Note: To qualify as an accredited reinsurer, an assuming insurer must meet all of the requirements and the standards set forth in Subsection B. If the commissioner of insurance determines that the assuming insurer has failed to continue to meet any of these qualifications, the commissioner may, upon written notice and hearing, revoke accreditation.

C. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a U.S. branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or U.S. branch of an alien assuming insurer:

(a) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(b) Submits to the authority of this state to examine its books and records.

(2) The requirement of Section 2C(1)(a) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

Drafting Note: The term "substantially similar" means standards that equal or exceed the standards of the enacting state, as determined by the commissioner of the enacting state. It is expected that the NAIC will maintain a list of states whose laws establish standards that equal or exceed the standards of this model act.

D. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified U.S. financial institution, as defined in Section 4B, for the payment of the valid claims of its U.S. ceding insurers, their assigns and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination.

(2) (a) Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(i) The commissioner of the state where the trust is domiciled; or

(ii) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(b) The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's U.S. ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner.

(c) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing the balance of the trust and listing the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(3) The following requirements apply to the following categories of assuming insurer:

(a) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Paragraph 3(b) of this subsection.

(b) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

(c) (i) In the case of a group including incorporated and individual unincorporated underwriters:

(I) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;

(II) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, not-withstanding the other provisions of this Act, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(III) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all years of account; and

(ii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(iii) Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements,

prepared by independent public accountants, of each underwriter member of the group.

(d) In the case of a group of incorporated underwriters under common administration, the group shall:

(i) Have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation;

(ii) Maintain aggregate policyholders' surplus of at least $10,000,000,000;

(iii) Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(iv) In addition, maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(v) Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

Drafting Note: Unless otherwise stated, "commissioner" refers to the commissioner of insurance in the state where credit or a reduction from liability is taken.

Drafting Note: Consideration was given to deferring to state capital and surplus requirements as a threshold for the trusteed surplus, but it was concluded that, on the basis of risk exposure and current industry security practices, the standards for credit should be higher under Subsection D. The $100,000,000 trusteed surplus requirement for a group including incorporated and individual unincorporated underwriters reflects the higher financial standards currently found among the states for a group of this type. The $20,000,000 trusteed surplus requirement is an option available to assuming insurers that do not satisfy both the licensing and financial standards of Subsection B or C.

E. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

(1) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Paragraph (3) of this subsection;

(b) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to regulation;

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner pursuant to regulation;

(d) The assuming insurer must agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment;

(e) The assuming insurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(f) The assuming insurer must satisfy any other requirements for certification deemed relevant by the commissioner.

(2) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of Paragraph (1):

(a) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

(b) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(c) Within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(3) The commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(a) In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final U.S. judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.

(b) A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.

(c) U.S. jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

(d) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(4) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to regulation. The commissioner shall publish a list of all certified reinsurers and their ratings.

(5) A certified reinsurer shall secure obligations assumed from U.S. ceding insurers under this subsection at a level consistent with its rating, as specified in regulations promulgated by the commissioner.

(a) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with the provisions of Section 3, or in a multibeneficiary trust in accordance with Subsection D of this section, except as otherwise provided in this subsection.

(b) If a certified reinsurer maintains a trust to fully secure its obligations subject to Subsection D of this section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other U.S. jurisdictions and for its obligations subject to Subsection D of this section. It shall be a condition to the grant of certification under Subsection E of this section that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(c) The minimum trusteed surplus requirements provided in Subsection D are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10,000,000.

(d) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(e) For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations.

(i) As used in this subsection, the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

(ii) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(6) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(7) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

F. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below.

(a) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a Reciprocal Jurisdiction. A "Reciprocal Jurisdiction" is a jurisdiction that meets one of the following:

(i) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(ii) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(iii) A qualified jurisdiction, as determined by the commissioner pursuant to [Subsection 2E(3) of *Credit for Reinsurance Model Law* (#785)], which is not otherwise described in Subparagraphs (a)(i) or (a)(ii) above and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in regulation.

(b) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in regulation.

(c) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which will be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the Reciprocal Jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(d) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner pursuant to regulation, as follows:

(i) The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in Subparagraphs (b) or (c), or if any regulatory action is taken against it for serious noncompliance with applicable law;

(ii) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(iii) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(iv) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(v) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of Section 2E and Section 3 and as specified by the commissioner in regulation.

Drafting Note: Section 9C(4)(e) of the *Credit for Reinsurance Model Regulation* (#786) sets forth the acceptable forms of security under this subparagraph by specifically referencing Sections 12, 13 and 14 of Model #786.

(e) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner in regulation.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in regulation.

(g) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, that the assuming insurer complies with the requirements set forth in Subparagraphs (b) and (c).

(h) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(2) The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

(a) A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner's list shall include any Reciprocal Jurisdiction as defined under Section 2F(1)(a)(i) and (ii), and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions in accordance with criteria to be developed under regulations issued by the commissioner.

(b) The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a Reciprocal Jurisdiction, in accordance with a process set forth in regulations issued by the commissioner, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 2F(1)(a)(i) and (ii). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to [cite to state law equivalent to *Credit for Reinsurance Model Law* (#785)].

(3) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The commissioner may add an assuming insurer to such list if an NAIC accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under Paragraph (1)(d) of this subsection and complies with any additional requirements that the commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

(4) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in regulation.

(a) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Section 3.

(b) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 3.

(5) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(6) Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this [cite to state law equivalent to *Credit for Reinsurance Model Law* (#785)] or other applicable law or regulation.

(7) Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

(a) This paragraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of [cite to state law equivalent to *Credit for Reinsurance Model Law* (#785)].

(b) Nothing in this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(c) Nothing in this subsection shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

G. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of Subsections A, B, C, D, E or F of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

Drafting Note: For purposes of this subsection, "jurisdiction" refers to those jurisdictions other than the United States and also to any state, district or territory of the United States. Subsection E allows credit to ceding insurers that are mandated by these jurisdictions to cede to state-owned or controlled insurance or reinsurance companies or to participate in pools, guaranty associations or residual market mechanisms.

H. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted by Subsections C and D of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(1) (a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

(2) This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

I. If the assuming insurer does not meet the requirements of Subsections A, B, C or F, the credit permitted by Subsection D or E of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by Subsection D(3) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(2) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(4) The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

J. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(1) The commissioner must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the commissioner's order on hearing, unless:

(a) The reinsurer waives its right to hearing;

(b) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under Subparagraph E(6) of this section; or

(c) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(2) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 3. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection E(5) or Section 3.

K. Concentration Risk.

(1) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(2) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty (30) days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Section 3. Asset or Reduction from Liability for Reinsurance Ceded by a Domestic Insurer to an Assuming Insurer not Meeting the Requirements of Section 2

An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 2 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer; provided further, that the commissioner may adopt by regulation pursuant to Section 5B specific additional requirements relating to or setting forth: (1) the valuation of assets or reserve credits; (2) the amount and forms of security supporting reinsurance arrangements described in Section 5B; and/or (3) the circumstances pursuant to which credit will be reduced or eliminated.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.

The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified U.S. financial institution, as defined in Section 4B. This security may be in the form of:

A. Cash;

B. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

C. (1) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified U.S. financial institution, as defined in Section 4A, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(2) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

Drafting Note: Providing for the continuing acceptability of letters of credit whose issuers were acceptable when the credit support facility was first obtained is intended to avoid abrupt interruptions in the acceptability of credit support arrangements that run for specific periods of time, and thus unnecessary disruptions in the marketplace, on account of the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability (whether by virtue of a change in the issuing institution's ability to qualify under the original standards or as a result of revisions to the applicable standards). The provision stipulates that letters of credit acceptable when first obtained will, in the event of the subsequent nonqualification of the issuing (or confirming) institution, continue to be acceptable as security until the account party and beneficiary would first have, in the normal course of business, an opportunity to replace the credit support facility.

D. Any other form of security acceptable to the commissioner.

Drafting Note: There is no implication in the requirement that the security for the payment of obligations must be held under the exclusive control of the ceding insurer that either the reserve liability or the assets held in relation to the reserve liability have not been transferred for the purposes of statutory accounting by the ceding insurer to the reinsurer.

Section 4. Qualified U.S. Financial Institutions

A. For purposes of Section 3C, a "qualified U.S. financial institution" means an institution that:

(1) Is organized or (in the case of a U.S. office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(2) Is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

Drafting Note: The NAIC's Securities Valuation Office (SVO) maintains, on a current basis, a list of all U.S. financial institutions that have, upon application to the SVO, been determined to meet the eligibility standards of its *Purposes and Procedures Manual*. These standards, developed by the NAIC's Letter of Credit (EX4) Study Group, make use of nationally recognized ratings services, and are more rigorous in the case of foreign banking organizations (whose standby letters of credit must be issued or confirmed by a qualified U.S. financial institution) than those that are applicable to domestic financial institutions whose standby letters of credit would be considered acceptable.

B. A "qualified U.S. financial institution" means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(1) Is organized, or, in the case of a U.S. branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

Drafting Note: Because assets held in a fiduciary capacity are not subject to the claims of the trustee's creditors, and because the trust departments of all U.S. financial institutions (including U.S. branch or agency offices of foreign banking organizations having fiduciary powers in the U.S.) are regulated, supervised and examined by the institution's primary U.S. bank regulatory authority (federal or state), there is no need to apply additional standards measuring the financial condition or standing of the institution, as in the case of determining those institutions whose standby letter of credit obligations will be considered acceptable.

Section 5. Rules and Regulations

A. The commissioner may adopt rules and regulations implementing the provisions of this law.

Drafting Note: It is recognized that credit for reinsurance also can be affected by other sections of the enacting state's code, e.g., a statutory insolvency clause or an intermediary clause. It is recommended that states that do not have a statutory insolvency clause or an intermediary clause consider incorporating such clauses in their legislation.

B. The commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in Paragraph (1) of this Section 5B.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such policies and reinsurance arrangements.

(1) A regulation adopted pursuant to this Section 5B, may apply only to reinsurance relating to:

(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) Variable annuities with guaranteed death or living benefits;

(d) Long-term care insurance policies; or

(e) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to Paragraph 1(a) or 1(b) of this Section 5B, may apply to any treaty containing (i) policies issued on or after January 1, 2015, and/or (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

Drafting Note: The NAIC's Actuarial Guideline XLVIII (AG 48) became effective January 1, 2015, and covers policies ceded on or after this date unless they were ceded as part of a reserve financing arrangement as of December 31, 2014. One regulation contemplated by this revision to the NAIC *Credit for Reinsurance Model Law* (#785) is intended to substantially replicate the requirements for the amounts and forms of security held under the rules provided in AG 48. AG 48 was written to sunset upon a state's adoption (pursuant to the enabling authority of the preceding paragraph) of a regulation with terms substantially similar to AG 48. The preceding paragraph is intended to provide continuity of rules applicable to those policies and reinsurance arrangements, including continuity as to the policies covered by such rules. The preceding paragraph is not intended to change the scope of, or collateral requirements for policies and treaties covered under AG 48.

(3) A regulation adopted pursuant to this Section 5B may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this Section 5B shall not apply to cessions to an assuming insurer that:

(a) Meets the conditions set forth in Section 2F of the *Credit for Reinsurance Model Law* (#785) in this state or, if this state has not adopted provisions substantially equivalent to Section 2F of the *Credit for Reinsurance Model Law* (#785), the assuming insurer is operating in accordance with provisions substantially equivalent to Section 2F of the *Credit for Reinsurance Model Law* (#785) in a minimum of five (5) other states; or

(b) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 2E of the *Credit for Reinsurance Model Law* (#785), certified in a minimum of five (5) other states; or

(c) Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC *Accounting Practices and Procedures Manual*, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

(i) licensed in at least 26 states; or

(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this Section 5B does not limit the commissioner's general authority to adopt regulations pursuant to Section 5A of this law.

Section 6. Reinsurance Agreements Affected

This Act shall apply to all cessions after the effective date of this Act under reinsurance agreements that have an inception, anniversary or renewal date not less than six (6) months after the effective date of this Act.

Drafting Note: The enacting state may wish to provide a delay in the applicability greater than six (6) months to allow time for the insurance commissioner to promulgate regulations and to allow reinsurers to prepare and submit qualifying data.

Chronological Summary of Actions (All references are to the Proceedings of the NAIC).

1984 Proc. II 9, 29, 822, 836, 837-839 (adopted).
1986 Proc. I 9-10, 24, 799, 811, 812 (corrected).
1987 Proc. II 15, 24, 444-448, 832, 854, 856 (amended and reprinted).
1990 Proc. I 12-14, 851, 857-861 (amended at special plenary session September 1989 and reprinted).
1990 Proc. I 6, 30, 840, 872, 875-878 (technical amendments adopted at winter plenary and reprinted).
1990 Proc. II 7, 18, 748, 766, 780-783 (amended).
1993 Proc. 4th Quarter 6, 31, 835-836, 874, 891 (amended).
1996 Proc. 2nd Quarter 12, 12-17, 24, 862 (amended and reprinted).
2011 Proc. 3rd Quarter 113-114, 131-137, 222-236, 289-298 (amended).
2016 Proc. 1st Quarter Vol. I 111, 131, 138, 141, 145, 150-171 (amended).
2019 Proc. 2nd Quarter (amended).

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What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

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STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-5B-1 to 27-5B-20 (2021).		
Alaska	ALASKA Stat. § 21.12.020 (1966/2021).		
American Samoa	ORDER OF INS. COMM. (2022).		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-3601 to 20-3605 (2021).		
Arkansas	ARK. CODE ANN. §§ 23-62-305 to 23-62-309 (1991/2021).		
California	CAL. INS. CODE §§ 922.2 to 922.9 (2020).		BULLETIN 87-10 (1987); BULLETIN 2011-2 (2011).
Colorado	H.B. 21-1063 (2021).	COLO. REV. STAT. §§ 10-3-701 to 10-3-706 (2014).	
Connecticut	CONN. GEN. STAT. §§ 38a-85 to 38a-89 (1991/2022).		BULLETIN FS-24-2012 (2012); BULLETIN FS-25-2013 (2013); BULLETIN FS-25-1-2013 (2013).
Delaware	H.B. 44 (2021).		DEL. CODE ANN. tit. 18, §§ 910 to 916 (1953/2012).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. CODE ANN. §§ 31-501 to 31-504 (2022).		
Florida	S.B. 728 (2021).	FLA. STAT. ANN. § 624.610 (1959/2012); FLA. ADMIN. CODE ANN. r. 69o144.001 to 69o.144.010 (1991/2017).	
Georgia	S.B. 188 (2020).		GA. CODE ANN. § 33-7-14 (2012).
Guam	ORDER OF INS. COMM. (2022).		
Hawaii	HAW. REV. STAT. §§ 431:4A-101 to 431:4A-104 (1992/2022).		HAW. REV. STAT. § 431:5-306 (1988/2004).
Idaho	IDAHO CODE ANN. §§ 41-514 to 41-515 (1991/2021).		
Illinois	S.B. 3865 (2022).	215 ILL. COMP. STAT. 5/173.1 (1991/2018).	
Indiana	H.B. 1372 (2020).	IND. CODE §§ 27-6-10-1 to 27-6-10-15 (1994/2018).	
Iowa	S.F. 2131 (2020).	IOWA CODE §§ 521B.101 to 521B.106 (2013/2017).	
Kansas	S.B. No. 78 (2021).		KAN. STAT. ANN. § 40-221a (1965/2018).
Kentucky	H.B. 417 (2020).	KY. REV. STAT. ANN. § 304.5-140 (1970/2018).	
Louisiana	H.B. 247 (2020).	LA. REV. STAT. ANN. §§ 22:651 to 22:652 (1958/2016).	ADVISORY LETTER 2014-2 (2014).
Maine	ME. REV. STAT. ANN. tit. 24-A, § 731-B (1985/2021).		
Maryland	S.B. 167 (2020).	MD. CODE ANN. INS. §§ 5-901 to 5-916 (2013).	MD. CODE REGS. 31.05.08.01 to 31.05.08.07 (1993/2014).
Massachusetts	MASS. GEN. LAWS ch. 175, §§ 20 to 20A (1941/2022).		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	S.B. No. 1015 (2021).	MICH. COMP. LAWS §§ 500.1101 to 500.1127 (1994/2018).	
Minnesota	H.F. 6 (2021).	MINN. STAT. §§ 60a.091 to 60a.097 (1991/2018).	
Mississippi	H.B. 408 (2020).	MISS. CODE ANN. §§ 83-19-151 to 83-19-157 (1991/2017).	
Missouri	S.B. No. 6 (2021).	MO. REV. STAT. § 375.246 (1990/2013).	BULLETIN 2004-03 (2004).
Montana	MONT. CODE ANN. §§ 33-2-1216 to 33-2-1218 (1993/2019).		
Nebraska	L.B. 774 (2020).	NEB. REV. STAT. §§ 44-416.05 to 44-416.17 (1985/2018).	
Nevada	A.B. No 45 (2021).	NEV. REV. STAT. §§ 681A.110 to 681A.240 (1971/2017).	
New Hampshire	H.B. 1245 (2020).	N.H. REV. STAT. ANN. §§ 405:45 to 405:52 (1986/2018).	
New Jersey	N.J. STAT. ANN. §§ 17:51B-1 to 17:51B-4 (1993/2022).	N.J. ADMIN. CODE §§11:2-28.1 to 11:2-28.14 (1993/2018).	BULLETIN 2012-04 (2012).
New Mexico	S.B. 150 (2022).	N.M. STAT. ANN. § 59A-7-11 (1985/2014),	
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 125.1 to 125.8 (1977/2013) (Regulation Nos. 17, 20, and 20-A).		N.Y. INS. LAW § 1308 (1984/2008); CIRCULAR LETTER 1988-5 (1988).
North Carolina	S.B. 299 (2021).	N.C. GEN. STAT. §§ 58-7-21 to 58-7-30 (1985/2019).	
North Dakota	S.B. 2076 (2021).	N.D. CENT. CODE §§ 26.1-31.2-01 to 26.1-31.2-05 (1991/2015).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	ORDER OF INS. COMM. (2022).		
Ohio	OHIO REV. CODE ANN. §§ 3901.61 to 3901.65 (1991/2021).		
Oklahoma	S.B. 122 (2021).	OKLA. STAT. tit. 36, §§ 5121 to 5124 (1992/2016).	
Oregon	H.B. No. 2045 (2021).	OR. REV. STAT. §§ 731.509 to 731.511 (1994/2019).	
Pennsylvania	S.B. 1195 (2020).	40 PA. CONS. STAT. § 442.1 (1993/2012).	NOTICE 1-18-2014 (#1) (2014); NOTICE 1-25-2014 (#1 & #3) (2014).
Puerto Rico	P.S. 722 (2022).	P.R. REGS. 9086 (2012/2018).	P.R. LAWS ANN. tit. 26, § 412 (1973/2000).
Rhode Island	S.B. 980 (2021).	R.I. GEN. LAWS §§ 27-1.1-0.5 to 27-1.1-10 (1991/2017).	
South Carolina	S.B. 881 (2020).	S.C. CODE ANN. §§ 38-9-200 to 38-9-220 (1991/2018).	
South Dakota	H.B. 1003 (2021).	S.D. CODIFIED LAWS §§ 58-14-1 to 58-14-33 (1993/2017).	S.D. CODIFIED LAWS § 58-13-4 (1966).
Tennessee	TENN. CODE ANN. §§ 56-2-208 to 56-2-209 (1994/2018).		
Texas	H.B. No. 1689 (2021).		TEX. INS. CODE ANN. §§ 493.101 to 493.107 (2005/2017).
Utah	H.B. 37 (2020).	UTAH CODE ANN. §§ 31A-17-404 to 31A-17-404.4 (1992/2017); UTAH ADMIN. CODE r. 590-173 (1997/2017).	
Vermont	Act No. 103 (2020).	VT. STAT. ANN. tit. 8, § 3634a (1992/2013).	

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	BILL NO. 34-0255 (2022).	22 V.I. CODE § 1443 (2018).	
Virginia	H.B. 154 (2020).	VA. CODE ANN. §§ 38.2-1316.1 to 38.2-1316.8 (1991/2017).	ADMIN. LETTER No. 2012-11 (2012).
Washington	S.B. 5048 (2021).	WASH. REV. CODE ANN. §§ 48.12.400 to 48.12.499 (1947/2015).	
West Virginia	H.B. 4146 (2020).	W. VA. CODE § 33-4-15a (1992/2018).	
Wisconsin	WIS. ADMIN. CODE INS. §§ 52.01 to 52.07 (1993/2022).		
Wyoming	WYO. STAT. ANN. §§ 26-5-112 to 26-5-117 (1992/2017).		

PROJECT HISTORY – 2019

CREDIT FOR REINSURANCE MODEL LAW (#785)

CREDIT FOR REINSURANCE MODEL REGULATION (#786)
(Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance)

1. Description of the Project, Issues Addressed, etc.

On Sept. 22, 2017, the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) signed the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement). The EU Covered Agreement includes requirements on group capital, group supervision and reinsurance collateral. The EU Covered Agreement would eliminate reinsurance collateral requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction.

On Dec. 11, 2018, the Treasury Department and the USTR announced that the U.S. and the United Kingdom (UK) had reached a final agreement on reinsurance collateral and other insurance regulatory measures outlined in the "Bilateral Agreement Between the United States Of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement). A separate Covered Agreement for the UK was necessary due to plans by the UK to exit the EU. The UK Covered Agreement mirrors the language in the prior Covered Agreement between the U.S. and the EU, and, for the purposes of this project history, they will be referred to collectively as the "Covered Agreement."

While the group capital and group supervision provisions of the Covered Agreement are not expected to require changes to state laws, the Covered Agreement will require the states to take action with respect to the reinsurance collateral provisions within 60 months (five years) of signing or face potential federal preemption by the Federal Insurance Office (FIO) under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. Specifically, in 2011, the NAIC membership adopted revisions to Section 2E of the *Credit for Reinsurance Model Law* (#785) and Section 8 of the *Credit for Reinsurance Model Regulation* (#786) which will be affected by the Covered Agreement. These revisions served to reduce reinsurance collateral requirements for certified non-U.S. licensed reinsurers that are licensed and domiciled in qualified jurisdictions. Prior to these amendments, in order for domestic U.S. ceding companies to receive reinsurance credit, the reinsurance must either have been ceded to U.S. licensed reinsurers or secured by collateral representing 100% of liabilities for which the credit was recorded.

On Feb. 20, 2018, the NAIC and the Reinsurance (E) Task Force held a Public Hearing in New York to address the reinsurance collateral provisions of the Covered Agreement. On April 17, 2018, based on public comments and testimony received at the Public Hearing, the Executive (EX) Committee agreed to the following actions with respect to the Covered Agreement:

> Adopted a Request for NAIC Model Law Development with respect to Model #785 and Model #786. The motion adopted was that these models be revised to: 1) conform to the requirements in the covered agreement with respect to EU reinsurers; and 2) provide reinsurers domiciled in NAIC-qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the covered agreement, with provisions regarding group supervision, group capital, information-sharing and enforcement.

On May 15, 2019, the Task Force adopted revisions to Model #785 and Model #786 consistent with these charges during a public conference call, which were then approved by the Financial Condition (E) Committee on May 28, 2019. The revisions would eliminate reinsurance collateral requirements for "reciprocal" reinsurers that have their head office or are domiciled in any of the following:

1. An EU-member country (or any other non-U.S. jurisdiction) that is subject to an in-force covered agreement addressing the elimination of reinsurance collateral requirements with U.S. ceding insurers (Covered Agreement Reciprocal Jurisdictions).
2. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program (Accredited State Reciprocal Jurisdictions).

3. A non-U.S. jurisdiction recognized as a qualified jurisdiction that meets certain additional requirements consistent with the terms of a covered agreement (Qualified Jurisdiction Reciprocal Jurisdictions).

The requirements for reciprocal reinsurers under the revisions to Model #785 and Model #786 mirror the requirements for reinsurers under the Covered Agreement, and they would place the following additional requirements with respect to reciprocal reinsurers:

- Maintain minimum capital and surplus of no less than $250 million.
- Maintain a minimum solvency or capital ratio, as applicable, of 100% of the SCR or a risk-based capital (RBC) ratio of 300% of the authorized control level, or such other solvency or capital ratio that the commissioner determines is an effective measure of solvency.
- Provide certain assurances to the state insurance commissioner on a new form (Form RJ-1), which includes providing prompt notice to the state insurance commissioner in the event of noncompliance with the minimum capital and surplus and minimum solvency requirements; or serious noncompliance with applicable law, consent to service of process, consent to payment of final judgments, nonparticipation in solvent schemes; and other assurances.
- Provide annual audited financial statements and other specified financial information for the two years preceding entry into the reinsurance agreement, and file annual audited financial statements and other specified financial information on a semi-annual basis.
- Maintain a practice of prompt payment of claims under reinsurance agreements.

2. Name of Group Responsible for Drafting the Model and States Participating

The Reinsurance (E) Task Force of the Financial Condition (E) Committee was responsible for drafting the revisions to the Model #785 and Model #786:

Chlora Lindley-Myers, Chair	Missouri	Eric A. Cioppa	Maine
Raymond G. Farmer, Vice Chair	South Carolina	Gary Anderson	Massachusetts
Jim L. Ridling	Alabama	Matthew Rosendale	Montana
Lori K. Wing-Heier	Alaska	Bruce R. Ramge	Nebraska
Peter Fuimaono	American Samoa	Barbara D. Richardson	Nevada
Allen W. Kerr	Arkansas	John Elias	New Hampshire
Ricardo Lara	California	Marlene Caride	New Jersey
Michael Conway	Colorado	Linda A. Lacewell	New York
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Trinidad Navarro	Delaware	Jon Godfread	North Dakota
Stephen C. Taylor	District of Columbia	Jillian Froment	Ohio
David Altmaier	Florida	Glen Mulready	Oklahoma
Jim Beck	Georgia	Elizabeth Kelleher Dwyer	Rhode Island
Dafne M. Shimizu	Guam	Julie Mix McPeak	Tennessee
Dean L. Cameron	Idaho	Kent Sullivan	Texas
Stephen W. Robertson	Indiana	Todd E. Kiser	Utah
Doug Ommen	Iowa	Michael S. Pieciak	Vermont
Vicki Schmidt	Kansas	Scott A. White	Virginia
Nancy G. Atkins	Kentucky	James A. Dodrill	West Virginia
James J. Donelon	Louisiana	Mark Afable	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

On April 17, 2018, the Executive (EX) Committee adopted the following charges to the Reinsurance (E) Task Force and a Request for NAIC Model Law Development with respect to these charges, which were reapproved by the Committee for 2019:

- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to conform to the terms of the Covered Agreement.
- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the

same collateral requirement treatment as provided to EU-domiciled reinsurers, that non-EU qualified jurisdiction must agree to adhere to all other standards imposed upon the EU in the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states' approach to group supervision, including group capital. As part of its deliberations, the Task Force should consult with international regulators, in addition to all other interested parties.

- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to address the effect of a breach of the Covered Agreement (as determined pursuant to its terms) on a reinsurer's collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or the model law and regulation.

- In conjunction with any revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786), the Qualified Jurisdiction (E) Working Group is directed to consider changes to the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision, group capital standards, and as well as require strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach.

- The Reinsurance Financial Analysis (E) Working Group is directed to consider changes in its current methods of monitoring certified reinsurers domiciled in Qualified Jurisdictions to incorporate changes to state reinsurance collateral requirements caused by the EU Covered Agreement and any changes to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to provide similar treatment to reinsurers domiciled in Qualified Jurisdictions.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

At the 2017 Fall National Meeting, the NAIC membership tasked a leadership group of commissioners to develop a strategy for proceeding forward with revisions to Model #785 and Model #786. This included the 2018 NAIC officers: President Julie Mix McPeak (TN); President-Elect Eric A. Cioppa (ME); Vice President Raymond G. Farmer (SC); and Secretary-Treasurer Gordon I. Ito (HI). It also included Commissioner David Altmaier (FL), chair of the Financial Condition (E) Committee; then-Superintendent Maria T. Vullo (NY), then-chair of the Reinsurance (E) Task Force; and then-Director Peter L. Hartt (NJ), the state insurance commissioner representative on the Financial Stability Oversight Council (FSOC).

On Feb. 20, 2018, the NAIC and Reinsurance (E) Task Force held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. The public hearing was presided over by Commissioner Mix McPeak, Commissioner Altmaier and then-Superintendent Vullo. Also in attendance at the public hearing were: then-Commissioner Katharine L. Wade (CT); Superintendent Cioppa; Director Chlora Lindley-Myers represented by John Rehagen (MO); then-Acting Commissioner Marlene Caride and then-Director Hartt (NJ); Superintendent Elizabeth Kelleher Dwyer (RI); Director Farmer; then-Commissioner Ted Nickel (WI); and Commissioner Tom Glause (WY). During the public hearing, the NAIC and the Task Force heard from 18 speakers, including a representative of the Treasury Department, as well as U.S. domestic insurers, U.S. trade associations, international reinsurers and international trade associations. The NAIC also received 20 comment letters from a wide variety of stakeholders and interested parties. There were approximately 160 people in attendance at the public hearing, with another 181 participating via conference call.

On March 14, 2018, a memorandum titled, "Covered Agreement: Proposed Next Steps," was sent to the Financial Condition (E) Committee by Commissioner Mix McPeak; Commissioner Altmaier, chair of the Committee; and then-Superintendent Vullo, then-chair of the Reinsurance (E) Task Force. This memorandum recommended that the Committee take the following actions with respect to the Covered Agreement, based on public comments and testimony received at the public hearing:

- Adopt a Request for NAIC Model Law Development with respect to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786). Specifically, these models should be revised to (a) conform to the requirements in the Covered Agreement with respect to EU reinsurers, and (b) provide reinsurers domiciled in NAIC qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the Covered Agreement, with provisions regarding group supervision, group capital, information sharing and enforcement.

- Adopt charges to the Reinsurance (E) Task Force, and its Qualified Jurisdiction (E) Working Group and Reinsurance Financial Analysis (E) Working Group to make certain revisions to Model #785 and Model #786, and to develop processes to implement the changes to the models.

- Adopt charges to the Capital Adequacy (E) Task Force and the Statutory Accounting Principles (E) Working Group to address related reinsurance collateral issues raised at the Public Hearing.

The Financial Condition (E) Committee adopted the Request for NAIC Model Law Development at the 2018 Spring National Meeting. The Executive (EX) Committee adopted the Request for NAIC Model Law Development for amendments to Model #785 and Model #786, as well as the proposed related charges for various Financial Condition (E) Committee groups, during its April 17, 2018, conference call. These charges were renewed for the 2019 calendar year.

The Reinsurance (E) Task Force adopted draft revisions to Model #785 and Model #786 at the 2018 Fall National Meeting. The Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed that were consistent with the issues raised at the Task Force meeting. The Executive (EX) Committee and Plenary were prepared to consider the draft revisions for adoption during its Dec. 19, 2018, conference call; however, the vote was delayed due to feedback received from the Treasury Department and the USTR. In a memorandum to the Financial Condition (E) Committee dated Feb. 11, 2019, the NAIC leadership group on reinsurance made a recommendation that the Task Force and its drafting group consider making additional revisions to resolve the following issues:

- **Recognition of Reciprocal Jurisdictions**. Whether any additional revisions are necessary with respect to a state insurance commissioner's discretion to make a determination as to whether an EU jurisdiction should be recognized as a Reciprocal Jurisdiction.

- **Determination of Compliance with the Covered Agreement**. Whether any additional revisions are necessary with respect to a state insurance commissioner's discretion to determine whether each EU member state is in compliance with the Covered Agreement.

- **Commissioner Discretion to Impose Additional Requirements**. Whether any additional revisions are necessary with respect to any additional requirements being imposed on EU reinsurers.

- **Effective Date**. Whether any additional revisions are necessary with respect to the effective date provision in the model revisions regarding which reinsurance agreements and policies are covered.

- **Service of Process**. Whether any additional revisions are necessary with respect to requiring assuming reinsurers to submit the confirmation of consent to service of process to each state in which the reinsurer intends to operate.

- **Other Covered Agreement Issues**. Whether any additional technical revisions are necessary to make the draft models more consistent with the Covered Agreement.

- **Additional Requirements for Qualified Jurisdictions**. Whether any additional revisions are necessary and appropriate with respect to requirements that are applicable to Qualified Jurisdictions but are not applicable to EU jurisdictions.

- **Recognition of U.S. State Regulatory System by Qualified Jurisdictions**. Whether any additional revisions are necessary with respect to the requirement for Qualified Jurisdictions to recognize aspects of the U.S. state regulatory system in order to be considered a Reciprocal Jurisdiction.

- **Recognition of NAIC Accredited Jurisdictions as Reciprocal Jurisdictions**. Whether U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Standards and Accreditation Program should be recognized as Reciprocal Jurisdictions.

The Financial Condition (E) Committee adopted these recommendations during its Feb. 19, 2019, conference call. At the direction of Director Lindley-Myers, current chair of the Reinsurance (E) Task Force, draft revisions to Model #785 and Model #786 were released May 1, 2019, which were then approved by the Task Force during its May 15, 2019, conference call. The Financial Condition (E) Committee adopted the draft revisions to Model #785 and Model #786 during its May 28, 2019, conference call, with the following revision to Section 2F(7) of Model #785:

Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed ~~on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection~~ on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

Drafting Group. At the 2018 Summer National Meeting, then-Superintendent Vullo (NY), then-chair of the Reinsurance (E) Task Force, directed NAIC staff to create an informal drafting group composed of members of the Task Force tasked with developing the initial draft revisions to Model #785 and Model #786 incorporating the provisions of the Covered Agreement for discussion and consideration by the Task Force. The members of the drafting group were composed of state insurance regulators from the following states: California, Colorado, Connecticut, Florida, Maine, Missouri, Nebraska, New Jersey, New York and Texas. The drafting group met Aug. 16, Aug. 23, Sept. 5, Sept. 7, Oct. 22, Nov. 2 and Nov. 29, 2018, via conference call in regulator-to-regulator session. The drafting group also met Feb. 20, Feb. 22, Feb. 27, April 16 and April 30, 2019, via conference call in regulator-to-regulator session. The drafting group discussed and drafted multiple proposed revisions to Model #785 and Model #786, which were presented to the Task Force for consideration of adoption.

Federal and International Regulators. NAIC staff met via conference call with representatives of the European Commission on Oct. 29, 2018 and May 13, 2019, and received comment letters from the European Commission—dated Oct. 16, Nov. 16 and Dec. 18, 2018; and March 28 and May 13, 2019—in which the European Commission expressed concerns about the consistency of the draft revisions with the EU Covered Agreement. State insurance regulators and NAIC staff also met via conference call with representatives of the Treasury Department and the USTR on Nov. 16, Nov. 30 and Dec. 4, 2018, and on March 8, April 25 and May 23, 2019, to discuss their concerns regarding the consistency of the draft revisions with the Covered Agreement. During these conference calls, Director Steven Seitz (FIO) advised that any past or future discussion of Model #785 and Model #786 would be without prejudice to any future preemption analysis of state law the FIO may conduct. The Task Force and its drafting group took into account the concerns expressed by both the European Commission and the U.S. federal regulators, and the Task Force and its drafting group are of the opinion that the final revisions to Model #785 and Model #786 are entirely consistent with the provisions of the Covered Agreement.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Feb. 20, 2018, Public Hearing. On Feb. 20, 2018, the NAIC held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. A detailed discussion of the public hearing and the actions taken by the Financial Condition (E) Committee and Executive (EX) Committee with respect to the results of the public hearing can be found under Section 4—General Description of the Drafting Process of this project history.

June 21, 2018, Exposure. On June 13, 2018, the Reinsurance (E) Task Force met in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. During the conference call, the Task Force agreed to expose proposed revisions to Model #785 and Model #786 dated June 21, 2018, for a public comment period ending July 23, 2018. The Task Force received 18 comment letters, which included 16 from international and domestic insurance companies and industry groups, as well as two from state insurance regulators. The Task Force discussed the comment letters at the 2018 Summer National Meeting and directed a newly formed drafting group to work with NAIC staff to consider the comments and determine whether to incorporate them into the models and create updated drafts.

Sept. 25, 2018, Exposure. The drafting group considered the comment letters received at the 2018 Summer National Meeting and prepared draft revisions for the consideration of the Reinsurance (E) Task Force, which met Sept. 25, 2018, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. The Task Force agreed to expose the proposed revisions to Model #785 and Model #786 for a 21-day public comment period ending Oct. 16, 2018. The Task Force received 14 comment letters on the Sept. 25, 2018, exposure documents, which were posted to the Task Force's page on the NAIC website for public viewing.

Nov. 9, 2018, Exposure. The drafting group considered the comment letters received on the Sept. 25, 2018, exposure and again prepared draft revisions for the consideration of the Reinsurance (E) Task Force. The Task Force met Nov. 9, 2018, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 for discussion by the Task Force at the 2018 Fall National Meeting. The Task Force received 16 comment letters, which were discussed during its Nov. 17, 2018, meeting. At that meeting, the Task Force adopted the draft revisions to Model

#785 and Model #786, and the Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed consistent with the issues raised by the Task Force. A detailed discussion of the action taken by the Executive (EX) Committee and Plenary and the Financial Condition (E) Committee with respect to these draft revisions can be found under Section 4—General Description of the Drafting Process of this project history.

March 7, 2019, Exposure. The drafting group again considered the comment letters and public discussion, as well as recommendations made by the Financial Condition (E) Committee in its memorandum dated Feb. 11, 2019. The drafting group again prepared draft revisions to Model #785 and Model #786 for discussion by the Task Force. The Task Force met March 7, 2019, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 on March 7, 2019, for a 25-day public comment period ending April 1, 2019. The Task Force received 10 comment letters on the March 7, 2019, exposure, which were discussed by the Task Force at the 2019 Spring National Meeting. The Task Force did not take a vote on the proposed revisions at this meeting, but it directed the drafting group to consider the comments heard and the comment letters received to update the draft revisions, which will not require a separate formal exposure period.

May 1, 2019, Exposure. The drafting group again considered the comment letters and public discussion, and it prepared draft revisions to Model #785 and Model #786 dated May 1, 2019, for discussion by the Reinsurance (E) Task Force during its May 15, 2019, conference call. During this conference call, the Task Force adopted the revisions and agreed to refer the proposed revisions to the Financial Condition (E) Committee for consideration of adoption.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The following significant issues were discussed extensively with state insurance regulators and interested parties during the drafting process:

- **NAIC Compliance with the Covered Agreement**. The NAIC initially opposed the EU Covered Agreement, primarily for failing to provide for formal recognition of the U.S. by the EU as a fully "equivalent" regulatory jurisdiction for Solvency II purposes. Following the signing of the EU Covered Agreement, the NAIC released a statement that it was pleased that the Treasury Department and the USTR clarified its interpretation in key areas and appreciated their affirmation of the primacy of state-based insurance regulation. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to conform to the terms of the Covered Agreement.

- **Similar Treatment for Qualified Jurisdictions**. In the NAIC "Notice of Public Hearing and Request for Comments," the Reinsurance (E) Task Force requested specific comments on providing reinsurers domiciled in NAIC qualified jurisdictions with similar reinsurance collateral requirements as those provided under the Covered Agreement. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Task Force to develop revisions to Model #785 and Model #786 to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the same collateral requirement treatment as provided to EU-domiciled reinsurers, the non-EU qualified jurisdiction must agree to adhere to all other standards imposed under the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states' approach to group supervision, including group capital.

- **Breach of the Covered Agreement**. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to address the effect of a breach of the Covered Agreement on a reinsurer's collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or Model #785 and Model #786. The Sept. 25, 2018, exposure draft of Model #785 contained a requirement that the reciprocal jurisdiction "is a member state of the European Union, and has been determined by the Commissioner to be in compliance with all material terms of the agreement." In its comment letters, the European Commission argued that this section provides the commissioner with the power to determine if each individual EU member state complies with the terms of the Covered Agreement, which appears to be inconsistent with the terms of the Covered Agreement. The drafting group deleted this provision from the May 1, 2019, draft of Model #785, and substituted "is subject to an in-force covered agreement."

- **Recognition of Qualified Jurisdictions**. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Qualified Jurisdiction (E) Working Group to consider changes to the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision and group capital standards, as well as require the strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach. The Nov. 9, 2018, exposure draft of Model #786 contained a provision that it "[r]ecognizes the U.S. state regulatory system, including its approach to group supervision and group capital, by providing through statute, regulation or the equivalent, including but not limited to confirmation by a competent regulatory authority, in such qualified jurisdiction…." Interested parties requested clarification on the process of recognition, and Section 9B(3)(c) of the March 7, 2019, exposure draft of Model #786 was revised to provide, as follows: "Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction…."

- **Recognition of Group-wide Supervision**. Due to concerns expressed by interested parties that Section 9B(3)(c) of Model #786 might act to change the group supervisor of a U.S.-domiciled affiliate, the drafting group clarified in a drafting note in the March 7, 2019, exposure that nothing in this provision is intended to enhance or limit the authority of U.S. state insurance regulation with respect to the group-wide supervision of insurance holding company systems pursuant to state law.

- **Recognition of NAIC-Accredited Jurisdictions as Reciprocal Jurisdictions**. The initial June 21, 2018, exposure drafts did not include U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions. Interested parties commented that this was not consistent with the current qualified jurisdiction provisions of Model #785 and Model #786, noting that U.S. reinsurers domiciled in accredited states should receive similar treatment to EU reinsurers and other reinsurers domiciled in qualified jurisdictions. The Reinsurance (E) Task Force added U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions in the March 7, 2019, exposure drafts.

- **Memorandum of Understanding**. At the suggestion of interested parties, the memorandum of understanding required for qualified jurisdictions and reciprocal jurisdictions under Section 9B of Model #786 was clarified to include the International Association of Insurance Supervisors' (IAIS) Multilateral Memorandum of Understanding (MMoU) or other multilateral memoranda of understanding coordinated by the NAIC in the Sept. 25, 2018, exposure.

- **Annual Reduction in Collateral by 20%**. Article 9(3)(a) of the Covered Agreement provides that "the United States shall encourage each U.S. State to promptly adopt the following measures: (a) the reduction, in each year following the date of entry into force or provisional application of this Agreement, of the amount of collateral required by each State to allow full credit for reinsurance by 20 percent of the collateral that the U.S. State required as of the January 1 before signature of this Agreement." The Task Force determined that it was not consistent with the current Model #785 and Model #786 to meet this requirement. Instead, the Task Force determined that the best course of action was to work in an expeditious manner to amend Model #785 and Model #786 for enactment by the states to eliminate collateral for assuming insurers domiciled in Covered Agreement jurisdictions.

- **Commissioner Discretion: EU Jurisdictions**. The European Commission's comment letters argued that the draft revisions to Model #785 and Model #786 contained additional requirements on EU reinsurers that were not provided in the Covered Agreement. For example, the European Commission argued that a state insurance commissioner does not have the discretion to determine whether an individual EU jurisdiction is in compliance with the Covered Agreement, and Section 9C(8) of Model #786 provided in its initial drafts that "the assuming insurer must satisfy any other requirements deemed relevant by the commissioner." The May 1, 2019, exposure drafts removed all elements of commissioner discretion with respect to reinsurers domiciled in Covered Agreement reciprocal jurisdictions.

- **Commissioner Discretion: Qualified Jurisdictions**. The original draft revisions to Model #785 and Model #786 contained additional requirements that were applicable to assuming insurers domiciled in qualified jurisdictions, but they were not applicable to those reinsurers domiciled in jurisdictions subject to a Covered Agreement. For example, Section 2F(1)(h) of Model #785 required the assuming insurer to "satisfy any other requirement deemed relevant by the commissioner" for its cedant to receive the benefit of the credit for reinsurance provisions. In addition, the definition of "reciprocal jurisdiction" in Model #786 included "[s]uch additional factors as may be considered in the discretion of the commissioner." Interested parties representing qualified jurisdictions argued that the NAIC should work toward a framework that treats EU and non-EU jurisdictions equivalently and provide additional clarity

regarding the standards imposed on non-EU jurisdictions. The May 1, 2019, exposure drafts have removed the remaining distinctions between EU and non-EU jurisdictions, and they treat qualified jurisdictions similarly to EU jurisdictions.

- **Effective Date**. The original June 21, 2018, draft of Section 2F(7) of Model #785 contains the following provision: "This subsection shall not apply to reinsurance agreements entered into before the subsection's application, or to losses incurred or to reserves posted before the subsection's application." This was to clarify that these revisions would not eliminate reinsurance collateral that is currently in place, similar to the current certified reinsurer provisions of Model #785 and Model #786. This provision was included in the *Statement of the United States on the Covered Agreement with the European Union* issued Sept. 22, 2017. There were concerns expressed by interested parties, including the European Commission, that this sentence was not consistent with Article 3(8) of the Covered Agreement. The Task Force removed this provision in the March 7, 2019, exposure draft.

  In its comment letter dated March 28, 2019, the European Commission also argued that Section 2F(7) was not consistent with Article 3(8) of the Covered Agreement, which provides that the Covered Agreement takes effect "only to reinsurance agreements entered into, amended, or renewed on or after the date on which a measure that reduces collateral pursuant to this Article takes effect…" The Task Force disagreed with this interpretation, noting that there are additional requirements contained in Article 3 of the Covered Agreement that also must be met before an EU reinsurer is permitted to eliminate reinsurance collateral, including meeting minimum capital and surplus requirements of $250 million, 100% SCR, consent to the jurisdiction of the courts, service of process requirements, filing of audited financial statements, actuarial opinions, list of all disputed and overdue claims, information on prompt payment of claims, etc. Therefore, the Task Force made the determination that Section 2F(7) should remain, as follows: "Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection, and only with respect to losses incurred and reserves reported on or after the later of **(i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein** [emphasis added], and (ii) the effective date of the new reinsurance agreement, amendment, or renewal."

- **Foreign Currency Exchange**. Section 9C(2)(c), Section 9C(6)(b) and Section 9C(6)(c) of Model #786 in the initial June 21, 2018, exposure draft contained a reference to foreign currency exchange rates to calculate the $250 million capital and surplus requirement for EU reinsurers under Article 3(4)(a) of the Covered Agreement. The European Commission commented that a reference to foreign currency exchange rates was not necessary with respect to EU reinsurers, because the Covered Agreement made 226 million euros equivalent to $250 million for these purposes. The drafting group disagreed with this interpretation, but it removed the reference in the May 1, 2019, exposure draft of Model #786, because commissioners are already utilizing foreign currency exchange rates in the calculation of minimum capital and surplus with respect to certified reinsurers licensed and domiciled in qualified jurisdictions.

- **Service of Process**. Section 2F(1)(d)(ii) of the Sept. 25, 2018, draft to Model #785 provided: "The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. Either by law, regulation or request of the commissioner, such consent shall be included in each reinsurance agreement." The European Commission commented that Article 3(4)(e) of the Covered Agreement provides that "where applicable for 'service of process' purposes, the assuming reinsurer provides written confirmation to the Host supervisory authority of consent to the appointment of that supervisory authority as agent for service of process. The Host supervisory authority may require that such consent be provided to it and included in each reinsurance agreement under its jurisdiction." This section was amended in the March 7, 2019, exposure draft to be consistent with the Covered Agreement: "The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement."

- **Insolvency of U.S. Ceding Insurer**. The June 21, 2018, exposure of Model #785 contained the following provision: "The **commissioner shall require** [emphasis added] an assuming insurer under this subsection to post one hundred percent (100%) security, for the benefit of the ceding insurer or its estate, upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer." Interested parties noted that Article 3(4)(k) of the Covered Agreement instead provides: "if subject to a legal process of resolution, receivership, or winding-up proceedings as applicable, **the ceding insurer, or its representative,** [emphasis added] may seek and, if determined appropriate by the court in which the resolution, receivership, or winding-up proceedings is pending, **may obtain an order** [emphasis added] requiring that the assuming reinsurer post collateral for all outstanding ceded liabilities." The Task Force agreed that the Covered Agreement required the ceding insurer or its representative to seek such an order from the

court, not the insurance commissioner, and amended Section 9H of Model #786 in the March 7, 2019, exposure draft accordingly.

- **Audited Financial Statements for Certified Reinsurers**. At the request of the European Commission, the drafting group and Reinsurance (E) Task Force amended Section 8B(4)(h) and Section 8B(7)(d) of Model #786 to require the filing of annual financial statements for certified reinsurers consistent with the requirements of Article 3(4)(h) of the Covered Agreement; i.e., two years of audited financial statements filed with the assuming insurer's supervisor. This makes the certified reinsurer provisions consistent with Article 3(4)(h)(i) of the Covered Agreement.

- **Passporting Process**. Section 9C(5) of the June 21, 2018, draft of Model #786 provided that the assuming insurer "must provide the following documentation to the commissioner." The European Commission noted that Article 3(4)(h) of the Covered Agreement provides that this information must only be provided "if requested by that supervisory authority." The Task Force amended Section 9C(5) in the March 7, 2019, exposure draft to be consistent with the language of the Covered Agreement, but it added a drafting note encouraging the states to utilize the "passporting" process under which the commissioner has the discretion to defer to another state's determination with respect to compliance. In order to facilitate the passporting process, the states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) so that other states may rely on the lead state's determination.

- **Serious Noncompliance**. Section 9C(4)(a) of the Sept. 25, 2018, draft of Model #786 provided a definition for "serious noncompliance with applicable law" in order to promote uniformity among the states and provide guidance to reciprocal jurisdiction reinsurers. Interested parties noted that Article 3(4)(c)(ii) of the Covered Agreement does not contain a definition of "serious noncompliance," and, as such, the drafting group and the Reinsurance (E) Task Force deleted this definition in the March 7, 2019, exposure draft due to perceived inconsistency with the Covered Agreement.

- **Solvent Schemes of Arrangement**. The Nov. 9, 2018, exposure draft of Model #785 deleted the definition of "solvent scheme of arrangement" from Section 2F(1)(d)(v), but it retained it in Section 9C(4)(e) of Model #786. Interested parties recommended that the Reinsurance (E) Task Force should clarify that the requirements with respect to solvent schemes also apply to Part VII-like transfers under UK law, and U.S. state insurance regulators should treat Part VII transfers the same as solvent schemes of arrangement. Interested parties argued that Part VII transfers should not be treated differently than a solvent scheme for the purposes of triggering the posting of 100% collateral because a Part VII transfer typically produces the same result to ceding insurers as a commutation in that a Part VII transfer typically involves a transfer of assumed business by an assuming reinsurer to another reinsurer that: 1) does not write new business; 2) does not have access to additional capital; and 3) does not have the intent or ability to raise additional capital, if necessary, to satisfy all remaining assumed obligations. The drafting group and the Task Force determined not to make this clarification, and Part VII-like transfers are not intended to be solvent schemes of arrangement for the purposes of this provision.

- **Reciprocal Jurisdiction Process**. The Reinsurance (E) Task Force added a drafting note after Section 9D of Model #786 at the request of interested parties to address the process with respect to the revocation or suspension of the status of a reciprocal jurisdiction. Interested parties requested that the process specifically be included in either Model #785 or Model #786, but the drafting group determined that this process should be developed after adoption of the revisions to the models. The drafting group also added a provision to the drafting note in the March 7, 2019, exposure draft that "such process would not conflict with the terms of an in-force covered agreement" to clarify that such jurisdictions are automatically included on the NAIC List of Reciprocal Jurisdictions.

- **Other Inconsistencies with the Covered Agreement**. Throughout the exposure process, interested parties made numerous comments about perceived inconsistencies between the language of the Covered Agreement and the exposure drafts of Model #785 and Model #786. The drafting group and the Reinsurance (E) Task Force have made every attempt to conform the language of Model #785 and Model #786 to the specific language utilized by the Covered Agreement.

- **Material Adverse Development Coverage**. Interested parties commented that Section 2F(7) of Model #785 (Effective Date) does not account for certain agreements entered into in contemplation of some long-tail losses, such as adverse development covers that are signed after losses occur, but before the reserves have developed to be within the limits of the adverse development cover. This could have the unintended consequence of excluding adverse development coverage contracts from application of the reciprocal jurisdiction provisions. Tying the application of reciprocal status requirements to only those "losses incurred" after reciprocal status may negatively impact loss portfolio transfers and adverse development covers. The drafting group recognized the value of such reinsurance as a useful regulatory and commercial tool to facilitate the transfer of blocks of business and rehabilitate financially distressed companies, and discussed various options in addressing this issue, but ultimately it was unable to agree upon specific language satisfactory to everyone. In addition, there were some concerns expressed with providing the commissioner additional discretion in this area. Therefore, the Task Force does not take a position on whether material adverse development coverage agreements are or should be subject to reduced collateral authorized by the changes to the model law.

- **Kroll Bond Rating Agency**. On Dec. 3, 2017, the Reinsurance (E) Task Force adopted the recommendation that the states may consider Kroll Bond Rating Agency as an acceptable rating agency for certified reinsurer purposes, and the Task Force adopted the *Uniform Application Checklist for Certified Reinsurers* with the additional language, stating that it be "recognized by the SEC to provide financial strength ratings on insurance companies" and included the proposed matrix of ratings and collateral levels for use with Kroll Bond Rating Agency. However, the Task Force could not agree on language to amend the ratings matrix found in Section 8B of Model #786 to include Kroll Bond Rating Agency.

7. Any Other Important Information (e.g., amending an accreditation standard)

The Reinsurance (E) Task Force has not had formal discussions with respect to whether the current *Reinsurance Ceded* accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #785 and/or Model #786. However, these revisions would have the effect of eliminating reinsurance collateral with respect to reinsurers domiciled in reciprocal jurisdictions, so, at a minimum, it will be necessary to amend the accreditation standards to reflect these revisions with respect to *Reinsurance Ceded to Certified Reinsurers*, which reduce but do not completely eliminate reinsurance collateral. In addition, it is further the recommendation of the Task Force that it is necessary to expeditiously modify these standards in accordance with the *Procedure for the Adoption of Additional Model Laws, Regulations or Standards for Accreditation*. This waiver in procedure is necessary because the states are expected to immediately begin considering these revisions for enactment into state law and regulation due to the 60-month (five-year) period in which the states are required to enact the revisions to in order to be consistent with the Covered Agreement or face potential federal preemption.

The Task Force has not determined whether these revisions should result in an "optional" accreditation standard or a "uniform" accreditation standard. The NAIC originally adopted the significant elements of the 2011 revisions to Model #785 and Model #786 as an "optional" accreditation standard. Specifically, under this optional standard, a state was not required to enact the certified reinsurer revisions to the models, but if it chose to reduce its reinsurance collateral requirements, the state's laws and regulations must be substantially similar to the key elements of the revisions. Upon further review and consultation with state insurance regulators and interested parties, the Financial Regulation Standards and Accreditation (F) Committee determined that the certified reinsurer provisions result in increased financial solvency regulation and increased consumer protection to policyholders, and they should be adopted as a "uniform" standard applicable to all NAIC-accredited jurisdictions under the "substantially similar" definition. The 2019 revisions to Model #785 and Model #786 could be considered under either an "optional" or a "uniform" accreditation standard.

Finally, the Task Force should consider whether to make the "passporting" process subject to the *Part B: Regulatory Practices and Procedures* accreditation standards. Generally, models are incorporated into the *Part A: Laws and Regulations* accreditation standards, but the NAIC's passporting process is not specifically required in Model #785 and/or Model #786. Model #786 does contain the following drafting note found after Section 9C(5):

> **Drafting Note:** In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called "passporting" under which the commissioner has the discretion to defer to another state's determination with respect to compliance with this Section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. It is anticipated that "lead" states will uniformly

require assuming insurers to provide the documentation described in Section 9C(5) of this regulation, so that other states may rely upon the lead state's determination.

The Task Force should consider whether the passporting process should become part of the Part B accreditation requirements and require states to participate in passporting consistent with the guidance provided in the drafting note.

PROJECT HISTORY - 2016

CREDIT FOR REINSURANCE MODEL LAW (#785)

This memorandum will discuss the background and history of the changes proposed to the NAIC *Credit for Reinsurance Model Law* (#785). To provide a more complete picture as to why changes to Model #785 are needed, this memorandum will also provide an overview of the captive reinsurance finance issues that prompted a regulatory response, the framework adopted by the NAIC to respond to those issues, the development and adoption of Actuarial Guideline XLVIII (AG 48) to implement the framework, and the status of a new NAIC regulation being developed to replace AG 48. In summary, the revisions to Model #785 are designed to provide commissioners with the specific authority to adopt the new model regulation being developed to replace AG 48.

1. Description of the Project, Issues Addressed, etc.

The NAIC Principle-Based Reserving Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. This Task Force was also charged with further assessing, and making recommendations regarding, the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013 NAIC White Paper of the Captives and Special Purpose Vehicle Use (E) Subgroup of the Financial Condition (E) Committee. On its June 30, 2014 conference call, this Task Force adopted the recommendations in the report of Rector & Associates, Inc. dated June 4, 2014, regarding a proposal for an XXX/AXXX Reinsurance Framework (Framework). This Framework sought to address concerns regarding reserve financing transactions and to do so without encouraging them to move off-shore. The changes would be prospective and apply only to the XXX term life insurance business and AXXX universal life with secondary guarantees (ULSG) business; i.e., the Framework applies only to reinsurance involving XXX and AXXX policies required to be valued under Sections 6 or 7 of the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830). The Framework would not change the statutory reserve requirements applicable to a ceding insurer; rather, the Framework addresses the types of security that can back those reserves in connection with reserve financing transactions.

The Framework does not materially change the ability of insurers to obtain credit for reinsurance ceded to "certified" reinsurers or to obtain credit for reinsurance ceded to "licensed" or "accredited" reinsurers that follow statutory accounting and RBC rules. As a practical matter, the Framework requirements apply to reinsurance ceded to captive insurers, special purpose vehicles, reinsurers that are not eligible to become "certified" reinsurers, or reinsurers that materially deviate from statutory accounting and/or RBC rules. In those situations, the ceding insurer may receive credit for reinsurance if:

- The ceding insurer establishes gross reserves, in full, using applicable reserving guidance (currently, the "formulaic" approach under the Standard Valuation Law);
- Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis;
- Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held are held by or on behalf of the ceding insurer as security under the reinsurance contract;
- At least one party to the financing transaction holds an appropriate RBC "cushion;" and
- The reinsurance arrangement is approved by the ceding insurer's domestic regulator.

The NAIC Executive (EX) Committee adopted the Framework (in concept) on August 17, 2014. As an interim step to implementing the Framework, the NAIC adopted Actuarial Guideline XLVIII *Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830)* (AG 48) on December 16, 2014. Expectation was that AG 48 would eventually be replaced by effective codification through the *Credit for Reinsurance Model Law* (#785) and creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies. The Reinsurance (E) Task Force and Financial Condition (E) Committee will meet on a joint conference call on January 6, 2016, and will consider adoption of revisions to Model #785 to give the Commissioner authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework. At some future date, both the revisions to Model #785 and new model regulation (once approved by the NAIC) are intended to be adopted by the NAIC as a new accreditation standard.

2. Name of Group Responsible for Drafting the Model and States Participating

Reinsurance (E) Task Force: Missouri (Chair), California (Vice Chair), Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Utah, Virginia, Washington and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

On June 30, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted the XXX/AXXX Reinsurance Framework in concept, and adopted draft charges to the Reinsurance (E) Task Force with respect to implementation of the Framework. On August 17, 2014, the Executive (EX) Committee adopted the following charges to the Reinsurance (E) Task Force and a request for model law development with respect to these charges:

- Request permission from the Executive (EX) Committee to create a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies. The Principle-Based Reserving Implementation (EX) Task Force's XXX/AXXX Reinsurance Framework Exhibit 4 should be considered for this model regulation, modified as deemed appropriate by the Task Force.—*Essential*

- Request permission from the Executive (EX) Committee to amend the *Credit for Reinsurance Model Law* (#785) and draft the amendments to reference the new model regulation drafted in accordance with the previous charge.—*Essential*

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

On a conference call on October 29, 2014, the Reinsurance (E) Task Force created the XXX/AXXX Model Regulation Drafting Group, which is an informal drafting group composed of members of the Task Force tasked with developing an initial draft of a model regulation incorporating the provisions of proposed AG 48 for discussion and consideration by the Task Force. The members of the Drafting Group were Doug Stolte (VA), Chair; John Finston and Monica Macaluso (CA); Kathy Belfi (CT); Linda Sizemore, David Lonchar and Steve Kinion (DE); Robert Wake (ME); John Rehagen (MO); Justin C. Schrader (NE); Richard Schlesinger (NJ); Mike Maffei (NY); and David Provost (VT). On that call, Director Huff directed the Drafting Group to refrain from beginning any drafting on the model regulation until the Principle-Based Reserving Implementation (EX) Task Force had finished its work on AG 48. Once this Task Force has completed its work on AG 48, the Drafting Group could determine whether it believes that any changes to the AG 48 approach should be made in the model regulation. If the Drafting Group is of the opinion that any substantive modifications should to be made to the AG 48 approach as it finalizes the model regulation, it should submit these proposed changes back to the Principle-Based Reserving Implementation (EX) Task Force for further guidance. The overall objective is to implement the AG 48 approach unless there are significant issues with respect to this implementation.

The Drafting Group met via conference call in regulator-to-regulator session on Oct. 14, 2014, and then again on March 10, March 23, April 21, May 11, June 23, June 24, July 14, and Oct. 23, 2015. The Drafting Group, with assistance from Rector and Associates and NAIC staff, reviewed, discussed and drafted a proposed draft XXX/AXXX Model Regulation and proposed revisions to Model #785, which were presented to the Task Force at the 2015 Summer National Meeting.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

As previously noted, AG 48 will be the basis for the new regulation currently being drafted, and provides the detail for what will ultimately be included in the new regulation. AG 48 went through its own separate public drafting process, with multiple exposure periods, public hearings and opportunities for the NAIC to receive public comment from industry, consumers, legislators and regulators. A general description of this due process will be found in the Project History for AG 48. The revisions to Model #785 will provide commissioners with the authority to adopt the new regulation that is based on AG 48.

At the 2015 Summer National Meeting, the Reinsurance (E) Task Force exposed a draft XXX/AXXX Model Regulation, revisions to Model #785 (Options 1 & 2), and a July 28 memorandum from NAIC staff listing key discussion topics that were identified during the drafting process for a 45-day public comment period ending Sept. 30, 2015. The Task Force received 17 comment letters, and a note from NAIC staff on the applicability of regulation on policies issued prior to adoption of Model #830. The Task Force met again via conference call on Oct. 26 to discuss the comment letters received, and agreed to expose a

new Option 3 of the proposed revisions to Model #785 for a comment period ending Nov. 11, 2015. The Task Force received 7 comment letters from regulators and interested parties.

At the Fall National Meeting, the Task Force discussed Options 1, 2 & 3 to Model #785, and voted to expose five options of the proposed revisions to Model #785 for a public comment period ending Dec. 6, 2015. These five options can be summarized, as follows: 1) Option 1, which would limit the scope of commissioner authority to adopt regulations with respect to XXX/AXXX transactions; 2) Option 2, which would provide commissioner authority to adopt regulations with respect to variable annuities, long-term care and XXX/AXXX captive reinsurance transactions; 3) Option 3, which incorporates language suggested and comments received from New York Life and the American Insurance Association (AIA) and is broader in scope than either Option 1 or Option 2, as it would provide the commissioner with the authority to adopt regulations in connection with particular types of reinsurance arrangements, or may specify by regulation that credit will be reduced or eliminated in connection with particular types of reinsurance arrangements. In addition, Option 3 clarifies that these revisions were not intended to impact P/C reinsurers; 4) New York Life's modified Option 2, which covers the same types of policies as Option 2 (i.e., XXX/AXXX, long term care and variable annuities), and in addition covers any other product for which the NAIC develops a model regulation related to Model #785; and 5) the American Council of Life Insurer's (ACLI) modified Option 2 that incorporates an exemption for professional reinsurers if they meet specific requirements, which includes maintaining, at minimum, $250 million in capital and surplus determined in accordance with statutory accounting principles, without deviation, and is licensed in at least 26 states, or licensed and accredited in at least 35 states with a minimum of 10 licenses.

The Task Force received 7 comment letters, and discussed these along with the 5 proposed options for revisions to Model #785 on its conference call on Dec. 9, 2015. The Task Force directed NAIC to re-expose the revisions to Model #785 with comments due by Dec. 31. The Task Force further directed NAIC staff to draft these revisions made in accordance with the following determinations made on the call: 1) Option 4, which was New York Life's modified Option 2; 2) correct the "flaw" issue identified by the ACLI, that in specifically referencing Model #830, Actuarial Guideline 43, and the *Health Insurance Reserves Model Regulation* (#10) to define the scope of the policies covered, these changes to Model #785 would cease to have any effect after Principle-Based Reserving goes into effect, because those reserving requirements sunset for new business after the PBR Valuation Manual becomes operative; 3) professional reinsurer exemption should be included in Model #785, and not just in the new XXX/AXXX model regulation; and 4) AG 48 "grandfather" provision should also be included in Model #785, and not just the model regulation. Two updated revisions containing these changes were exposed for public comment on Dec. 15, 2015, the first document containing these revisions in Section 2 & 3 of Model #785, with the second document containing these revisions in Sections 2, 3 & 5 (Rules and Regulations) of Model #785. The Task Force has scheduled a joint conference call with the Financial Condition (E) Committee on January 6, 2016, to consider the exposed revisions to Model #785 for adoption, with the Executive (EX) Committee and NAIC Plenary to consider the revisions for final approval on a conference call scheduled for January 8, 2016.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The following significant issues were discussed extensively with regulators and interested parties during the process:

- **Consequence Options for Non-Compliance with the XXX/AXXX Model Regulation.** The Drafting Group members proposed several potential credit for reinsurance "consequences" for ceding insurers that have a shortfall in either Primary Security or Other Security. These options include: 1) All or Nothing; 2) Dollar for Dollar Reduction in Credit for Reinsurance for any shortfall; 3) Percentage reduction in Credit for Reinsurance for any shortfall and 4) Primary Security limitation, which would allow credit for reinsurance up to the amount of Primary Security held. At the 2015 Summer National Meeting, the Drafting Group advised the Reinsurance (E) Task Force that it decided to draft Sections 7(A)(3) and 7(A)(4) of the Model Regulation under the all or nothing option, but the Task Force encouraged regulators and interested parties to review the four consequence options with respect to the Model Regulation and provide any comments or suggested language.

- **Scope of Authority.** The scope of the authority to be provided to the commissioner to adopt model regulations under Model 785, whether it is limited in nature to specific types of policies, or whether it is broad enough to permit regulation of other types of policies. These are exposure documents Options 1—5 described above. The Task Force decided upon Option 4, New York Life's modified Option 2, which covers the same types of policies as Option 2 (i.e., XXX/AXXX, long term care and variable annuities), and in addition covers any other product for which the NAIC develops a model regulation related to Model #785.

- **ACLI Issue.** In specifically referencing Model #830, Actuarial Guideline 43, and the *Health Insurance Reserves Model Regulation* (#10) to define the scope of the policies covered, these changes to Model #785 would cease to have any effect after Principle-Based Reserving goes into effect, because those reserving requirements sunset for new business after the PBR Valuation Manual becomes operative. Specifically, the ACLI recommended referencing these types of policies, as follows: "in connection with reinsurance arrangements pertaining to certain term insurance policies, universal life insurance policies with secondary guarantees, variable annuities with guaranteed death and/or living benefits, and long term care insurance policies." The Task Force agreed with this recommendation, in modified form.

- **Professional Reinsurer Exemption.** The draft XXX/AXXX Model Regulation currently provides for exemptions for certain reinsurers under Section 4, which includes an exemption for reinsurers that do not have a permitted practice under the NAIC *Accounting Practices and Procedures Manual*. The ACLI proposed alternative language for either the model that would permit an exemption for reinsurers that 1) maintain at least $250 million in capital and surplus determined in accordance with statutory accounting principles, without deviation; and 2) is licensed in at least 26 states; or Licensed or accredited in at least 35 states with a minimum of ten licenses. The Task Force agreed with this recommendation, in modified form.

- **AG 48 Grandfathering Provision.** The ACLI recommended that a "grandfathering" provision similar to that found in AG 48 be included in the model law, because they believe that it is necessary to give the commissioner specific authority to adopt a regulation that contains some limited retroactive application. Currently, AG 48 does not apply to XXX/AXXX policies "that were both (1) issued prior to 1/1/2015 and (2) ceded so that they were part of a reinsurance arrangement, as of 12/31/2014, that would not qualify for exemption as described in Section 3 of this Actuarial Guideline." In addition, AG 48 has a Sunset provision to the effect that AG 48 "shall cease to apply as to ceding insurers domiciled in a jurisdiction that has in effect, as of January 1st of the calendar year immediately preceding the year in which the actuarial opinion is to be filed, a law and regulation substantially similar to the amendment to the Credit for Reinsurance Model Law and new Model Regulation adopted by the NAIC pursuant to Recommendation #5 of the June 2014 Rector Report." The Task Force agreed with this recommendation, in modified form.

- **Objections by Delaware and Captive Insurance Industry.** Delaware and many interested parties in the captive insurance industry opposed Option 3 with respect to the scope of authority, stating that the captive insurance industry is concerned with the impact these revisions will have not only on life insurance captives, but also all kinds of captives that the commissioner may deem to be classified as a particular type of reinsurance arrangement. In addition, Delaware has consistently asked for consideration to be given to the impact these actions have on consumers, specifically the impact to the cost of insurance.

7. Any Other Important Information (e.g., amending an accreditation standard).

The revisions to Model #785, if adopted, would be considered by the Financial Regulation Standards and Accreditation (F) Committee as an amendment to the existing standard for Reinsurance Ceded. In addition, it is intended under the XXX/AXXX Reinsurance Framework that these revisions, in addition to the proposed XX/AXXX model regulation, would become an accreditation standard.

PROJECT HISTORY - 2011

CREDIT FOR REINSURANCE MODEL LAW (#785)

CREDIT OF REINSURANCE MODEL REGULATION (#786)

1. Description of the Project, Issues Addressed, etc.

Under the current NAIC Credit for Reinsurance Model Law & Regulation, in order for U.S. ceding companies to receive reinsurance credit, the reinsurance must either be ceded to U.S. licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. The collateral requirements for non-U.S. licensed reinsurers have been a frequent subject of debate over the past decade, with various groups calling for the elimination of the collateral requirement for reinsurers licensed in well-regulated jurisdictions. On September 19, 2011, both the Reinsurance (E) Task Force and Financial Condition (E) Committee adopted revisions to the *Credit for Reinsurance Model Law* (#785) *and Regulation* (#786) at a meeting held in Jersey City, New Jersey. These amendments will act to reduce reinsurance collateral requirements for non-U.S. reinsurers domiciled in qualified jurisdictions, and will be up for consideration by NAIC Executive (EX) Committee and Plenary at the Fall National Meeting in Washington, D.C.

2. Name of Group Responsible for Drafting the Model and States Participating

The Reinsurance Task Force of the Financial Condition (E) Committee was responsible for drafting the revisions to the Credit for Reinsurance Models:

Thomas B. Considine, Chair	New Jersey	John M. Huff	Missouri
James J. Wrynn, Vice Chair	New York	Bruce R. Ramge	Nebraska
Jim L. Ridling	Alabama	Amy Parks	Nevada
Christina Urias	Arizona	Roger A. Sevigny	New Hampshire
Jay Bradford	Arkansas	John G. Franchini	New Mexico
Dave Jones	California	John D. Doak	Oklahoma
Thomas B. Leonardi	Connecticut	Michael F. Consedine	Pennsylvania
Karen Weldin Stewart	Delaware	Ramón Cruz-Colón	Puerto Rico
Kevin M. McCarty	Florida	Joseph Torti III	Rhode Island
Gordon I. Ito	Hawaii	David Black	South Carolina
Jack Messmore	Illinois	Neal T. Gooch	Utah
Stephen W. Robertson	Indiana	Stephen W. Kimbell	Vermont
James J. Donelon	Louisiana	Jacqueline K. Cunningham	Virginia
Eric A. Cioppa	Maine	Mike Kreidler	Washington
Mike Rothman	Minnesota	Ted Nickel	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

This Project History supplements the Project History for the Reinsurance Regulatory Modernization Framework, which is attached hereto and incorporated by reference. The Task Force received charges in both 2009 and 2010 to "promote and facilitate the implementation of the adopted Reinsurance Regulatory Modernization Framework." The project was specifically authorized in 2011 when the Task Force received the following charge: "Consider amendments to the *Credit for Reinsurance Model Law* (#785) *and Credit for Reinsurance Model Regulation* (#786) to incorporate key elements of the Reinsurance Regulatory Modernization Framework." The Executive (EX) Committee approved the model law request for revising the Model #785 and Model #786 at the 2010 Fall National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The NAIC adopted the Reinsurance Regulatory Modernization Framework ("Framework") at its Winter 2008 National Meeting as the first step in an effort to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. The Framework recommended implementation through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation of this legislation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation.

On September 15, 2009, the Reinsurance Task Force adopted the Reinsurance Regulatory Modernization Act of 2009, which was approved on September 23, 2009, by the NAIC Government Relations Leadership Council. This proposed federal legislation was based on the Framework, and underwent an extensive review process. The Task Force released drafts of the proposed federal legislation to the public on March 24, July 27 & September 3, 2009, and the legislation was extensively revised based upon comments received from regulators and interested parties. The Task Force also held an open forum in New York on May 6-7, 2009, to receive public comments on the legislation, in addition to the numerous opportunities for public comment that were afforded during the drafting of the Framework.

The NAIC was unable to find a sponsor for the federal legislation in Congress, and it did not receive passage. Instead, Congress enacted the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, which was signed into law on July 21, 2010. This act includes the Nonadmitted and Reinsurance Reform Act ("NRRA"), as well as creates the Federal Insurance Office ("FIO"). The NRRA prohibits a state from denying credit for reinsurance if the domiciliary state of the ceding insurer recognizes such credit and is either (1) an NAIC-accredited state; or (2) has financial solvency requirements substantially similar to NAIC accreditation requirements. This permitted the NAIC to move forward with individual state-based reinsurance collateral reduction reforms.

The revisions to the Credit for Reinsurance Models were drafted by the Task Force through a deliberate process that included two exposure periods and consideration of voluminous comments submitted by interested parties representing U.S. ceding insurers, non-U.S. reinsurers and regulators. Much of the actual drafting of the language within the proposal was undertaken during regulator-to-regulator sessions due to discussion of company specific information and consultation with NAIC staff. The Task Force considered comments from interested parties related to each of these exposure drafts in order to further develop and refine the revisions. In many cases, specific concepts or specific language recommended by interested parties has been included within the revisions, as deemed appropriate by the Task Force. In addition, the Task Force considered information that it received from various international regulators.

The Reinsurance Task Force further adopted a Preface to the Credit for Reinsurance Models on September 19, 2011. The Preface is a statement by the Task Force of the next steps to be taken after the adoption of the revised models, including (1) a proposal to form a new group to provide high quality review of reinsurance collateral reduction applications and assistance to the states; (2) consider reinsurance diversification and notification requirements for ceding insurers; (3) requirements for NAIC review and approval of qualified jurisdiction; and (4) a re-examination of the collateral requirements within two years after the effective date of the revised Credit for Reinsurance Models.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

On February 22, 2011, the Task Force released exposure drafts of revisions to Model #785 and Model #786 for a 30-day comment period. The Task Force received several comment letters from interested parties and discussed these drafts on March 26 during the Spring National Meeting in Austin, Texas. The Task Force then held an interim meeting in Jersey City, New Jersey on July 11 and took public testimony from interested parties on the proposed amendments. On July 26, the Task Force released a second set of proposed amendments to the Credit for Reinsurance Models, which were exposed for a 30-day public comment period ending on August 24. The Task Force and Financial Condition (E) Committee adopted these drafts at a meeting in Jersey City, New Jersey on September 19, with additional amendments made during each meeting (discussion following). Some of the major revisions to the models include:

- Each state will have the authority to certify reinsurers, or a commissioner has the authority to recognize the certification issued by another NAIC-accredited state. This eliminates the need for a reinsurer to be evaluated by each and every state, but preserves a commissioner's right to do so.

- Reinsurers are subject to certain criteria in order to be eligible for certification, as well as ongoing requirements in order to maintain certification. Examples of evaluation criteria include, but are not limited to, financial strength, timely claims payment history, and the requirement that a reinsurer be domiciled and licensed in a "qualified jurisdiction."

- Each state may evaluate a non-U.S. jurisdiction in order to determine if it is a "qualified jurisdiction." The state may also defer to an NAIC list of recommended qualified jurisdictions.

- A certified reinsurer will be eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification [Note: clarification added in September 19 amendments]. A state will evaluate a reinsurer that applies for certification, and will assign a rating based on the evaluation. A certified reinsurer will be required to post collateral in an amount that corresponds with its assigned rating (0%, 10%, 20%, 50%, 75% or 100%), in order for a U.S. ceding insurer to be allowed full credit for the reinsurance ceded. Note: in the July 26 revisions, the collateral/rating matrix was changed with regard to companies with A- financial strength ratings, and a new Secure 4 tier was added for A- rating at 50% collateral.

- A certified reinsurer is allowed to utilize a multiple-beneficiary trust account for the purposes of securing its obligations to U.S. ceding insurers, but it must be separate from any existing multiple-beneficiary trust account.

- Proportional credit will still be permitted if there is insufficient security provided by a certified reinsurer. Specific provisions are also included to address a change in, or revocation of, the certified reinsurer's status.

- Contracts entered into by certified reinsurers are subject to certain mandatory contract clauses in order for a U.S. ceding insurer to be allowed credit for the reinsurance ceded.

- Certified reinsurers are subject to additional filing requirements, including but not limited to new forms CR-1, CR-F and CR-S.

- The revised models also include proposed changes with respect to the trusteed surplus requirement for a multiple-beneficiary trust account maintained by an assuming insurer in run-off (Tawa proposal).

- Finally, technical amendments were incorporated into the models revising language that had grown outdated and needed updating.

On September 19, 2011, both the Task Force and Financial Condition (E) Committee adopted additional revisions to the Credit for Reinsurance Models, but the amendments made during this meeting were not exposed for a public comment period. However, each of the revisions addressed issues that had been substantively debated by both the Task Force and interested parties over the previous years during discussions regarding the Framework and proposed federal legislation, as well as the revisions to the models. These revisions can be summarized as follows:

- Prospective Application. The Task Force adopted an amendment intended for clarification and to close a perceived loophole with respect to the effective date of the revised reinsurance collateral requirements, and to confirm that any potential collateral reductions would be phased-in as any future reductions would be done on a prospective basis and any prior liabilities would remain secured at 100% collateral.

- PCI/RAA Compromise. The Task Force adopted amendments related to a compromise proposal submitted by the Property Casualty Insurers Association of America ("PCI") and the Reinsurance Association of America ("RAA") regarding 4 important issues: (1) 30-day comment period on application for certified reinsurer status; (2) slow payment analysis of reinsurers; (3) financial statement reporting requirements for certified reinsurers and applicants for certification; and (4) disclosure of reinsurance counterparty information on new forms CR-S and CR-F. The specific amendments adopted as part of the PCI/RAA compromise include.

    1. Information will be provided with respect to how interested parties may specifically respond/comment on applications for certified reinsurers during a 30-day notice period. However, this should not trigger any Administrative Procedures Act requirements;

    2. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements will now be based specifically on an analysis of cedents' Schedule F reporting of overdue reinsurance recoverables, and may increase collateral requirements in certain specified situations;

3. Certified Reinsurers must submit audited financial statements, and, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company are acceptable;

4. Certified reinsurers must submit Forms CR-S or CR-F, at a level of detail in accordance with instructions to be developed by the NAIC.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

- Federal v. State Implementation. The Framework recommended implementation through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation of this legislation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation. The NAIC was unable to find congressional sponsorship for this proposed federal legislation. The Nonadmitted and Reinsurance Reform Act, which became effective July 21, 2011, preempts the extraterritorial application of state credit for reinsurance law, and now permits states to proceed forward with reinsurance collateral reforms on an individual basis if they are accredited.

- Federal Insurance Office. The Dodd-Frank Act established the FIO to receive information on the insurance sector from the NAIC and enter into binding "covered agreements" with international bodies. It is widely understood that reinsurance collateral may be an initial subject of these agreements. The Dodd Frank Act allows the office in Treasury to preempt a state insurance measure to the extent that it (1) results in less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a covered agreement than a U.S. insurer domiciled, licensed, admitted, or otherwise authorized in that state; and (2) is inconsistent with such covered agreement.

- Individual State Initiatives. Some states have begun moving forward with individual state-based reinsurance collateral reforms. Florida adopted changes to its credit for reinsurance laws and regulations in 2007 and 2008 respectively, New York adopted similar changes in November 2010, and New Jersey and Indiana recently enacted similar legislation as well. In addition, bills have been discussed in Illinois, Texas and Louisiana, as well as other states. In response, the NAIC Plenary approved the Recommendations Regarding Key Elements of the Reinsurance Framework for Accreditation Purposes in December 2010.

- Requirements for Certified Reinsurers. The Task Force addressed what requirements an assuming insurer must meet in order to be approved as a certified reinsurer, and the specific information that certified reinsurers should be required to file, including questions regarding proposed schedules CR-F and CR-S as well as financial statements.

- Reciprocity. The NAIC Reinsurance Supervision Review Department (RSRD) Proposal in 2007 proposed a mutual recognition framework that would take into consideration the reciprocal treatment of non-U.S. jurisdictions. At the request of interested parties, the NAIC Legal Division issued a memorandum addressing the constitutional issues of the mutual recognition framework on July 15, 2008. The Framework adopted in December of 2008 provided that the reciprocal treatment of non-U.S. reinsurers would be a factor to be considered in the review of non-U.S. jurisdictions. The model regulation considers mutual recognition to be a factor in reviewing non-U.S. jurisdictions.

- Concentration of Risk. The Task Force considered restrictions to limit concentration risk by a ceding insurer to any reinsurer or group of reinsurers. The Task Force will make a referral to E Committee to address this issue.

- Life Reinsurance & Other Long Tail Contracts. The Task Force considered whether special limitations should be placed on life insurance and other longer tail-types of reinsurance agreements. The Reinsurance Framework Proposal originally included a 2-year moratorium on collateral reduction to life contracts, but the revised models no longer include this distinction.

- Reconciliation to U.S. GAAP. The Task Force considered the accounting and reporting basis that would be applicable to financial statements filed by certified reinsurers. Earlier versions of the models required financial statements to be filed on an audited U.S. GAAP basis, or on an IFRS basis with an audited reconciliation to U.S. GAAP for equity and net income. At the September 19 meetings, an amendment was adopted to allow audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company, with the permission of the state insurance commissioner.

- Prospective Application of Revisions. During the course of drafting the Framework and model revisions, the Task Force has consistently taken the position that any potential collateral reductions would be phased-in as any future reductions would be done on a prospective basis and any prior liabilities would remain secured at 100% collateral. Property and Casualty ceding insurers were strongly opposed to permitting reinsurance collateral under existing reinsurance agreements to be reduced or eliminated. Reinsurers and some ceding insurers would like to be able to amend existing agreements to reduce collateral requirements. At the September 19, 2011 meetings the Task Force adopted an amendment intended for clarification and to close a perceived loophole with respect to the effective date of the revised reinsurance collateral requirements.

7. Any Other Important Information (e.g., amending an accreditation standard).

In December 2010, the NAIC Plenary approved the Recommendations Regarding Key Elements of the Reinsurance Framework for Accreditation Purposes (Accreditation Recommendations), which are the key elements of the Reinsurance Regulatory Modernization Framework that should be considered in reviewing any individual state initiatives with respect to reinsurance collateral reduction reforms. The Accreditation Recommendations were intended as an interim solution to guide the Financial Regulation Standards and Accreditation (F) Committee and the NAIC during the transition period between adoption of the Framework and proposed revisions to the reinsurance models.

The revisions, if adopted, would become part of the Credit for Reinsurance Models, and would be considered by the Financial Regulation Standards and Accreditation (F) Committee as an amendment to the existing standard for Reinsurance Ceded. It should also be noted that the proposed revisions to the models would not require a state to reduce its reinsurance collateral requirements. It is further the recommendation of the Task Force that it is necessary to expeditiously modify these standards in accordance with the Procedure for the Adoption of Additional Model Laws, Regulations or Standards for Accreditation.

CREDIT FOR REINSURANCE MODEL REGULATION

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Section 1. Authority

This regulation is promulgated pursuant to the authority granted by Sections [insert applicable section number] and [insert applicable section number] of the Insurance Code.

Section 2. Purpose

The purpose of this regulation is to set forth rules and procedural requirements that the commissioner deems necessary to carry out the provisions of the [cite state law equivalent to the *Credit for Reinsurance Model Law* (#785)] (the Act). The actions and information required by this regulation are declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state.

Section 3. Severability

If any provision of this regulation, or the application of the provision to any person or circumstance, is held invalid, the remainder of the regulation, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 4. Credit for Reinsurance—Reinsurer Licensed in this State

Pursuant to Section [cite state law equivalent of Section 2A of the *Credit for Reinsurance Model Law* (#785)] the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in this state as of any date on which statutory financial statement credit for reinsurance is claimed.

Drafting Note: "Statutory financial statement" means quarterly, annual or other financial statements required by state law. The drafters conditioned the recognition of credit on matters reported, existing or occurring "as of any date on which" statutory financial statement credit is claimed or a financial statement is filed to ensure that requisite conditions for credit exist at the time the credit is claimed or reported and that the conditions remained satisfied at all times thereafter until information reported in one statement was replaced by information reported in a subsequently filed statement. Insurers are to satisfy requisite conditions at the time credit is first taken and shall maintain compliance at all times thereafter in which the credit is taken. The drafters believe the requirements to be perpetual, not periodic.

Section 5. Credit for Reinsurance—Accredited Reinsurers

A. Pursuant to Section [cite state law equivalent of Section 2B of the *Credit for Reinsurance Model Law* (#785)] the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in this state as of the date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer must:

(1) File a properly executed Form AR-1 (attached as an exhibit to this regulation) as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(2) File with the commissioner a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(3) File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

(4) Maintain a surplus as regards policyholders in an amount not less than $20,000,000, or obtain the affirmative approval of the commissioner upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

B. If the commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, the commissioner may upon written notice and opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this section if the assuming insurer's accreditation has been revoked by the commissioner, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the commissioner.

Section 6. Credit for Reinsurance—Reinsurer Domiciled in Another State

A. Pursuant to Section [cite state law equivalent to Section 2C of the *Credit for Reinsurance Model Law* (#785)] the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial statement credit for reinsurance is claimed:

(1) Is domiciled in (or, in the case of a U.S. branch of an alien assuming insurer, is entered through) a state that employs standards regarding credit for reinsurance substantially similar to those applicable under the Act and this regulation;

Drafting Note: This subsection is intended to apply to an assuming insurer domiciled in (or, in the case of the U.S. branch of an alien assuming insurer, entered through) another state only if the assuming insurer also is licensed in that state and is therefore subject to the application of the state's credit for reinsurance standards as the result of the imposition of licensure requirements and also regulatory oversight and examination as a domiciliary company.

(2) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(3) Files a properly executed Form AR-1 with the commissioner as evidence of its submission to this state's authority to examine its books and records.

B. The provisions of this section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this section, "substantially similar" standards means credit for reinsurance standards that the commissioner determines equal or exceed the standards of the Act and this regulation.

Section 7. Credit for Reinsurance—Reinsurers Maintaining Trust Funds

A. Pursuant to Section [cite state law equivalent to Section 2D of the *Credit for Reinsurance Model Law* (#785)] the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified U.S. financial institution as defined in Section [cite state law equivalent to Section 4B of the *Credit for Reinsurance Model Law* (#785)] of the Act, for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Paragraph (2) of this subsection.

(2) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

(3) (a) The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this regulation, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to these trusts, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.

(b) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the commissioner:

(i) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(ii) If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.

(4) (a) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and *Accounting Practices and Procedures Manual* of the NAIC) and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall:

(i) Consist of funds in trust in an amount not less than the assuming insurers' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;

(ii) Maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and

(iii) File a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.

(b) Within ninety (90) days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group.

C. (1) Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that:

(a) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States;

(b) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;

(c) The trust shall be subject to examination as determined by the commissioner;

(d) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and

(e) No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

(2) (a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

(c) If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

(d) The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

D. For purposes of this section, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include:

(1) For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:

(a) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;

(b) Reserves for losses reported and outstanding;

(c) Reserves for losses incurred but not reported;

(d) Reserves for allocated loss expenses; and

(e) Unearned premiums.

(2) For business ceded by domestic insurers authorized to write life, health and annuity insurance:

(a) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(b) Aggregate reserves for accident and health policies;

(c) Deposit funds and other liabilities without life or disability contingencies; and

(d) Liabilities for policy and contract claims.

E. Assets deposited in trusts established pursuant to [cite state law equivalent to Section 2 of the *Credit for Reinsurance Model Law* (#785)] and this section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in [cite state law equivalent of Section 4A of the *Credit for Reinsurance Model Law* (#785)], clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in [cite state law equivalent of Section 4A of the *Credit for Reinsurance Model Law* (#785)], and investments of the type specified in this subsection, but investments

in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under Paragraphs (1)(e), (3), (6)(b) or (7) of this subsection, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Section [cite state law equivalent to Section 2 of the *Credit for Reinsurance Model Law* (#785)] shall be invested only as follows:

(1) Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

(a) The United States or by any agency or instrumentality of the United States;

(b) A state of the United States;

(c) A territory, possession or other governmental unit of the United States;

(d) An agency or instrumentality of a governmental unit referred to in Subparagraphs (b) and (c) of this paragraph if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or

(e) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(2) Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(a) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(b) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

(c) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

(3) Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(4) An investment made pursuant to the provisions of Paragraph (1), (2) or (3) of this subsection shall be subject to the following additional limitations:

(a) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;

(b) An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

(c) The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and

(d) Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under Paragraphs (2)(a) and (2)(c) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

(5) As used in this regulation:

(a) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(i) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(I) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(II) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C. Sections 1709 and 1715b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C. Section 1703; or

(ii) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of Items (i)(I) and (i)(II) of this subsection;

(b) "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

(6) Equity interests

(a) Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:

(i) Its obligations and preferred shares, if any, are eligible as investments under this subsection; and

(ii) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent (1%) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;

(b) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:

(i) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(ii) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

(c) An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not exceed ten percent (10%) of the assets in the trust;

(7) Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

Drafting Note: Banks such as the International Bank for Reconstruction and Development, European Bank for Reconstruction and Development, Inter-American Development Bank, Asian Development Bank, African Development Bank, International Finance Corporation are intended to qualify under this section.

(8) Investment companies

(a) Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. § 80a, are permissible investments if the investment company:

(i) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under Paragraph (1), (2) or (3) of this subsection or invests in securities that are determined by the commissioner to be substantively similar to the types of securities set forth in Paragraph (1), (2) or (3) of this subsection; or

(ii) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under Paragraph (6)(a) of this subsection;

(b) Investments made by a trust in investment companies under this paragraph shall not exceed the following limitations:

(i) An investment in an investment company qualifying under Subparagraph (a)(i) of this paragraph shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust; and

(ii) Investments in an investment company qualifying under Subparagraph (a)(ii) of this paragraph shall not exceed five percent (5%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to Paragraph (6)(a) of this subsection.

(9) Letters of Credit

(a) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the commissioner), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(b) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

F. A specific security provided to a ceding insurer by an assuming insurer pursuant to Section 11 of this regulation shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section.

Section 8. Credit for Reinsurance—Certified Reinsurers

A. Pursuant to [cite state law equivalent of Section 2E of the *Credit for Reinsurance Model Law* (#785)], the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with the provisions of [cite state law equivalent of Section 2E and Section 3 of the *Credit for Reinsurance Model Law* (#785)] and 12, 13 or 14 of this regulation. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

(1)

Ratings	**Security Required**
Secure – 1	0%
Secure – 2	10%
Secure – 3	20%
Secure – 4	50%
Secure – 5	75%
Vulnerable – 6	100%

(2) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(3) The commissioner shall require the certified reinsurer to post one hundred percent (100%), for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

(4) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for

only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(a) Line 1: Fire
(b) Line 2: Allied Lines
(c) Line 3: Farmowners multiple peril
(d) Line 4: Homeowners multiple peril
(e) Line 5: Commercial multiple peril
(f) Line 9: Inland Marine
(g) Line 12: Earthquake
(h) Line 21: Auto physical damage

(5) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(6) Nothing in this section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

B. Certification Procedure.

(1) The commissioner shall post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

Drafting Note: States that do not wish to make the internet the required mechanism for providing public notice should modify this provision accordingly. This provision was intended to provide a less formal notice requirement than is typically called for under state Administrative Procedure Acts.

(2) The commissioner shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with Subsection A of this section. The commissioner shall publish a list of all certified reinsurers and their ratings.

(3) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the commissioner pursuant to Subsection C of this section.

(b) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with Subparagraph (4)(h) of this subsection. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(i) Standard & Poor's;
(ii) Moody's Investors Service;
(iii) Fitch Ratings;
(iv) A.M. Best Company; or
(v) Any other Nationally Recognized Statistical Rating Organization.

(d) The certified reinsurer must comply with any other requirements reasonably imposed by the commissioner.

(4) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(a) The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

Ratings	Best	S&P	Moody's	Fitch
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

(b) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

(c) For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

(d) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (attached as exhibits to this regulation);

(e) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(f) Regulatory actions against the certified reinsurer;

(g) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Subparagraph (h) below;

(h) For certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the commissioner will consider audited financial statements for the last two (2) years filed with its non-U.S. jurisdiction supervisor;

(i) The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;

(j) A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(k) Any other information deemed relevant by the commissioner.

(5) Based on the analysis conducted under Subparagraph (4)(e) of a certified reinsurer's reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under Subparagraph (4)(a) if the commissioner finds that:

(a) More than fifteen percent (15%) of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more which are not in dispute and which exceed $100,000 for each cedent; or

(b) The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety (90) days or more exceeds $50,000,000.

(6) The assuming insurer must submit a properly executed Form CR-1 (attached as an exhibit to this regulation) as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(7) The certified reinsurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under [cite state law equivalent of Freedom of Information Act] and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

(a) Notification within ten (10) days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;

(b) Annually, Form CR-F or CR-S, as applicable [per the instructions to be developed as an exhibit to this model];

(c) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Subsection (d) below;

(d) Annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two (2) years filed with the certified reinsurer's supervisor;

(e) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;

(f) A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and

(g) Any other information that the commissioner may reasonably require.

(8) Change in Rating or Revocation of Certification.

(a) In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of Subparagraph (4)(a).

(b) The commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(c) If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(d) Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with Section 11 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with Section 7, the commissioner may allow additional credit equal to the ceding insurer's *pro rata* share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

C. Qualified Jurisdictions.

(1) If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the commissioner determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the commissioner shall publish notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

(2) In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the commissioner as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the commissioner, include but are not limited to the following:

(a) The framework under which the assuming insurer is regulated.

(b) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.

(c) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(d) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.

(e) The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the commissioner in particular.

(f) The history of performance by assuming insurers in the domiciliary jurisdiction.

(g) Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(h) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.

(i) Any other matters deemed relevant by the commissioner.

(3) A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under Subsection 8C(2)(a) to (i).

(4) U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.

(1) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

(2) Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the commissioner of any change in its status or rating within 10 days after receiving notice of the change.

(3) The commissioner may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with Subsection B(8) of this section.

(4) The commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer's certification in accordance with Subsection B(8) of this section, the certified reinsurer's certification shall remain in good standing in this state for a period of three (3) months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

E. Mandatory Funding Clause. In addition to the clauses required under Section 15, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

F. The commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

Section 9. Credit for Reinsurance—Reciprocal Jurisdictions

A. Pursuant to [cite state law equivalent of Section 2F of the *Credit for Reinsurance Model Law* (#785)], the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets the other requirements of this regulation.

B. A "Reciprocal Jurisdiction" is a jurisdiction, as designated by the commissioner pursuant to Subsection D, that meets one of the following:

(1) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(2) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(3) A qualified jurisdiction, as determined by the commissioner pursuant to [cite state law equivalent of Section 2E(3) of the *Credit for Reinsurance Model Law* (#785) and Section 8C of the *Credit for Reinsurance Model Regulation* (#786)], which is not otherwise described in Paragraph (1) or (2) above and which the commissioner determines meets all of the following additional requirements:

(a) Provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(b) Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(c) Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and

Drafting Note: Nothing in this subparagraph is intended to enhance or limit the authority of U.S. state insurance regulation with respect to the group-wide supervision of insurance holding company systems pursuant to the state law equivalent of the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation* (#450), or other applicable state law.

(d) Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

C. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the conditions set forth below.

(1) The assuming insurer must be licensed to transact reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction.

(2) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, and confirmed as set forth in Subsection C(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:

(a) No less than $250,000,000; or

(b) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(i) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000; and

(ii) A central fund containing a balance of the equivalent of at least $250,000,000.

(3) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

(a) If the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(1), the ratio specified in the applicable covered agreement;

Drafting Note: The United States has entered into bilateral agreements with both the European Union and United Kingdom, signed on September 22, 2017, and December 18, 2018, respectively, which specify a solvency ratio of one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union with respect to assuming insurers which have their head office or are domiciled in those jurisdictions.

(b) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(2), a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

(c) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(3), after consultation with the Reciprocal Jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.

(4) The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (attached as an exhibit to this regulation), of its agreement to the following:

(a) The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in Paragraphs (2) or (3) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law.

(b) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process.

(i) The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner's jurisdiction.

(ii) Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

(c) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

(d) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

(e) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of [cite state law equivalent of Section 2E and Section 3 of the *Credit for Reinsurance Model Law* (#785)] and Section 12, 13 or 14 of this regulation. For purposes of this regulation, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

(f) The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in Paragraph (5) of this subsection.

(5) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

(a) For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(b) For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

(c) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

(d) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in Paragraph (6) of this subsection.

Drafting Note: In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called "passporting" under which the commissioner has the discretion to defer to another state's determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. It is anticipated that "lead" states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) of this regulation, so that other states may rely upon the lead state's determination.

(6) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(a) More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;

(b) More than fifteen percent (15%) of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

(c) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

(7) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) and (3) of this subsection.

(8) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

D. The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

(1) A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner's list shall include any Reciprocal Jurisdiction as defined under Section 9B(1) and (2), and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions as provided by applicable law, regulation, or in accordance with criteria published through the NAIC Committee Process.

(2) The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC Committee Process, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 9B(1) and (2). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to [cite to state law equivalent of *Credit for Reinsurance Model Law* (#785) or *Credit for Reinsurance Model Regulation* (#786)].

Drafting Note: It is anticipated that the NAIC will develop criteria and a process with respect to Reciprocal Jurisdictions that is similar to the NAIC *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions.* Included will be processes for revocation or suspension of the status as a Reciprocal Jurisdiction, provided that such process would not conflict with the terms of an in-force covered agreement. The NAIC and the states intend to communicate and coordinate with the U.S. Department of Treasury and United States Trade Representative and other relevant federal authorities with respect to the evaluation of Reciprocal Jurisdictions, as appropriate.

E. The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

(1) If an NAIC accredited jurisdiction has determined that the conditions set forth in Subsection C have been met, the commissioner has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.

(2) When requesting that the commissioner defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

F. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this section.

(1) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Section 11.

(2) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 11.

G. Before denying statement credit or imposing a requirement to post security with respect to Section 9F of this regulation or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall:

(1) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in Subsection C of this section;

(2) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(3) After the expiration of 90 days or less, as set out in Paragraph (2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements as set out in this subsection; and

(4) Provide a written explanation to the assuming insurer of any of the requirements set out in this subsection.

H. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

Section 10. Credit for Reinsurance Required by Law

Pursuant to Section [cite state law equivalent of Section 2G of the *Credit for Reinsurance Model Law* (#785)], the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section [cite state law equivalent of Sections 2A, B, C, D, E, F or other appropriate section of the of the *Credit for Reinsurance Model Law* (#785)] but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means state, district or territory of the United States and any lawful national government.

Drafting Note: Examples of assuming insurers for which credit may be allowed under this section include state owned or controlled insurance or reinsurance companies or ceding company participation in pools, guaranty associations or residual market mechanisms required by statute, regulation or administrative order.

Section 11. Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer not Meeting the Requirements of Sections 4 through 10

A. Pursuant to Section [cite state law equivalent of Section 3 of the *Credit for Reinsurance Model Law* (#785)], the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section [cite state law equivalent of Section 2 or other appropriate section of the *Credit for Reinsurance Model Law* (#785)] in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in Section [cite state law equivalent of Section 4B of the *Credit for Reinsurance Model Law* (#785)]. This security may be in the form of any of the following:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in Section [cite state law equivalent of Section 4A of the *Credit for Reinsurance Model Law* (#785)], effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer

acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the commissioner.

B. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this section shall be allowed only when the requirements of Section 15 and the applicable portions of Sections 12, 13 or 14 of this regulation have been satisfied.

Section 12. Trust Agreements Qualified under Section 11

A. As used in this section:

(1) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

Drafting Note: The NAIC has adopted the above definition as part of the "Uniform Letter of Credit." However, the state may choose to utilize the following definition: "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

(2) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

(3) "Obligations," as used in Subsection B(11) of this section means:

(a) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(b) Reserves for reinsured losses reported and outstanding;

(c) Reserves for reinsured losses incurred but not reported; and

(d) Reserves for allocated reinsured loss expenses and unearned premiums.

B. Required conditions.

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee, which shall be a qualified United States financial institution as defined in Section [insert citation to state law equivalent to Section 4B of the *Credit for Reinsurance Model Law* (#785)].

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee's office in the United States.

(4) The trust agreement shall provide that:

(a) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(b) No other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(c) It is not subject to any conditions or qualifications outside of the trust agreement; and

(d) It shall not contain references to any other agreements or documents except as provided for in Paragraphs (11) and (12) of this subsection.

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

(a) Receive assets and hold all assets in a safe place;

(b) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(c) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(d) Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account;

(e) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(f) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the commissioner), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(10) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

(11) Notwithstanding other provisions of this regulation, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(a) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(b) To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(c) Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution as defined in Section [insert citation to state law equivalent of Section 4B of the *Credit for Reinsurance Model Law* (#785)] apart from its general assets, in trust for such uses and purposes specified in Subparagraphs (a) and (b) above as may remain executory after such withdrawal and for any period after the termination date.

(12) Notwithstanding other provisions of this regulation, when a trust agreement is established to meet the requirements of Section 11 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(a) To pay or reimburse the ceding insurer for:

(i) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

(ii) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(b) To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

(c) Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in Subparagraphs (a) and (b) of this paragraph as may remain executory after withdrawal and for any period after the termination date.

(13) Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The agreement may further specify the types of investments to be deposited. If

the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement.

C. Permitted conditions.

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in Subsection D(1)(b) of this section.

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Additional conditions applicable to reinsurance agreements:

(1) A reinsurance agreement may contain provisions that:

(a) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(b) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(c) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(d) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) To pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(II) The assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(ii) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) The reinsurance agreement also may contain provisions that:

(a) Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(i) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(ii) After withdrawal and transfer, the current fair market value of the trust account is no less than 102 percent of the required amount.

(b) Provide for the return of any amount withdrawn in excess of the actual amounts required for Paragraph (1)(d) of this subsection, and for interest payments at a rate not in excess of the prime rate of interest on such amounts;

(c) Permit the award by any arbitration panel or court of competent jurisdiction of:

(i) Interest at a rate different from that provided in Subparagraph (b) of this paragraph;

(ii) Court or arbitration costs;

(iii) Attorney's fees; and

(iv) Any other reasonable expenses.

E. Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

F. Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to [insert date] will continue to be acceptable until [insert date], at which time the agreements will have to fully comply with this regulation for the trust agreement to be acceptable.

G. The failure of any trust agreement to specifically identify the beneficiary as defined in Subsection A of this section shall not be construed to affect any actions or rights that the commissioner may take or possess pursuant to the provisions of the laws of this state.

Section 13. Letters of Credit Qualified under Section 11

A. The letter of credit must be clean, irrevocable, unconditional and issued or confirmed by a qualified United States financial institution as defined in Section [insert citation to state law equivalent of Section 4A of the *Credit for Reinsurance Model Law* (#785)]. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in Subsection H(1) of this section. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

Drafting Note: The NAIC has adopted the above definition as part of the "Uniform Letter of Credit." However, the state may choose to utilize the following definition: "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

B. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

C. The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

D. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than thirty (30) days notice prior to expiration date or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

F. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600 or any other successor publication, occur.

G. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in Subsection A of this section, then the following additional requirements shall be met:

(1) The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

(2) The "evergreen clause" shall provide for thirty (30) days notice prior to expiration date for nonrenewal.

H. Reinsurance agreement provisions.

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

(a) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

(b) Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(i) To pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(II) The assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(ii) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in Subsection H(1)(b)(i) of this section as may remain after withdrawal and for any period after the termination date.

(c) All of the provisions of Paragraph (1) of this subsection shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in Paragraph (1) of this subsection shall preclude the ceding insurer and assuming insurer from providing for:

(a) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Subparagraph (1)(b) of this subsection; or

(b) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

Section 14. Other Security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Section 15. Reinsurance Contract

Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections 4, 5, 6, 7, 8, 9 or 11 of this regulation or otherwise in compliance with Section [cite state law equivalent of Section 2 of the *Credit for Reinsurance Model Law* (#785)] after the adoption of this regulation unless the reinsurance agreement:

A. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to Section [insert appropriate number] of the Insurance Code;

B. Includes a provision pursuant to Section [cite state law equivalent to Section 2 of the *Credit for Reinsurance Model Law* (#785)] whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of the court or panel; and

C. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

Drafting Note: It is recognized that credit for reinsurance may be affected by other sections of the adopting state's code, e.g., the statutory insolvency or intermediary clauses. It is recommended that states that have statutory insolvency or intermediary clauses consider incorporating those clauses into this regulation.

Section 16. Contracts Affected

All new and renewal reinsurance transactions entered into after [insert date] shall conform to the requirements of the Act and this regulation if credit is to be given to the ceding insurer for such reinsurance.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1991 Proc. 1 9, 18, 908,926-927, 930-939 (adopted).
1996 Proc. 3rd Quarter 9, 41, 1109, 1111, 1112-1125 (amended and reprinted).
2001 Proc. 1st Quarter 17, 738, 862, 863-872 (amended).
2006 Proc. 2nd Quarter 40, 91-93 (amended).
2011 Proc. 3rd Quarter Vol. 1 113-114, 126, 131-137, 237-288, 300-339 (amended).
2013 (editorial revisions).
2019 Proc. 2nd Quarter (amended).

FORM AR-1

CERTIFICATE OF ASSUMING INSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in

_____, hereby certify that
(name of state)

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in_____
(ceding insurer's state of domicile)

for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Commissioner of _____ to examine
(ceding insurer's state of domicile)
its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____
(ceding insurer's state of domicile)
reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated: _____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in _____,
in order to be considered for approval in this state, hereby certify that (name of state)

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer's state of domicile)
for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with [cite relevant provision of the state equivalent of the *Credit for Reinsurance Model Regulation* (#786)].

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with [cite relevant provision of the state equivalent of the *Credit for Reinsurance Model Regulation* (#786)].

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

FORM RJ-1

CERTIFICATE OF REINSURER DOMICILED IN RECIPROCAL JURISDICTION

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in _____, in order to
(name of state)

be considered for approval in this state, hereby certify that _____ ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in [Name of State] for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. The assuming insurer agrees that it will include such consent in each reinsurance agreement, if requested by the commissioner. Nothing in this paragraph constitutes or should be understood to constitute a waiver of assuming insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

2. Designates the Insurance Commissioner of [Name of State] as its lawful attorney in and for the [Name of State] upon whom may be served any lawful process in any action, suit or proceeding in this state arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

4. Agrees to provide prompt written notice and explanation if it falls below the minimum capital and surplus or capital or surplus ratio, or if any regulatory action is taken against it for serious noncompliance with applicable law.

5. Confirms that it is not presently participating in any solvent scheme of arrangement, which involves insurers domiciled in [Name of State]. If the assuming insurer enters into such an arrangement, the assuming insurer agrees to notify the ceding insurer and the commissioner, and to provide 100% security to the ceding insurer consistent with the terms of the scheme.

6. Agrees that in each reinsurance agreement it will provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final U.S. judgment, that is enforceable under the law of the territory in which it was obtained, or a properly enforceable arbitration award whether obtained by the ceding insurer or by its resolution estate, if applicable.

7. Agrees to provide the documentation in accordance with [cite relevant provision of the state equivalent of Section 9C(5) of the *Credit for Reinsurance Model Regulation* (#786)], if requested by the commissioner.

Dated: _____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

Form CR-F – PART 1

Assumed Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	Reinsurance On			9	10	11	12	13	14	15
					6	7	8							
Company Code or ID Number		Name of Reinsured	Domiciliary Jurisdiction	Assumed Premium	Paid Losses and Loss Adjustment Expenses	Known Case Losses and LAE	Cols. 6 + 7	Contingent Commissions Payable	Assumed Premiums Receivable	Unearned Premium	Funds Held By or Deposited With Reinsured Companies	Letters of Credit Posted	Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit	Amount of Assets Pledged or Collateral Held in Trust
9999999 Totals														

Form CR-F – PART 2

Ceded Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	6	Reinsurance Recoverable On									Reinsurance Payable		18	19
						7	8	9	10	11	12	13	14	15	16	17		
Company Code or ID Number		Name of Reinsurer	Domiciliary Jurisdiction	Reinsurance Contracts Ceding 75% or More of Direct Premiums Written	Reinsurance Premiums Ceded	Paid Losses	Paid LAE	Known Case Loss Reserves	Known Case LAE Reserves	IBNR Loss Reserves	IBNR LAE Reserves	Unearned Premiums	Contingent Commissions	Cols. 7 through 14 Totals	Ceded Balances Payable	Other Amounts Due to Reinsurers	Net Amount Recoverable From Reinsurers Cols. 15 – [16 + 17]	Funds Held by Company Under Reinsurance Treaties
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Form CR-S – PART 1 – SECTION 1

Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Location	6 Type of Reinsurance Assumed	7 Amount of In Force at End of Year	8 Reserve	9 Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 1 – SECTION 2

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Domiciliary Jurisdiction	6 Type of Reinsurance Assumed	7 Premiums	8 Unearned Premiums	9 Reserve Liability Other Than For Unearned Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Paid Losses	7 Unpaid Losses
Totals—Life, Annuity and Accident and Health						

Form CR-S – PART 3 – SECTION 1

Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Type of Reinsurance Ceded	7 Amount in Force at End of Year	Reserve Credit Taken		10 Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
							8 Current Year	9 Prior Year		11 Current Year	12 Prior Year		
Totals													

Form CR-S – PART 3 – SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1	2	3	4	5	6	7	8	9	Outstanding Surplus Relief		12	13
Company Code or ID Number		Effective Date	Name of Company	Location	Type	Premiums	Unearned Premiums (Estimated)	Reserve Credit Taken Other than for Unearned Premiums	10 Current Year	11 Prior Year	Modified Coinsurance Reserve	Funds Withheld Under Coinsurance
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Totals												

CREDIT FOR REINSURANCE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

CREDIT FOR REINSURANCE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-156-.01 to 482-1-156-.16 (2021).		
Alaska	S.B. 87 (2021).	ALASKA ADMIN. CODE tit. 3, §§ 21.600 to 21.695 (1994/2008).	
American Samoa	ORDER 8-1-22 (2022).		
Arizona	ARIZ. ADMIN. CODE §§ R20-6-1601 to R20-6-1612 (1993/2022).		
Arkansas	CODE ARK. R. 003.22.65-1 to 003.22.65-16 (rule 65) (2022).	054-00-65 ARK. CODE R. § 1-16 (1996/2016).	
California	A.B. 2049 (2020).	CAL. INS. CODE § 922.41 (2016); §§ 922.2 to 922.9 (2017); CAL. CODE REGS. tit. 10, §§ 2303 to 2303.22 (2006).	BULLETIN 97-5 (1997); BULLETIN 2011-2 (2011).
Colorado	3 COLO. CODE REGS. § 702-3:3-3-3 (2007/2022).		
Connecticut	H.B. 5506 (2022).	CONN. AGENCIES REGS. §§ 38a-88-1 to 38a-88-12 (1991/2013).	
Delaware	18 DEL. ADMIN. CODE §§ 1003-1 to 1003-16 (2013/2022).		

CREDIT FOR REINSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. ACT 24-537 (2022).	D.C. MUN. REGS. tit. 26, §§ 2800 to 2811 (1996).	
Florida		FLA. STAT. ANN. § 624.610 (1959/2012); FLA. ADMIN. CODE ANN. r. 69O.144.001 to 69O.144.010 (1991/2017).	
Georgia	GA. COMP. R. & REGS. 120-2-78-.01 to 120-2-78-.15 (1997/2022).		
Guam	ORDER OF INS. COMM. (2022).		
Hawaii	HAW. CODE R. §§ 16-168-1 to 16-168-14 (1997/2022).		
Idaho	IDAHO CODE § 41-515A (2021).		
Illinois	H.B. 4493 (2022).	ILL. ADMIN. CODE tit. 50, §§ 1104.10 to 1104.120 (1996/2018).	
Indiana	760 IND. ADMIN. CODE. 1-56-1 to 1-56-16 (2007/2022).		
Iowa	IOWA ADMIN. CODE r. 191-5.33 (1992/2021).		
Kansas	S.B. 28 (2022).	KAN. ADMIN. REGS. § 40-1-43 (1997/2002) (portions of previous version of model).	
Kentucky	H.B. 350 (2022).	806 KY. ADMIN. REGS. 5:025 (1996/2007).	
Louisiana	H.B. 664 (2022).	LA. ADMIN. CODE tit. 37, §§ XIII.3501 to XIII.3525 (Regulation No. 56) (1995/2013).	
Maine	02-031 ME. CODE R. ch. 740, §§ 1 to 18 (1993/2021).		
Maryland	MD. CODE REGS. 31.05.08.01 to 31.05.08.27 (1993/2022).		

CREDIT FOR REINSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts	211 MASS. CODE REGS. 130.01 to 130.17 (1997/2022).		
Michigan	S.B. 1015 (2021).		MICH. ADMIN. CODE r. 500.1122 to 500.1133 (1996/2019).
Minnesota	H.F. 6 (2021).		
Mississippi	MISS. CODE R. 19-1:22.01 to 19-1:22.19 (2012/2022).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-2.100 (1991/2022).		
Montana	MONT. ADMIN. R. 6.6.3810 to 6.6.3869 (2016/2022).		
Nebraska	210 NEB. ADMIN. CODE §§ 65-001 to 65-15 (1995/2021).		
Nevada	NEV. ADMIN. CODE §§ 681A.250 to 681A.380 (1996/2021).		
New Hampshire	H.B. 1558 (2022).	N.H. CODE ADMIN. R. INS. 601.01 to 601.13 (1995/2013).	
New Jersey		N.J. ADMIN. CODE §§ 11:2-28.1 to 28.14 (1993/2018).	BULLETIN 2012-4 (2012).
New Mexico	N.M. ADMIN. CODE 13.2.8 (2022).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 125.1 to 125.8 (Regulation Nos. 17, 20, 20-A) (1981/2013).		
North Carolina	S.B. 299 (2021).		N.C. GEN. STAT. § 58-7-21; § 58-7-26 (1991/2019).
North Dakota	N.D. ADMIN. CODE §§ 45-03-07.1-01 to 45-03-07.1-11 (1995/2022).		
Northern Marianas	ORDER OF INS. COMM. (2022).		

CREDIT FOR REINSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio	OHIO ADMIN. CODE 3901-3-16 (1997/2021).		
Oklahoma	S.B. 1240 (2022).	OKLA. ADMIN. CODE §§ 365:25-7-60 to 365:25-7-73 (1993/2017).	
Oregon	OR. ADMIN. R. 836-012-0000 to 836-012-0110 (1993/2022).		OR. ADMIN. R. 836-012-0300 to 836-012-0332 (1993/2010).
Pennsylvania	S.B. 1195 (2020).	31 PA. CODE §§ 161.1 to 161.9 (1993/2016).	NOTICE 1-18-2014 (#1) (2014); NOTICE 1-25-2014 (#1 & #3) (2014).
Puerto Rico	P.S. 722 (2022).	P.R. RULE 9086 (2012/2018).	
Rhode Island	230-20-45 R.I. CODE R. §§ 1 to 15 (2022).		
South Carolina	S.C. CODE ANN. REGS. 69-53 (1994/2022).		
South Dakota	H.B. 1003 (2021).	S.D. ADMIN. R. 20:06:31 (1995/2017).	
Tennessee	TENN. COMP. R. & REGS. 0780-01-63-.01 to 0780-01-63-.15 (1995/2022).		
Texas	H.B. 1689 (2022).	28 TEX. ADMIN. CODE §§ 7.601 to 7.627 (1976/2018).	
Utah	UTAH ADMIN. CODE r. R590-173 (1997/2022).		
Vermont	H. 515 (2022).	VT. ADMIN. CODE §§ 4-3-32:1 to 4-3-32:16 (Regulation 97-3) (1997/2015).	
Virgin Islands		BULLETIN 2019-02 (2019).	
Virginia	14 VA. ADMIN. CODE §§ 5-300-10 to 5-300-170 (1992/2020).		ADMIN. LETTER 2012-11 (2012).

CREDIT FOR REINSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	S.B. 5048 (2021).	WASH. ADMIN. CODE 284-13-500 to 284-13-59508 (1993/2015).	
West Virginia	W. VA. CODE R. §§ 114-40-1 to 114-40-13 (1995/2022).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 52.01 to 52.07 (1993/2022).		
Wyoming	044-50 WYO. CODE R. §§ 1 to 16 (1997/2021).		

PROJECT HISTORY – 2019

CREDIT FOR REINSURANCE MODEL LAW (#785)

CREDIT FOR REINSURANCE MODEL REGULATION (#786)
(Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance)

1. Description of the Project, Issues Addressed, etc.

On Sept. 22, 2017, the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) signed the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement). The EU Covered Agreement includes requirements on group capital, group supervision and reinsurance collateral. The EU Covered Agreement would eliminate reinsurance collateral requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction.

On Dec. 11, 2018, the Treasury Department and the USTR announced that the U.S. and the United Kingdom (UK) had reached a final agreement on reinsurance collateral and other insurance regulatory measures outlined in the "Bilateral Agreement Between the United States Of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement). A separate Covered Agreement for the UK was necessary due to plans by the UK to exit the EU. The UK Covered Agreement mirrors the language in the prior Covered Agreement between the U.S. and the EU, and, for the purposes of this project history, they will be referred to collectively as the "Covered Agreement."

While the group capital and group supervision provisions of the Covered Agreement are not expected to require changes to state laws, the Covered Agreement will require the states to take action with respect to the reinsurance collateral provisions within 60 months (five years) of signing or face potential federal preemption by the Federal Insurance Office (FIO) under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. Specifically, in 2011, the NAIC membership adopted revisions to Section 2E of the *Credit for Reinsurance Model Law* (#785) and Section 8 of the *Credit for Reinsurance Model Regulation* (#786) which will be affected by the Covered Agreement. These revisions served to reduce reinsurance collateral requirements for certified non-U.S. licensed reinsurers that are licensed and domiciled in qualified jurisdictions. Prior to these amendments, in order for domestic U.S. ceding companies to receive reinsurance credit, the reinsurance must either have been ceded to U.S. licensed reinsurers or secured by collateral representing 100% of liabilities for which the credit was recorded.

On Feb. 20, 2018, the NAIC and the Reinsurance (E) Task Force held a Public Hearing in New York to address the reinsurance collateral provisions of the Covered Agreement. On April 17, 2018, based on public comments and testimony received at the Public Hearing, the Executive (EX) Committee agreed to the following actions with respect to the Covered Agreement:

> Adopted a Request for NAIC Model Law Development with respect to Model #785 and Model #786. The motion adopted was that these models be revised to: 1) conform to the requirements in the covered agreement with respect to EU reinsurers; and 2) provide reinsurers domiciled in NAIC-qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the covered agreement, with provisions regarding group supervision, group capital, information-sharing and enforcement.

On May 15, 2019, the Task Force adopted revisions to Model #785 and Model #786 consistent with these charges during a public conference call, which were then approved by the Financial Condition (E) Committee on May 28, 2019. The revisions would eliminate reinsurance collateral requirements for "reciprocal" reinsurers that have their head office or are domiciled in any of the following:

1. An EU-member country (or any other non-U.S. jurisdiction) that is subject to an in-force covered agreement addressing the elimination of reinsurance collateral requirements with U.S. ceding insurers (Covered Agreement Reciprocal Jurisdictions).
2. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program (Accredited State Reciprocal Jurisdictions).

3. A non-U.S. jurisdiction recognized as a qualified jurisdiction that meets certain additional requirements consistent with the terms of a covered agreement (Qualified Jurisdiction Reciprocal Jurisdictions).

The requirements for reciprocal reinsurers under the revisions to Model #785 and Model #786 mirror the requirements for reinsurers under the Covered Agreement, and they would place the following additional requirements with respect to reciprocal reinsurers:

- Maintain minimum capital and surplus of no less than $250 million.
- Maintain a minimum solvency or capital ratio, as applicable, of 100% of the SCR or a risk-based capital (RBC) ratio of 300% of the authorized control level, or such other solvency or capital ratio that the commissioner determines is an effective measure of solvency.
- Provide certain assurances to the state insurance commissioner on a new form (Form RJ-1), which includes providing prompt notice to the state insurance commissioner in the event of noncompliance with the minimum capital and surplus and minimum solvency requirements; or serious noncompliance with applicable law, consent to service of process, consent to payment of final judgments, nonparticipation in solvent schemes; and other assurances.
- Provide annual audited financial statements and other specified financial information for the two years preceding entry into the reinsurance agreement, and file annual audited financial statements and other specified financial information on a semi-annual basis.
- Maintain a practice of prompt payment of claims under reinsurance agreements.

2. Name of Group Responsible for Drafting the Model and States Participating

The Reinsurance (E) Task Force of the Financial Condition (E) Committee was responsible for drafting the revisions to the Model #785 and Model #786:

Chlora Lindley-Myers, Chair	Missouri	Eric A. Cioppa	Maine
Raymond G. Farmer, Vice Chair	South Carolina	Gary Anderson	Massachusetts
Jim L. Ridling	Alabama	Matthew Rosendale	Montana
Lori K. Wing-Heier	Alaska	Bruce R. Ramge	Nebraska
Peter Fuimaono	American Samoa	Barbara D. Richardson	Nevada
Allen W. Kerr	Arkansas	John Elias	New Hampshire
Ricardo Lara	California	Marlene Caride	New Jersey
Michael Conway	Colorado	Linda A. Lacewell	New York
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Trinidad Navarro	Delaware	Jon Godfread	North Dakota
Stephen C. Taylor	District of Columbia	Jillian Froment	Ohio
David Altmaier	Florida	Glen Mulready	Oklahoma
Jim Beck	Georgia	Elizabeth Kelleher Dwyer	Rhode Island
Dafne M. Shimizu	Guam	Julie Mix McPeak	Tennessee
Dean L. Cameron	Idaho	Kent Sullivan	Texas
Stephen W. Robertson	Indiana	Todd E. Kiser	Utah
Doug Ommen	Iowa	Michael S. Pieciak	Vermont
Vicki Schmidt	Kansas	Scott A. White	Virginia
Nancy G. Atkins	Kentucky	James A. Dodrill	West Virginia
James J. Donelon	Louisiana	Mark Afable	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

On April 17, 2018, the Executive (EX) Committee adopted the following charges to the Reinsurance (E) Task Force and a Request for NAIC Model Law Development with respect to these charges, which were reapproved by the Committee for 2019:

- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to conform to the terms of the Covered Agreement.
- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the

same collateral requirement treatment as provided to EU-domiciled reinsurers, that non-EU qualified jurisdiction must agree to adhere to all other standards imposed upon the EU in the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states' approach to group supervision, including group capital. As part of its deliberations, the Task Force should consult with international regulators, in addition to all other interested parties.

- The Task Force is directed to develop revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) to address the effect of a breach of the Covered Agreement (as determined pursuant to its terms) on a reinsurer's collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or the model law and regulation.

- In conjunction with any revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786), the Qualified Jurisdiction (E) Working Group is directed to consider changes to the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision, group capital standards, and as well as require strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach.

- The Reinsurance Financial Analysis (E) Working Group is directed to consider changes in its current methods of monitoring certified reinsurers domiciled in Qualified Jurisdictions to incorporate changes to state reinsurance collateral requirements caused by the EU Covered Agreement and any changes to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to provide similar treatment to reinsurers domiciled in Qualified Jurisdictions.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated

At the 2017 Fall National Meeting, the NAIC membership tasked a leadership group of commissioners to develop a strategy for proceeding forward with revisions to Model #785 and Model #786. This included the 2018 NAIC officers: President Julie Mix McPeak (TN); President-Elect Eric A. Cioppa (ME); Vice President Raymond G. Farmer (SC); and Secretary-Treasurer Gordon I. Ito (HI). It also included Commissioner David Altmaier (FL), chair of the Financial Condition (E) Committee; then-Superintendent Maria T. Vullo (NY), then-chair of the Reinsurance (E) Task Force; and then-Director Peter L. Hartt (NJ), the state insurance commissioner representative on the Financial Stability Oversight Council (FSOC).

On Feb. 20, 2018, the NAIC and Reinsurance (E) Task Force held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. The public hearing was presided over by Commissioner Mix McPeak, Commissioner Altmaier and then-Superintendent Vullo. Also in attendance at the public hearing were: then-Commissioner Katharine L. Wade (CT); Superintendent Cioppa; Director Chlora Lindley-Myers represented by John Rehagen (MO); then-Acting Commissioner Marlene Caride and then-Director Hartt (NJ); Superintendent Elizabeth Kelleher Dwyer (RI); Director Farmer; then-Commissioner Ted Nickel (WI); and Commissioner Tom Glause (WY). During the public hearing, the NAIC and the Task Force heard from 18 speakers, including a representative of the Treasury Department, as well as U.S. domestic insurers, U.S. trade associations, international reinsurers and international trade associations. The NAIC also received 20 comment letters from a wide variety of stakeholders and interested parties. There were approximately 160 people in attendance at the public hearing, with another 181 participating via conference call.

On March 14, 2018, a memorandum titled, "Covered Agreement: Proposed Next Steps," was sent to the Financial Condition (E) Committee by Commissioner Mix McPeak; Commissioner Altmaier, chair of the Committee; and then-Superintendent Vullo, then-chair of the Reinsurance (E) Task Force. This memorandum recommended that the Committee take the following actions with respect to the Covered Agreement, based on public comments and testimony received at the public hearing:

- Adopt a Request for NAIC Model Law Development with respect to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786). Specifically, these models should be revised to (a) conform to the requirements in the Covered Agreement with respect to EU reinsurers, and (b) provide reinsurers domiciled in NAIC qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the Covered Agreement, with provisions regarding group supervision, group capital, information sharing and enforcement.

- Adopt charges to the Reinsurance (E) Task Force, and its Qualified Jurisdiction (E) Working Group and Reinsurance Financial Analysis (E) Working Group to make certain revisions to Model #785 and Model #786, and to develop processes to implement the changes to the models.

- Adopt charges to the Capital Adequacy (E) Task Force and the Statutory Accounting Principles (E) Working Group to address related reinsurance collateral issues raised at the Public Hearing.

The Financial Condition (E) Committee adopted the Request for NAIC Model Law Development at the 2018 Spring National Meeting. The Executive (EX) Committee adopted the Request for NAIC Model Law Development for amendments to Model #785 and Model #786, as well as the proposed related charges for various Financial Condition (E) Committee groups, during its April 17, 2018, conference call. These charges were renewed for the 2019 calendar year.

The Reinsurance (E) Task Force adopted draft revisions to Model #785 and Model #786 at the 2018 Fall National Meeting. The Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed that were consistent with the issues raised at the Task Force meeting. The Executive (EX) Committee and Plenary were prepared to consider the draft revisions for adoption during its Dec. 19, 2018, conference call; however, the vote was delayed due to feedback received from the Treasury Department and the USTR. In a memorandum to the Financial Condition (E) Committee dated Feb. 11, 2019, the NAIC leadership group on reinsurance made a recommendation that the Task Force and its drafting group consider making additional revisions to resolve the following issues:

- **Recognition of Reciprocal Jurisdictions**. Whether any additional revisions are necessary with respect to a state insurance commissioner's discretion to make a determination as to whether an EU jurisdiction should be recognized as a Reciprocal Jurisdiction.

- **Determination of Compliance with the Covered Agreement**. Whether any additional revisions are necessary with respect to a state insurance commissioner's discretion to determine whether each EU member state is in compliance with the Covered Agreement.

- **Commissioner Discretion to Impose Additional Requirements**. Whether any additional revisions are necessary with respect to any additional requirements being imposed on EU reinsurers.

- **Effective Date**. Whether any additional revisions are necessary with respect to the effective date provision in the model revisions regarding which reinsurance agreements and policies are covered.

- **Service of Process**. Whether any additional revisions are necessary with respect to requiring assuming reinsurers to submit the confirmation of consent to service of process to each state in which the reinsurer intends to operate.

- **Other Covered Agreement Issues**. Whether any additional technical revisions are necessary to make the draft models more consistent with the Covered Agreement.

- **Additional Requirements for Qualified Jurisdictions**. Whether any additional revisions are necessary and appropriate with respect to requirements that are applicable to Qualified Jurisdictions but are not applicable to EU jurisdictions.

- **Recognition of U.S. State Regulatory System by Qualified Jurisdictions**. Whether any additional revisions are necessary with respect to the requirement for Qualified Jurisdictions to recognize aspects of the U.S. state regulatory system in order to be considered a Reciprocal Jurisdiction.

- **Recognition of NAIC Accredited Jurisdictions as Reciprocal Jurisdictions**. Whether U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Standards and Accreditation Program should be recognized as Reciprocal Jurisdictions.

The Financial Condition (E) Committee adopted these recommendations during its Feb. 19, 2019, conference call. At the direction of Director Lindley-Myers, current chair of the Reinsurance (E) Task Force, draft revisions to Model #785 and Model #786 were released May 1, 2019, which were then approved by the Task Force during its May 15, 2019, conference call. The Financial Condition (E) Committee adopted the draft revisions to Model #785 and Model #786 during its May 28, 2019, conference call, with the following revision to Section 2F(7) of Model #785:

Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed ~~on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection~~ on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

Drafting Group. At the 2018 Summer National Meeting, then-Superintendent Vullo (NY), then-chair of the Reinsurance (E) Task Force, directed NAIC staff to create an informal drafting group composed of members of the Task Force tasked with developing the initial draft revisions to Model #785 and Model #786 incorporating the provisions of the Covered Agreement for discussion and consideration by the Task Force. The members of the drafting group were composed of state insurance regulators from the following states: California, Colorado, Connecticut, Florida, Maine, Missouri, Nebraska, New Jersey, New York and Texas. The drafting group met Aug. 16, Aug. 23, Sept. 5, Sept. 7, Oct. 22, Nov. 2 and Nov. 29, 2018, via conference call in regulator-to-regulator session. The drafting group also met Feb. 20, Feb. 22, Feb. 27, April 16 and April 30, 2019, via conference call in regulator-to-regulator session. The drafting group discussed and drafted multiple proposed revisions to Model #785 and Model #786, which were presented to the Task Force for consideration of adoption.

Federal and International Regulators. NAIC staff met via conference call with representatives of the European Commission on Oct. 29, 2018 and May 13, 2019, and received comment letters from the European Commission—dated Oct. 16, Nov. 16 and Dec. 18, 2018; and March 28 and May 13, 2019—in which the European Commission expressed concerns about the consistency of the draft revisions with the EU Covered Agreement. State insurance regulators and NAIC staff also met via conference call with representatives of the Treasury Department and the USTR on Nov. 16, Nov. 30 and Dec. 4, 2018, and on March 8, April 25 and May 23, 2019, to discuss their concerns regarding the consistency of the draft revisions with the Covered Agreement. During these conference calls, Director Steven Seitz (FIO) advised that any past or future discussion of Model #785 and Model #786 would be without prejudice to any future preemption analysis of state law the FIO may conduct. The Task Force and its drafting group took into account the concerns expressed by both the European Commission and the U.S. federal regulators, and the Task Force and its drafting group are of the opinion that the final revisions to Model #785 and Model #786 are entirely consistent with the provisions of the Covered Agreement.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Feb. 20, 2018, Public Hearing. On Feb. 20, 2018, the NAIC held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. A detailed discussion of the public hearing and the actions taken by the Financial Condition (E) Committee and Executive (EX) Committee with respect to the results of the public hearing can be found under Section 4—General Description of the Drafting Process of this project history.

June 21, 2018, Exposure. On June 13, 2018, the Reinsurance (E) Task Force met in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. During the conference call, the Task Force agreed to expose proposed revisions to Model #785 and Model #786 dated June 21, 2018, for a public comment period ending July 23, 2018. The Task Force received 18 comment letters, which included 16 from international and domestic insurance companies and industry groups, as well as two from state insurance regulators. The Task Force discussed the comment letters at the 2018 Summer National Meeting and directed a newly formed drafting group to work with NAIC staff to consider the comments and determine whether to incorporate them into the models and create updated drafts.

Sept. 25, 2018, Exposure. The drafting group considered the comment letters received at the 2018 Summer National Meeting and prepared draft revisions for the consideration of the Reinsurance (E) Task Force, which met Sept. 25, 2018, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. The Task Force agreed to expose the proposed revisions to Model #785 and Model #786 for a 21-day public comment period ending Oct. 16, 2018. The Task Force received 14 comment letters on the Sept. 25, 2018, exposure documents, which were posted to the Task Force's page on the NAIC website for public viewing.

Nov. 9, 2018, Exposure. The drafting group considered the comment letters received on the Sept. 25, 2018, exposure and again prepared draft revisions for the consideration of the Reinsurance (E) Task Force. The Task Force met Nov. 9, 2018, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 for discussion by the Task Force at the 2018 Fall National Meeting. The Task Force received 16 comment letters, which were discussed during its Nov. 17, 2018, meeting. At that meeting, the Task Force adopted the draft revisions to Model

#785 and Model #786, and the Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed consistent with the issues raised by the Task Force. A detailed discussion of the action taken by the Executive (EX) Committee and Plenary and the Financial Condition (E) Committee with respect to these draft revisions can be found under Section 4—General Description of the Drafting Process of this project history.

March 7, 2019, Exposure. The drafting group again considered the comment letters and public discussion, as well as recommendations made by the Financial Condition (E) Committee in its memorandum dated Feb. 11, 2019. The drafting group again prepared draft revisions to Model #785 and Model #786 for discussion by the Task Force. The Task Force met March 7, 2019, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 on March 7, 2019, for a 25-day public comment period ending April 1, 2019. The Task Force received 10 comment letters on the March 7, 2019, exposure, which were discussed by the Task Force at the 2019 Spring National Meeting. The Task Force did not take a vote on the proposed revisions at this meeting, but it directed the drafting group to consider the comments heard and the comment letters received to update the draft revisions, which will not require a separate formal exposure period.

May 1, 2019, Exposure. The drafting group again considered the comment letters and public discussion, and it prepared draft revisions to Model #785 and Model #786 dated May 1, 2019, for discussion by the Reinsurance (E) Task Force during its May 15, 2019, conference call. During this conference call, the Task Force adopted the revisions and agreed to refer the proposed revisions to the Financial Condition (E) Committee for consideration of adoption.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The following significant issues were discussed extensively with state insurance regulators and interested parties during the drafting process:

- **NAIC Compliance with the Covered Agreement**. The NAIC initially opposed the EU Covered Agreement, primarily for failing to provide for formal recognition of the U.S. by the EU as a fully "equivalent" regulatory jurisdiction for Solvency II purposes. Following the signing of the EU Covered Agreement, the NAIC released a statement that it was pleased that the Treasury Department and the USTR clarified its interpretation in key areas and appreciated their affirmation of the primacy of state-based insurance regulation. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to conform to the terms of the Covered Agreement.

- **Similar Treatment for Qualified Jurisdictions**. In the NAIC "Notice of Public Hearing and Request for Comments," the Reinsurance (E) Task Force requested specific comments on providing reinsurers domiciled in NAIC qualified jurisdictions with similar reinsurance collateral requirements as those provided under the Covered Agreement. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Task Force to develop revisions to Model #785 and Model #786 to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the same collateral requirement treatment as provided to EU-domiciled reinsurers, the non-EU qualified jurisdiction must agree to adhere to all other standards imposed under the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states' approach to group supervision, including group capital.

- **Breach of the Covered Agreement**. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to address the effect of a breach of the Covered Agreement on a reinsurer's collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or Model #785 and Model #786. The Sept. 25, 2018, exposure draft of Model #785 contained a requirement that the reciprocal jurisdiction "is a member state of the European Union, and has been determined by the Commissioner to be in compliance with all material terms of the agreement." In its comment letters, the European Commission argued that this section provides the commissioner with the power to determine if each individual EU member state complies with the terms of the Covered Agreement, which appears to be inconsistent with the terms of the Covered Agreement. The drafting group deleted this provision from the May 1, 2019, draft of Model #785, and substituted "is subject to an in-force covered agreement."

- **Recognition of Qualified Jurisdictions**. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Qualified Jurisdiction (E) Working Group to consider changes to the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision and group capital standards, as well as require the strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach. The Nov. 9, 2018, exposure draft of Model #786 contained a provision that it "[r]ecognizes the U.S. state regulatory system, including its approach to group supervision and group capital, by providing through statute, regulation or the equivalent, including but not limited to confirmation by a competent regulatory authority, in such qualified jurisdiction…." Interested parties requested clarification on the process of recognition, and Section 9B(3)(c) of the March 7, 2019, exposure draft of Model #786 was revised to provide, as follows: "Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction…."

- **Recognition of Group-wide Supervision**. Due to concerns expressed by interested parties that Section 9B(3)(c) of Model #786 might act to change the group supervisor of a U.S.-domiciled affiliate, the drafting group clarified in a drafting note in the March 7, 2019, exposure that nothing in this provision is intended to enhance or limit the authority of U.S. state insurance regulation with respect to the group-wide supervision of insurance holding company systems pursuant to state law.

- **Recognition of NAIC-Accredited Jurisdictions as Reciprocal Jurisdictions**. The initial June 21, 2018, exposure drafts did not include U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions. Interested parties commented that this was not consistent with the current qualified jurisdiction provisions of Model #785 and Model #786, noting that U.S. reinsurers domiciled in accredited states should receive similar treatment to EU reinsurers and other reinsurers domiciled in qualified jurisdictions. The Reinsurance (E) Task Force added U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions in the March 7, 2019, exposure drafts.

- **Memorandum of Understanding**. At the suggestion of interested parties, the memorandum of understanding required for qualified jurisdictions and reciprocal jurisdictions under Section 9B of Model #786 was clarified to include the International Association of Insurance Supervisors' (IAIS) Multilateral Memorandum of Understanding (MMoU) or other multilateral memoranda of understanding coordinated by the NAIC in the Sept. 25, 2018, exposure.

- **Annual Reduction in Collateral by 20%**. Article 9(3)(a) of the Covered Agreement provides that "the United States shall encourage each U.S. State to promptly adopt the following measures: (a) the reduction, in each year following the date of entry into force or provisional application of this Agreement, of the amount of collateral required by each State to allow full credit for reinsurance by 20 percent of the collateral that the U.S. State required as of the January 1 before signature of this Agreement." The Task Force determined that it was not consistent with the current Model #785 and Model #786 to meet this requirement. Instead, the Task Force determined that the best course of action was to work in an expeditious manner to amend Model #785 and Model #786 for enactment by the states to eliminate collateral for assuming insurers domiciled in Covered Agreement jurisdictions.

- **Commissioner Discretion: EU Jurisdictions**. The European Commission's comment letters argued that the draft revisions to Model #785 and Model #786 contained additional requirements on EU reinsurers that were not provided in the Covered Agreement. For example, the European Commission argued that a state insurance commissioner does not have the discretion to determine whether an individual EU jurisdiction is in compliance with the Covered Agreement, and Section 9C(8) of Model #786 provided in its initial drafts that "the assuming insurer must satisfy any other requirements deemed relevant by the commissioner." The May 1, 2019, exposure drafts removed all elements of commissioner discretion with respect to reinsurers domiciled in Covered Agreement reciprocal jurisdictions.

- **Commissioner Discretion: Qualified Jurisdictions**. The original draft revisions to Model #785 and Model #786 contained additional requirements that were applicable to assuming insurers domiciled in qualified jurisdictions, but they were not applicable to those reinsurers domiciled in jurisdictions subject to a Covered Agreement. For example, Section 2F(1)(h) of Model #785 required the assuming insurer to "satisfy any other requirement deemed relevant by the commissioner" for its cedant to receive the benefit of the credit for reinsurance provisions. In addition, the definition of "reciprocal jurisdiction" in Model #786 included "[s]uch additional factors as may be considered in the discretion of the commissioner." Interested parties representing qualified jurisdictions argued that the NAIC should work toward a framework that treats EU and non-EU jurisdictions equivalently and provide additional clarity

regarding the standards imposed on non-EU jurisdictions. The May 1, 2019, exposure drafts have removed the remaining distinctions between EU and non-EU jurisdictions, and they treat qualified jurisdictions similarly to EU jurisdictions.

- **Effective Date**. The original June 21, 2018, draft of Section 2F(7) of Model #785 contains the following provision: "This subsection shall not apply to reinsurance agreements entered into before the subsection's application, or to losses incurred or to reserves posted before the subsection's application." This was to clarify that these revisions would not eliminate reinsurance collateral that is currently in place, similar to the current certified reinsurer provisions of Model #785 and Model #786. This provision was included in the *Statement of the United States on the Covered Agreement with the European Union* issued Sept. 22, 2017. There were concerns expressed by interested parties, including the European Commission, that this sentence was not consistent with Article 3(8) of the Covered Agreement. The Task Force removed this provision in the March 7, 2019, exposure draft.

  In its comment letter dated March 28, 2019, the European Commission also argued that Section 2F(7) was not consistent with Article 3(8) of the Covered Agreement, which provides that the Covered Agreement takes effect "only to reinsurance agreements entered into, amended, or renewed on or after the date on which a measure that reduces collateral pursuant to this Article takes effect…" The Task Force disagreed with this interpretation, noting that there are additional requirements contained in Article 3 of the Covered Agreement that also must be met before an EU reinsurer is permitted to eliminate reinsurance collateral, including meeting minimum capital and surplus requirements of $250 million, 100% SCR, consent to the jurisdiction of the courts, service of process requirements, filing of audited financial statements, actuarial opinions, list of all disputed and overdue claims, information on prompt payment of claims, etc. Therefore, the Task Force made the determination that Section 2F(7) should remain, as follows: "Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection, and only with respect to losses incurred and reserves reported on or after the later of **(i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein** [emphasis added], and (ii) the effective date of the new reinsurance agreement, amendment, or renewal."

- **Foreign Currency Exchange**. Section 9C(2)(c), Section 9C(6)(b) and Section 9C(6)(c) of Model #786 in the initial June 21, 2018, exposure draft contained a reference to foreign currency exchange rates to calculate the $250 million capital and surplus requirement for EU reinsurers under Article 3(4)(a) of the Covered Agreement. The European Commission commented that a reference to foreign currency exchange rates was not necessary with respect to EU reinsurers, because the Covered Agreement made 226 million euros equivalent to $250 million for these purposes. The drafting group disagreed with this interpretation, but it removed the reference in the May 1, 2019, exposure draft of Model #786, because commissioners are already utilizing foreign currency exchange rates in the calculation of minimum capital and surplus with respect to certified reinsurers licensed and domiciled in qualified jurisdictions.

- **Service of Process**. Section 2F(1)(d)(ii) of the Sept. 25, 2018, draft to Model #785 provided: "The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. Either by law, regulation or request of the commissioner, such consent shall be included in each reinsurance agreement." The European Commission commented that Article 3(4)(e) of the Covered Agreement provides that "where applicable for 'service of process' purposes, the assuming reinsurer provides written confirmation to the Host supervisory authority of consent to the appointment of that supervisory authority as agent for service of process. The Host supervisory authority may require that such consent be provided to it and included in each reinsurance agreement under its jurisdiction." This section was amended in the March 7, 2019, exposure draft to be consistent with the Covered Agreement: "The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement."

- **Insolvency of U.S. Ceding Insurer**. The June 21, 2018, exposure of Model #785 contained the following provision: "The **commissioner shall require** [emphasis added] an assuming insurer under this subsection to post one hundred percent (100%) security, for the benefit of the ceding insurer or its estate, upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer." Interested parties noted that Article 3(4)(k) of the Covered Agreement instead provides: "if subject to a legal process of resolution, receivership, or winding-up proceedings as applicable, **the ceding insurer, or its representative,** [emphasis added] may seek and, if determined appropriate by the court in which the resolution, receivership, or winding-up proceedings is pending, **may obtain an order** [emphasis added] requiring that the assuming reinsurer post collateral for all outstanding ceded liabilities." The Task Force agreed that the Covered Agreement required the ceding insurer or its representative to seek such an order from the

court, not the insurance commissioner, and amended Section 9H of Model #786 in the March 7, 2019, exposure draft accordingly.

- **Audited Financial Statements for Certified Reinsurers**. At the request of the European Commission, the drafting group and Reinsurance (E) Task Force amended Section 8B(4)(h) and Section 8B(7)(d) of Model #786 to require the filing of annual financial statements for certified reinsurers consistent with the requirements of Article 3(4)(h) of the Covered Agreement; i.e., two years of audited financial statements filed with the assuming insurer's supervisor. This makes the certified reinsurer provisions consistent with Article 3(4)(h)(i) of the Covered Agreement.

- **Passporting Process**. Section 9C(5) of the June 21, 2018, draft of Model #786 provided that the assuming insurer "must provide the following documentation to the commissioner." The European Commission noted that Article 3(4)(h) of the Covered Agreement provides that this information must only be provided "if requested by that supervisory authority." The Task Force amended Section 9C(5) in the March 7, 2019, exposure draft to be consistent with the language of the Covered Agreement, but it added a drafting note encouraging the states to utilize the "passporting" process under which the commissioner has the discretion to defer to another state's determination with respect to compliance. In order to facilitate the passporting process, the states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) so that other states may rely on the lead state's determination.

- **Serious Noncompliance**. Section 9C(4)(a) of the Sept. 25, 2018, draft of Model #786 provided a definition for "serious noncompliance with applicable law" in order to promote uniformity among the states and provide guidance to reciprocal jurisdiction reinsurers. Interested parties noted that Article 3(4)(c)(ii) of the Covered Agreement does not contain a definition of "serious noncompliance," and, as such, the drafting group and the Reinsurance (E) Task Force deleted this definition in the March 7, 2019, exposure draft due to perceived inconsistency with the Covered Agreement.

- **Solvent Schemes of Arrangement**. The Nov. 9, 2018, exposure draft of Model #785 deleted the definition of "solvent scheme of arrangement" from Section 2F(1)(d)(v), but it retained it in Section 9C(4)(e) of Model #786. Interested parties recommended that the Reinsurance (E) Task Force should clarify that the requirements with respect to solvent schemes also apply to Part VII-like transfers under UK law, and U.S. state insurance regulators should treat Part VII transfers the same as solvent schemes of arrangement. Interested parties argued that Part VII transfers should not be treated differently than a solvent scheme for the purposes of triggering the posting of 100% collateral because a Part VII transfer typically produces the same result to ceding insurers as a commutation in that a Part VII transfer typically involves a transfer of assumed business by an assuming reinsurer to another reinsurer that: 1) does not write new business; 2) does not have access to additional capital; and 3) does not have the intent or ability to raise additional capital, if necessary, to satisfy all remaining assumed obligations. The drafting group and the Task Force determined not to make this clarification, and Part VII-like transfers are not intended to be solvent schemes of arrangement for the purposes of this provision.

- **Reciprocal Jurisdiction Process**. The Reinsurance (E) Task Force added a drafting note after Section 9D of Model #786 at the request of interested parties to address the process with respect to the revocation or suspension of the status of a reciprocal jurisdiction. Interested parties requested that the process specifically be included in either Model #785 or Model #786, but the drafting group determined that this process should be developed after adoption of the revisions to the models. The drafting group also added a provision to the drafting note in the March 7, 2019, exposure draft that "such process would not conflict with the terms of an in-force covered agreement" to clarify that such jurisdictions are automatically included on the NAIC List of Reciprocal Jurisdictions.

- **Other Inconsistencies with the Covered Agreement**. Throughout the exposure process, interested parties made numerous comments about perceived inconsistencies between the language of the Covered Agreement and the exposure drafts of Model #785 and Model #786. The drafting group and the Reinsurance (E) Task Force have made every attempt to conform the language of Model #785 and Model #786 to the specific language utilized by the Covered Agreement.

- **Material Adverse Development Coverage**. Interested parties commented that Section 2F(7) of Model #785 (Effective Date) does not account for certain agreements entered into in contemplation of some long-tail losses, such as adverse development covers that are signed after losses occur, but before the reserves have developed to be within the limits of the adverse development cover. This could have the unintended consequence of excluding adverse development coverage contracts from application of the reciprocal jurisdiction provisions. Tying the application of reciprocal status requirements to only those "losses incurred" after reciprocal status may negatively impact loss portfolio transfers and adverse development covers. The drafting group recognized the value of such reinsurance as a useful regulatory and commercial tool to facilitate the transfer of blocks of business and rehabilitate financially distressed companies, and discussed various options in addressing this issue, but ultimately it was unable to agree upon specific language satisfactory to everyone. In addition, there were some concerns expressed with providing the commissioner additional discretion in this area. Therefore, the Task Force does not take a position on whether material adverse development coverage agreements are or should be subject to reduced collateral authorized by the changes to the model law.

- **Kroll Bond Rating Agency**. On Dec. 3, 2017, the Reinsurance (E) Task Force adopted the recommendation that the states may consider Kroll Bond Rating Agency as an acceptable rating agency for certified reinsurer purposes, and the Task Force adopted the *Uniform Application Checklist for Certified Reinsurers* with the additional language, stating that it be "recognized by the SEC to provide financial strength ratings on insurance companies" and included the proposed matrix of ratings and collateral levels for use with Kroll Bond Rating Agency. However, the Task Force could not agree on language to amend the ratings matrix found in Section 8B of Model #786 to include Kroll Bond Rating Agency.

7. Any Other Important Information (e.g., amending an accreditation standard)

The Reinsurance (E) Task Force has not had formal discussions with respect to whether the current *Reinsurance Ceded* accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #785 and/or Model #786. However, these revisions would have the effect of eliminating reinsurance collateral with respect to reinsurers domiciled in reciprocal jurisdictions, so, at a minimum, it will be necessary to amend the accreditation standards to reflect these revisions with respect to *Reinsurance Ceded to Certified Reinsurers*, which reduce but do not completely eliminate reinsurance collateral. In addition, it is further the recommendation of the Task Force that it is necessary to expeditiously modify these standards in accordance with the *Procedure for the Adoption of Additional Model Laws, Regulations or Standards for Accreditation*. This waiver in procedure is necessary because the states are expected to immediately begin considering these revisions for enactment into state law and regulation due to the 60-month (five-year) period in which the states are required to enact the revisions to in order to be consistent with the Covered Agreement or face potential federal preemption.

The Task Force has not determined whether these revisions should result in an "optional" accreditation standard or a "uniform" accreditation standard. The NAIC originally adopted the significant elements of the 2011 revisions to Model #785 and Model #786 as an "optional" accreditation standard. Specifically, under this optional standard, a state was not required to enact the certified reinsurer revisions to the models, but if it chose to reduce its reinsurance collateral requirements, the state's laws and regulations must be substantially similar to the key elements of the revisions. Upon further review and consultation with state insurance regulators and interested parties, the Financial Regulation Standards and Accreditation (F) Committee determined that the certified reinsurer provisions result in increased financial solvency regulation and increased consumer protection to policyholders, and they should be adopted as a "uniform" standard applicable to all NAIC-accredited jurisdictions under the "substantially similar" definition. The 2019 revisions to Model #785 and Model #786 could be considered under either an "optional" or a "uniform" accreditation standard.

Finally, the Task Force should consider whether to make the "passporting" process subject to the *Part B: Regulatory Practices and Procedures* accreditation standards. Generally, models are incorporated into the *Part A: Laws and Regulations* accreditation standards, but the NAIC's passporting process is not specifically required in Model #785 and/or Model #786. Model #786 does contain the following drafting note found after Section 9C(5):

> **Drafting Note:** In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called "passporting" under which the commissioner has the discretion to defer to another state's determination with respect to compliance with this Section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. It is anticipated that "lead" states will uniformly

require assuming insurers to provide the documentation described in Section 9C(5) of this regulation, so that other states may rely upon the lead state's determination.

The Task Force should consider whether the passporting process should become part of the Part B accreditation requirements and require states to participate in passporting consistent with the guidance provided in the drafting note.

PROJECT HISTORY - 2011

CREDIT FOR REINSURANCE MODEL LAW (#785)

CREDIT OF REINSURANCE MODEL REGULATION (#786)

1. Description of the Project, Issues Addressed, etc.

Under the current NAIC Credit for Reinsurance Model Law & Regulation, in order for U.S. ceding companies to receive reinsurance credit, the reinsurance must either be ceded to U.S. licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. The collateral requirements for non-U.S. licensed reinsurers have been a frequent subject of debate over the past decade, with various groups calling for the elimination of the collateral requirement for reinsurers licensed in well-regulated jurisdictions. On September 19, 2011, both the Reinsurance (E) Task Force and Financial Condition (E) Committee adopted revisions to the *Credit for Reinsurance Model Law* (#785) *and Regulation* (#786) at a meeting held in Jersey City, New Jersey. These amendments will act to reduce reinsurance collateral requirements for non-U.S. reinsurers domiciled in qualified jurisdictions, and will be up for consideration by NAIC Executive (EX) Committee and Plenary at the Fall National Meeting in Washington, D.C.

2. Name of Group Responsible for Drafting the Model and States Participating

The Reinsurance Task Force of the Financial Condition (E) Committee was responsible for drafting the revisions to the Credit for Reinsurance Models:

Thomas B. Considine, Chair	New Jersey	John M. Huff	Missouri
James J. Wrynn, Vice Chair	New York	Bruce R. Ramge	Nebraska
Jim L. Ridling	Alabama	Amy Parks	Nevada
Christina Urias	Arizona	Roger A. Sevigny	New Hampshire
Jay Bradford	Arkansas	John G. Franchini	New Mexico
Dave Jones	California	John D. Doak	Oklahoma
Thomas B. Leonardi	Connecticut	Michael F. Consedine	Pennsylvania
Karen Weldin Stewart	Delaware	Ramón Cruz-Colón	Puerto Rico
Kevin M. McCarty	Florida	Joseph Torti III	Rhode Island
Gordon I. Ito	Hawaii	David Black	South Carolina
Jack Messmore	Illinois	Neal T. Gooch	Utah
Stephen W. Robertson	Indiana	Stephen W. Kimbell	Vermont
James J. Donelon	Louisiana	Jacqueline K. Cunningham	Virginia
Eric A. Cioppa	Maine	Mike Kreidler	Washington
Mike Rothman	Minnesota	Ted Nickel	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

This Project History supplements the Project History for the Reinsurance Regulatory Modernization Framework, which is attached hereto and incorporated by reference. The Task Force received charges in both 2009 and 2010 to "promote and facilitate the implementation of the adopted Reinsurance Regulatory Modernization Framework." The project was specifically authorized in 2011 when the Task Force received the following charge: "Consider amendments to the *Credit for Reinsurance Model Law* (#785) *and Credit for Reinsurance Model Regulation* (#786) to incorporate key elements of the Reinsurance Regulatory Modernization Framework." The Executive (EX) Committee approved the model law request for revising the Model #785 and Model #786 at the 2010 Fall National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The NAIC adopted the Reinsurance Regulatory Modernization Framework ("Framework") at its Winter 2008 National Meeting as the first step in an effort to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. The Framework recommended implementation through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation of this legislation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation.

On September 15, 2009, the Reinsurance Task Force adopted the Reinsurance Regulatory Modernization Act of 2009, which was approved on September 23, 2009, by the NAIC Government Relations Leadership Council. This proposed federal legislation was based on the Framework, and underwent an extensive review process. The Task Force released drafts of the proposed federal legislation to the public on March 24, July 27 & September 3, 2009, and the legislation was extensively revised based upon comments received from regulators and interested parties. The Task Force also held an open forum in New York on May 6-7, 2009, to receive public comments on the legislation, in addition to the numerous opportunities for public comment that were afforded during the drafting of the Framework.

The NAIC was unable to find a sponsor for the federal legislation in Congress, and it did not receive passage. Instead, Congress enacted the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, which was signed into law on July 21, 2010. This act includes the Nonadmitted and Reinsurance Reform Act ("NRRA"), as well as creates the Federal Insurance Office ("FIO"). The NRRA prohibits a state from denying credit for reinsurance if the domiciliary state of the ceding insurer recognizes such credit and is either (1) an NAIC-accredited state; or (2) has financial solvency requirements substantially similar to NAIC accreditation requirements. This permitted the NAIC to move forward with individual state-based reinsurance collateral reduction reforms.

The revisions to the Credit for Reinsurance Models were drafted by the Task Force through a deliberate process that included two exposure periods and consideration of voluminous comments submitted by interested parties representing U.S. ceding insurers, non-U.S. reinsurers and regulators. Much of the actual drafting of the language within the proposal was undertaken during regulator-to-regulator sessions due to discussion of company specific information and consultation with NAIC staff. The Task Force considered comments from interested parties related to each of these exposure drafts in order to further develop and refine the revisions. In many cases, specific concepts or specific language recommended by interested parties has been included within the revisions, as deemed appropriate by the Task Force. In addition, the Task Force considered information that it received from various international regulators.

The Reinsurance Task Force further adopted a Preface to the Credit for Reinsurance Models on September 19, 2011. The Preface is a statement by the Task Force of the next steps to be taken after the adoption of the revised models, including (1) a proposal to form a new group to provide high quality review of reinsurance collateral reduction applications and assistance to the states; (2) consider reinsurance diversification and notification requirements for ceding insurers; (3) requirements for NAIC review and approval of qualified jurisdiction; and (4) a re-examination of the collateral requirements within two years after the effective date of the revised Credit for Reinsurance Models.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

On February 22, 2011, the Task Force released exposure drafts of revisions to Model #785 and Model #786 for a 30-day comment period. The Task Force received several comment letters from interested parties and discussed these drafts on March 26 during the Spring National Meeting in Austin, Texas. The Task Force then held an interim meeting in Jersey City, New Jersey on July 11 and took public testimony from interested parties on the proposed amendments. On July 26, the Task Force released a second set of proposed amendments to the Credit for Reinsurance Models, which were exposed for a 30-day public comment period ending on August 24. The Task Force and Financial Condition (E) Committee adopted these drafts at a meeting in Jersey City, New Jersey on September 19, with additional amendments made during each meeting (discussion following). Some of the major revisions to the models include:

- Each state will have the authority to certify reinsurers, or a commissioner has the authority to recognize the certification issued by another NAIC-accredited state. This eliminates the need for a reinsurer to be evaluated by each and every state, but preserves a commissioner's right to do so.

- Reinsurers are subject to certain criteria in order to be eligible for certification, as well as ongoing requirements in order to maintain certification. Examples of evaluation criteria include, but are not limited to, financial strength, timely claims payment history, and the requirement that a reinsurer be domiciled and licensed in a "qualified jurisdiction."

- Each state may evaluate a non-U.S. jurisdiction in order to determine if it is a "qualified jurisdiction." The state may also defer to an NAIC list of recommended qualified jurisdictions.

- A certified reinsurer will be eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification [Note: clarification added in September 19 amendments]. A state will evaluate a reinsurer that applies for certification, and will assign a rating based on the evaluation. A certified reinsurer will be required to post collateral in an amount that corresponds with its assigned rating (0%, 10%, 20%, 50%, 75% or 100%), in order for a U.S. ceding insurer to be allowed full credit for the reinsurance ceded. Note: in the July 26 revisions, the collateral/rating matrix was changed with regard to companies with A- financial strength ratings, and a new Secure 4 tier was added for A- rating at 50% collateral.

- A certified reinsurer is allowed to utilize a multiple-beneficiary trust account for the purposes of securing its obligations to U.S. ceding insurers, but it must be separate from any existing multiple-beneficiary trust account.

- Proportional credit will still be permitted if there is insufficient security provided by a certified reinsurer. Specific provisions are also included to address a change in, or revocation of, the certified reinsurer's status.

- Contracts entered into by certified reinsurers are subject to certain mandatory contract clauses in order for a U.S. ceding insurer to be allowed credit for the reinsurance ceded.

- Certified reinsurers are subject to additional filing requirements, including but not limited to new forms CR-1, CR-F and CR-S.

- The revised models also include proposed changes with respect to the trusteed surplus requirement for a multiple-beneficiary trust account maintained by an assuming insurer in run-off (Tawa proposal).

- Finally, technical amendments were incorporated into the models revising language that had grown outdated and needed updating.

On September 19, 2011, both the Task Force and Financial Condition (E) Committee adopted additional revisions to the Credit for Reinsurance Models, but the amendments made during this meeting were not exposed for a public comment period. However, each of the revisions addressed issues that had been substantively debated by both the Task Force and interested parties over the previous years during discussions regarding the Framework and proposed federal legislation, as well as the revisions to the models. These revisions can be summarized as follows:

- Prospective Application. The Task Force adopted an amendment intended for clarification and to close a perceived loophole with respect to the effective date of the revised reinsurance collateral requirements, and to confirm that any potential collateral reductions would be phased-in as any future reductions would be done on a prospective basis and any prior liabilities would remain secured at 100% collateral.

- PCI/RAA Compromise. The Task Force adopted amendments related to a compromise proposal submitted by the Property Casualty Insurers Association of America ("PCI") and the Reinsurance Association of America ("RAA") regarding 4 important issues: (1) 30-day comment period on application for certified reinsurer status; (2) slow payment analysis of reinsurers; (3) financial statement reporting requirements for certified reinsurers and applicants for certification; and (4) disclosure of reinsurance counterparty information on new forms CR-S and CR-F. The specific amendments adopted as part of the PCI/RAA compromise include.

    1. Information will be provided with respect to how interested parties may specifically respond/comment on applications for certified reinsurers during a 30-day notice period. However, this should not trigger any Administrative Procedures Act requirements;

    2. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements will now be based specifically on an analysis of cedents' Schedule F reporting of overdue reinsurance recoverables, and may increase collateral requirements in certain specified situations;

3. Certified Reinsurers must submit audited financial statements, and, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company are acceptable;

4. Certified reinsurers must submit Forms CR-S or CR-F, at a level of detail in accordance with instructions to be developed by the NAIC.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

- Federal v. State Implementation. The Framework recommended implementation through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation of this legislation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation. The NAIC was unable to find congressional sponsorship for this proposed federal legislation. The Nonadmitted and Reinsurance Reform Act, which became effective July 21, 2011, preempts the extraterritorial application of state credit for reinsurance law, and now permits states to proceed forward with reinsurance collateral reforms on an individual basis if they are accredited.

- Federal Insurance Office. The Dodd-Frank Act established the FIO to receive information on the insurance sector from the NAIC and enter into binding "covered agreements" with international bodies. It is widely understood that reinsurance collateral may be an initial subject of these agreements. The Dodd Frank Act allows the office in Treasury to preempt a state insurance measure to the extent that it (1) results in less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a covered agreement than a U.S. insurer domiciled, licensed, admitted, or otherwise authorized in that state; and (2) is inconsistent with such covered agreement.

- Individual State Initiatives. Some states have begun moving forward with individual state-based reinsurance collateral reforms. Florida adopted changes to its credit for reinsurance laws and regulations in 2007 and 2008 respectively, New York adopted similar changes in November 2010, and New Jersey and Indiana recently enacted similar legislation as well. In addition, bills have been discussed in Illinois, Texas and Louisiana, as well as other states. In response, the NAIC Plenary approved the Recommendations Regarding Key Elements of the Reinsurance Framework for Accreditation Purposes in December 2010.

- Requirements for Certified Reinsurers. The Task Force addressed what requirements an assuming insurer must meet in order to be approved as a certified reinsurer, and the specific information that certified reinsurers should be required to file, including questions regarding proposed schedules CR-F and CR-S as well as financial statements.

- Reciprocity. The NAIC Reinsurance Supervision Review Department (RSRD) Proposal in 2007 proposed a mutual recognition framework that would take into consideration the reciprocal treatment of non-U.S. jurisdictions. At the request of interested parties, the NAIC Legal Division issued a memorandum addressing the constitutional issues of the mutual recognition framework on July 15, 2008. The Framework adopted in December of 2008 provided that the reciprocal treatment of non-U.S. reinsurers would be a factor to be considered in the review of non-U.S. jurisdictions. The model regulation considers mutual recognition to be a factor in reviewing non-U.S. jurisdictions.

- Concentration of Risk. The Task Force considered restrictions to limit concentration risk by a ceding insurer to any reinsurer or group of reinsurers. The Task Force will make a referral to E Committee to address this issue.

- Life Reinsurance & Other Long Tail Contracts. The Task Force considered whether special limitations should be placed on life insurance and other longer tail-types of reinsurance agreements. The Reinsurance Framework Proposal originally included a 2-year moratorium on collateral reduction to life contracts, but the revised models no longer include this distinction.

- Reconciliation to U.S. GAAP. The Task Force considered the accounting and reporting basis that would be applicable to financial statements filed by certified reinsurers. Earlier versions of the models required financial statements to be filed on an audited U.S. GAAP basis, or on an IFRS basis with an audited reconciliation to U.S. GAAP for equity and net income. At the September 19 meetings, an amendment was adopted to allow audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company, with the permission of the state insurance commissioner.

- Prospective Application of Revisions. During the course of drafting the Framework and model revisions, the Task Force has consistently taken the position that any potential collateral reductions would be phased-in as any future reductions would be done on a prospective basis and any prior liabilities would remain secured at 100% collateral. Property and Casualty ceding insurers were strongly opposed to permitting reinsurance collateral under existing reinsurance agreements to be reduced or eliminated. Reinsurers and some ceding insurers would like to be able to amend existing agreements to reduce collateral requirements. At the September 19, 2011 meetings the Task Force adopted an amendment intended for clarification and to close a perceived loophole with respect to the effective date of the revised reinsurance collateral requirements.

7. Any Other Important Information (e.g., amending an accreditation standard).

In December 2010, the NAIC Plenary approved the Recommendations Regarding Key Elements of the Reinsurance Framework for Accreditation Purposes (Accreditation Recommendations), which are the key elements of the Reinsurance Regulatory Modernization Framework that should be considered in reviewing any individual state initiatives with respect to reinsurance collateral reduction reforms. The Accreditation Recommendations were intended as an interim solution to guide the Financial Regulation Standards and Accreditation (F) Committee and the NAIC during the transition period between adoption of the Framework and proposed revisions to the reinsurance models.

The revisions, if adopted, would become part of the Credit for Reinsurance Models, and would be considered by the Financial Regulation Standards and Accreditation (F) Committee as an amendment to the existing standard for Reinsurance Ceded. It should also be noted that the proposed revisions to the models would not require a state to reduce its reinsurance collateral requirements. It is further the recommendation of the Task Force that it is necessary to expeditiously modify these standards in accordance with the Procedure for the Adoption of Additional Model Laws, Regulations or Standards for Accreditation.

PROJECT HISTORY - 2006

CREDIT FOR REINSURANCE MODEL REGULATION (#786)

1. Project Description

Prior to changes made to the U.S. Bankruptcy Code §304, there existed a tension between McCarran-Ferguson and the Bankruptcy Code, and which would prevail in the event of a direct challenge on point.

The Task Force adopted certain revisions to the model regulation, which was considered unnecessary and potentially inconsistent with Section 304 of the U.S. Bankruptcy Code. The revision relates to Section 10(b)(14), which governs the procedure for administering the assets of a single beneficiary trust.

In the 1990's, amendments were made to the Credit for Reinsurance Model Act and Regulation aimed at addressing concerns adopting parallel language for single beneficiary trusts (SBTs) versus multiple beneficiary trusts (MBTs). However, with the following amendment to the Bankruptcy code, that language is no longer required.

Bankruptcy Code Amendments

Congress recently adopted amendments to the Bankruptcy Code, including the following which can be found in a new Chapter 15 to U.S.C. Title II, §1501(d):

> The court may not grant relief under this chapter with respect to any deposit, escrow, trust fund, or other security required or permitted under any applicable State insurance law or regulation for the benefit of claim holders in the United States.

This language is broad enough to apply to all security devices, whether MBTs or SBTs. This section makes clear and summarizes the treatment of trusts, the requirement that they be maintained in the U.S. and that assets be distributed in accordance with the laws of the state in which the trust is domiciled.

The Task Force also referred the issue to the Financial Regulation Standards and Accreditation (F) Committee so that for accreditation purposes, both the current model law and regulation as well as any amended version(s) arising from changes relating to this issue, be considered acceptable.

2. Group Responsible for the Report

The project was assigned to the Reinsurance (G) Task Force. The members of the task force at the time were: Julie Bowler (MA), Chair; John Oxendine (GA), Vice-Chair; Walter Bell (AL); John Garamendi (CA); Susan Cogswell (CT); Matthew Denn (DE); Thomas Hampton (DC); Kevin McCarty (FL); Michael McRaith (IL); Martin Koetters (KY); Alessandro Iuppa (ME); Glenn Wilson (MN); Alice Molasky-Arman (NV); Roger Sevigny (NH); Steven Goldman (NJ); Howard Mills (NY); Jim Poolman (ND); Diane Koken (PA); Dorelisse Juarbe Jimenez (PR); Mike Geeslin (TX); Alfred Gross (VA); Mike Kriedler (WA) and Jorge Gomez (WI).

3. Charge Authorizing the Project

As part of the NAIC 2006 Model Law Review, changes were proposed to the Credit for Reinsurance Model Regulation.

4. General Description of the Drafting Process and Discussion of Key Issues

The issue was proposed while changes to the U.S. bankruptcy code were in the process of being amended. After the changes were reviewed, it was determined that Section 10(b)(14) was unnecessary. The proposed amendment to the Model Regulation was exposed for a 60-day comment period where no opposition came from either interested parties or regulators. Receiving no additional comments or disagreement with the proposal, the task force adopted amendments during the NAIC 2006 Spring National Meeting.

PROJECT HISTORY – 2001

CREDIT FOR REINSURANCE MODEL REGULATION (#786)

1. Project Description

The Reinsurance (G) Task Force was charged with reviewing the Credit for Reinsurance Model Regulation to allow multi-beneficiary trust funds to be funded, in whole or in part, with clean, irrevocable, unconditional "evergreen" letters of credit. The charge was proposed by the Task Force at the NAIC 2000 Spring National Meeting.

2. Group Responsible for the Report

The project was assigned to the Reinsurance (G) Task Force. The members of the task force at that time were: John Oxendine (GA), Chair; Alessandro Iuppa (ME), Harry Low (CA), Donna Lee Williams (DE), Nathaniel Shapo (IL), Neil Levin (NY), Diane Koken (PA), and Jose Montemayor (TX). New members of the Task Force during the NAIC 2001 Spring National Meeting were Elisara Togiai (AS) and David Parsons (AL) replacing Pennsylvania.

3. Charge Authorizing the Project

The following charge was given to the Reinsurance (G) Task Force on March 12, 2000:

> The Reinsurance (G) Task Force shall consider the adequacy and appropriateness of currently applicable collateralization requirement regarding alien insurers.

4. General Description of the Drafting Process and Discussion of Key Issues

A draft of revisions to the Credit for Reinsurance Model Regulation was prepared in November 2000 by the task force, with input from interested parties. The task force accepted these amendments and proposed additional revisions from a January 25, 2001 conference call. The new additions give the trustee the right and the obligation to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire before being renewed or replaced. Also, the failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct. The Regulation was presented and adopted by the Task Force and the Special Insurance Issues (G) Committee at the NAIC 2001 Spring National Meeting.

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

TABLE OF CONTENTS:

Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to [insert provision of state law equivalent to Section 5 of the Credit for Reinsurance Model Law] of the [name of state] Insurance Code.

Section 2. Purpose and Intent

The purpose and intent of this regulation is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of Primary Security and Other Security, as defined in Section 5, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

Section 3. Applicability

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to Covered Policies, as that term is defined in Section 5B, issued by any life insurance company domiciled in this state. This regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation] shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation], the provisions of this regulation shall apply, but only to the extent of the conflict.

Section 4. Exemptions from this Regulation

This regulation does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6F of the Valuation of Life Insurance Policies Model Regulation] or [insert provision of state law equivalent to Section 6G of the Valuation of Life Insurance Policies Model Regulation]; and which are issued before the later of:

(a) The effective date of this regulation, and

(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6E of the Valuation of Life Insurance Policies Model Regulation] and which are issued before the later of:

(a) The effective date of this regulation, and

(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

(a) Secondary guarantee period, if any, is five (5) years or less;

(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provision of state law equivalent to Section 2D of the Credit for Reinsurance Model Law]; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:

(1) Is not an affiliate, as that term is defined in [insert provision of state law equivalent to Section 1A of the Insurance Holding Company System Regulatory Model Act], of:

(a) The insurer ceding the business to the assuming insurer; or

(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its Risk-Based Capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus; or

E. Reinsurance ceded to an assuming insurer that meets the requirements of [insert provision of state law equivalent to Section 5B(4) of the Credit for Reinsurance Model Law]; or

Drafting Note: A state may satisfy the requirements of Section 4E above by either adopting Section 5B(4) of the *Credit for Reinsurance Model Law* (#785), or it may include the specific provisions of Section 5B(4) of the *Credit for Reinsurance Model Law* (#785) directly into its adoption of this regulation, *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).

F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in Section 2 above);

(2) The risks are included within the scope of this regulation only as a technicality; and

(3) The application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 4F to exempt a reinsurance treaty from this regulation, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 4F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this regulation purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called "normal course" reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 4A, B, C, D, or E or meet the substantive requirements of this regulation.

Section 5. Definitions

A. "Actuarial Method" means the methodology used to determine the Required Level of Primary Security, as described in Section 6.

B. "Covered Policies" means the following: Subject to the exemptions described in Section 4, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

(2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. "Grandfathered Policies" means policies of the types described in Subsections B1 and B2 above that were:

(1) Issued prior to January 1, 2015; and

(2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 had that section then been in effect.

D. "Non-Covered Policies" means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

E. "Required Level of Primary Security" means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

F. "Primary Security" means the following forms of security:

(1) Cash meeting the requirements of [insert provision of state law equivalent to Section 3A of the Credit for Reinsurance Model Law];

(2) Securities listed by the Securities Valuation Office meeting the requirements of [insert provision of state law equivalent to Section 3B of the Credit for Reinsurance Model Law], but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(a) Commercial loans in good standing of CM3 quality and higher;

(b) Policy Loans; and

(c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. "Other Security" means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. "Valuation Manual" means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

Drafting Note: Section 5H presumes that each state is permitted under its state laws to directly reference the Valuation Manual adopted by the NAIC. If a state is required by its state laws to reference a state law or regulation, it should modify Section 5H as appropriate to do so.

I. "VM-20" means "Requirements for Principle-Based Reserves for Life Products," including all relevant definitions, from the Valuation Manual.

Drafting Note: Sections 5H and I presume that each state is permitted under its state laws to "adopt" the Valuation Manual in a manner similar to how the Accounting Practices and Procedures Manual becomes effective in many states, without a separate regulatory process such as adoption by regulation. It is desirable that all states adopt the Valuation Manual requirements and that such adoption be achieved without a separate state regulatory process in order to achieve uniformity of reserve standards in all states. However, to the extent that a state may need to adopt the valuation manual through a formal state regulatory process, these sections may be amended to reflect any state's need to adopt the Valuation Manual through regulation or otherwise.

Section 6. The Actuarial Method

A. Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 5B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 5B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

(2) For Covered Policies described in Section 5B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed [c_x/ (2 * number of reinsurance premiums per year)] where c_x is calculated using the same mortality table used in calculating the Net Premium Reserve; and

(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Regulation, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Regulation;

(7) If a reinsurance treaty subject to this Regulation cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and Section 7 shall be used to determine the reinsurance credit for the Covered Policy reserves; and

(b) Credit for the Non-Covered Policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Subparagraph (a), is held by or on behalf of the ceding insurer in accordance with [cite the state's version of Sections 2 and 3 of the Credit for Reinsurance Model Law]. Any Primary Security used to meet the requirements of this Subparagraph may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC's Life Actuarial (A) Task Force no later than the Dec. 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

Section 7. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

A. Requirements

Subject to the exemptions described in Section 4 and the provisions of Section 7B, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to [insert provisions of state law equivalent to Sections 2 or 3 of the Credit for Reinsurance Model Law] if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

(1) The ceding insurer's statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of [insert provisions of state law equivalent to the Standard Valuation Law] and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and

(2) The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this regulation and provides support for its calculation as determined to be acceptable to the commissioner; and

(3) Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law], on a funds withheld, trust, or modified coinsurance basis; and

(4) Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law]; and

(5) Any trust used to satisfy the requirements of this Section 7 shall comply with all of the conditions and qualifications of [insert provision of state law equivalent to Section 12 of the Credit for Reinsurance Model Regulation], except that:

(a) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 6B, be valued according to the valuation rules set forth in Section 6B, as applicable; and

(b) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 7A(3); and

(c) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 7A(3)) below 102% of the level required by Section 7A(3) at the time of the withdrawal or substitution; and

(d) The determination of reserve credit under [insert provision of state law equivalent to Section 12E of the Credit for Reinsurance Model Regulation] shall be determined according to the valuation rules set forth in Section 6B, as applicable; and

(6) The reinsurance treaty has been approved by the commissioner.

B. Requirements at Inception Date and on an On-going Basis; Remediation

(1) The requirements of Section 7A must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under Section 7A(3) or 7A(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

(2) Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of Section 3 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of Sections 7A(3) and 7A(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 7A(3), unless either:

(a) The requirements of Section 7A(3) and 7A(4) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 7A(3) and 7A(4) to be fully satisfied as of the valuation date.

(3) Nothing in Section 7B(2) shall be construed to allow a ceding company to maintain any deficiency under Section 7A(3) or 7A(4) for any period of time longer than is reasonably necessary to eliminate it.

Section 8. Severability

If any provision of this regulation is held invalid, the remainder shall not be affected.

Section 9. Prohibition against Avoidance

No insurer that has Covered Policies as to which this regulation applies (as set forth in Section 3) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in Section 2.

Section 10. Effective Date

This regulation shall become effective [insert date] and shall pertain to all Covered Policies in force as of and after that date.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2016 Proc. 3rd Quarter (adopted).
2020 1st Quarter (technical revisions).

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-167 (2021).		
Alaska	ALASKA ADMIN. CODE tit. 3, § 21.615 (2021) ; § 21.659 (2021); §§ 21.694 to 21.695 (2021).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-A1601 to R20-6-A1612 (2022).		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. CODE REGS. tit. 10, §§ 2303.23 to 2303.28 (2017).		
Colorado	3 CCR 702-4 (2021).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-88-13 to 38a-88-19 (2019).		
Delaware	BULLETIN 113 (2022).		
District of Columbia	NO CURRENT ACTIVITY		

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia	GA COMP. R. & REGS. 120-2-109-.07 (2022).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. ADMIN. CODE §§ 16-187-101 to 16-187-109 (2022).		
Idaho	BULLETIN 22-06 (2022).		
Illinois	Relying on adoption of AP&P Manual.		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-112.1 to 191-112.9 (2018).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. ADMIN. CODE 37 :XIII.18301 to 18317 (2022).		
Maine	CODE ME. R. tit. 02-031 Ch. 735, §§ 1 to 9 (2022).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	Relying on adoption of AP&P Manual.		
Minnesota	Relying on adoption of AG 48.		
Mississippi	19 MISS. ADMIN. CODE Pt. 2, R. 20.01 to 20.10 (2022).		
Missouri	MO. CODE REGS. ANN. Tit. 20, § 200-2.900 (2022).		
Montana	MONT. ADMIN. R. 6.6.6701 to 6.6.6707 (2022).		

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	BULLETIN 2022-015 (2022).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. ANN. § 58-7-22 (2021).		
North Dakota	N.D. ADMIN. CODE 45-03-26-01 to 45-03-26-09 (2022).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	Relying on adoption of AP&P Manual.		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	31 PA. CODE ch. 90J (2022).		
Rhode Island	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. REGS. 69-81 (2022).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	Bulletin 22-03 (2022).		
Texas	28 ADMIN. CODE §§ 7.614 to 7.616 (2022).		
Utah	U.A.C. R590-289 (2022).		
Vermont	VT. ADMIN. CODE 4-3-65:1 to 4-3-65:10 (2022).		

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	14 VA. ADMIN. CODE §§ 5-318-10 to 5-318-80 (2017).		
Virgin Islands	22 V.I.C. § 1446-3 to 1446-11.		
Washington	WASH. ADMIN. CODE 284-13-53903 (2022).		
West Virginia	W.V. ADMIN. CODE 114-102-1 to 114-102-6 (2022).		
Wisconsin	WIS. ADM. CODE §§ INS 52.005 to 52.07 (2022).		
Wyoming	WY RULES AND REGULATIONS 044.0002.69 §§ 1 to 10 (2018).		

PROJECT HISTORY - 2016

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION (#787)

This memorandum will discuss the background and history of the proposed *Term and Universal Life Insurance Reserve Financing Model Regulation* (#___) (XXX/AXXX Model Regulation). To provide a more complete picture with respect to the background behind this model regulation, this memorandum will provide an overview of the captive reinsurance financing issues that prompted a regulatory response, the framework adopted by the NAIC to respond to those issues, the development and adoption of *Actuarial Guideline XLVIII— Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48) to implement the framework, and the revisions to the *Credit for Reinsurance Model Law* (#785) adopted by the NAIC on Jan. 8, 2016, which were designed to provide commissioners with the specific authority to adopt the new model regulation developed to codify AG 48.

1. Description of the Project, Issues Addressed, etc.

The Principle-Based Reserving Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the principle-based reserving (PBR) initiative for life and health policies. This Task Force was also charged with further assessing and making recommendations regarding the solvency implications of life insurance reserve financing mechanisms addressed in the June 2013 *Captives and Special Purpose Vehicles: An NAIC White Paper*, which was drafted by the Captives and Special Purpose Vehicle (SPV) Use (E) Subgroup of the Financial Condition (E) Committee.

On its June 30, 2014, conference call, the Principle-Based Reserving Implementation (EX) Task Force adopted the recommendations in the report of Rector & Associates, Inc. (Consultants) dated June 4, 2014, regarding a proposal for the XXX/AXXX Reinsurance Framework (Framework). The Framework sought to address concerns regarding reserve financing transactions and to do so without encouraging them to move offshore. The changes would be prospective and apply only to the XXX term life insurance business and AXXX universal life with secondary guarantees (ULSG) business; i.e., the Framework applies only to reinsurance involving XXX and AXXX policies currently required to be valued under Section 6 or Section 7 of the *Valuation of Life Insurance Policies Model Regulation* (#830). The Framework would not change the statutory reserve requirements applicable to a ceding insurer; rather, it addresses the types of security that can back those reserves in connection with reserve financing transactions.

The Framework does not materially change the ability of insurers to obtain credit for reinsurance ceded to "certified" reinsurers or to obtain credit for reinsurance ceded to "licensed" or "accredited" reinsurers that follow statutory accounting and risk-based capital (RBC) rules. As a practical matter, the Framework requirements apply to reinsurance ceded to captive insurers, SPVs, reinsurers that are not eligible to become "certified" reinsurers, or reinsurers that materially deviate from statutory accounting and/or RBC rules. In those situations, the ceding insurer may receive credit for reinsurance if:

- The ceding insurer establishes gross reserves, in full, using applicable reserving guidance (currently, the "formulaic" approach under the *Standard Valuation Law* (#820), then later PBR reserves);

- Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis;

- Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held are held by or on behalf of the ceding insurer as security under the reinsurance contract;

- At least one party to the financing transaction holds an appropriate RBC "cushion"; and

- The reinsurance arrangement is approved by the ceding insurer's domestic regulator.

The Executive (EX) Committee adopted the Framework (in concept) on Aug. 17, 2014. As an interim step to implementing the Framework, the NAIC adopted AG 48 on Dec. 16, 2014. The expectation is that AG 48 would eventually be replaced by effective codification through revisions to Model #785 and creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies. The Reinsurance (E) Task Force and the Financial Condition (E) Committee adopted the revisions to Model #785 on a joint conference call on Jan. 6, 2016; these revisions were later adopted by the Executive (EX) Committee and Plenary on Jan. 8, 2016.

The Reinsurance (E) Task Force adopted the XXX/AXXX Model Regulation at the Summer National Meeting on Aug. 27, 2016, and it was adopted by the Financial Condition (E) Committee via conference call on Sept. 30, 2016. Both the revisions to Model #785 and the proposed XXX/AXXX Model Regulation (once adopted by the Executive (EX) Committee and Plenary) are intended to be adopted by the NAIC as a new accreditation standard.

2. Name of Group Responsible for Drafting the Model and States Participating

Reinsurance (E) Task Force: California (Chair), Nebraska (Vice Chair) Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

On June 30, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted the XXX/AXXX Reinsurance Framework in concept, and adopted draft charges to the Reinsurance (E) Task Force with respect to implementation of the Framework. On Aug. 17, 2014, the Executive (EX) Committee adopted the following charges to the Reinsurance (E) Task Force and a request for model law development with respect to these charges:

- Request permission from the Executive (EX) Committee to create a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies. The Principle-Based Reserving Implementation (EX) Task Force's XXX/AXXX Reinsurance Framework Exhibit 4 should be considered for this model regulation, modified as deemed appropriate by the Task Force.—*Essential*

- Request permission from the Executive (EX) Committee to amend the *Credit for Reinsurance Model Law* (#785) and draft the amendments to reference the new model regulation drafted in accordance with the previous charge.—*Essential*

On Nov. 20, 2015, April 4, 2016, and Aug. 27, 2016, the Reinsurance (E) Task Force requested extensions from the Financial Condition (E) Committee in order to continue working on the proposed XXX/AXXX Model Regulation.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.); Include any parties outside the members that participated

On Oct. 29, 2014, the Reinsurance (E) Task Force appointed the XXX/AXXX Captive Reinsurance Regulation Drafting Group (Drafting Group), an informal drafting group composed of members of the Task Force, which was tasked with developing an initial draft of the XXX/AXXX Model Regulation incorporating the provisions of proposed AG 48. The members of the Drafting Group were: Doug Stolte (VA), Chair; John Finston and Monica Macaluso (CA); Kathy Belfi (CT); Linda Sizemore, Dave Lonchar and Steve Kinion (DE); Robert Wake (ME); John Rehagen (MO); Justin C. Schrader (NE); Richard Schlesinger (NJ); Mike Maffei (NY); and David Provost (VT). The Task Force directed the Drafting Group to refrain from beginning any drafting on the model regulation until the Principle-Based Reserving Implementation (EX) Task Force had finished its work on AG 48. Once this Task Force completed its work on AG 48, the Drafting Group could determine whether any changes to the AG 48

approach should be made in the model regulation. If the Drafting Group was of the opinion that any substantive modifications should be made to the AG 48 approach as it finalized the model regulation, it was to have submitted those proposed changes to the Principle-Based Reserving Implementation (EX) Task Force for further guidance. The overall objective was to implement the AG 48 approach, unless there were significant issues with respect to this implementation.

The Drafting Group met via conference call in regulator-to-regulator session on the following dates: Oct. 14, 2014; March 10, 2015; March 23, 2015; April 21, 2015; May 11, 2015; June 23, 2015; June 24, 2015; July 14, 2015; Oct. 23, 2015; and June 1, 2016. The Drafting Group, with assistance from Consultants and NAIC staff, reviewed, discussed and drafted a proposed XXX/AXXX Model Regulation and proposed revisions to Model #785, which were presented to the Reinsurance (E) Task Force at the 2015 Summer National Meeting. The Drafting Group continued to work on the XXX/AXXX Model Regulation at the direction of the Task Force. Principal interested parties involved in the drafting process were: the American Council of Life Insurers (ACLI); the Reinsurance Association of America (RAA); New York Life and Northwestern Mutual; and members of the captive insurance industry.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Revisions to Model # 785

As previously noted, AG 48 is the basis for the new regulation, and provides the detail for what was included in the new regulation. AG 48 went through a separate public drafting process, with multiple exposure periods, public hearings and opportunities for the NAIC to receive public comment from the industry, consumers, legislators and regulators. A general description of this due process is found in the Project History for AG 48. The revisions to Model #785 will provide commissioners with the authority to adopt the new regulation that is based on AG 48. A more detailed description of the due process involved in drafting the revisions to Model #785 can be found in the Project History for the XXX/AXXX Framework.

On Aug. 16, 2015, at the Summer National Meeting, the Reinsurance (E) Task Force exposed a draft of the XXX/AXXX Model Regulation—along with revisions to Model #785 and a July 28, 2015, memorandum from NAIC staff listing key discussion topics that were identified during the drafting process—for a 45-day public comment period ending Sept. 30, 2015. The Task Force received 17 comment letters and a note from NAIC staff on the applicability of the regulation on policies issued prior to adoption of Model #830. The Task Force met again via conference call on Oct. 26, 2015, to discuss the comment letters received, and agreed to expose new proposed revisions to Model #785 for a comment period ending Nov. 11, 2015. The Task Force received seven comment letters from regulators and interested parties.

On Nov. 20, 2015, at the Fall National Meeting, the Reinsurance (E) Task Force voted to expose proposed revisions to Model #785 for a public comment period ending Dec. 6, 2015. The Task Force received seven comment letters, and discussed these, along with the proposed revisions to Model #785, on its Dec. 9, 2015, conference call. The Task Force directed NAIC staff to re-expose the revisions to Model #785 for a public comment period ending Dec. 31, 2015. Two updated versions containing these changes were exposed for public comment on Dec. 15, 2015: 1) a version containing revisions to Section 2 and Section 3 of Model #785; and 2) a version containing these similar revisions in Section 2, Section 3 and Section 5 (Rules and Regulations) of Model #785. The Task Force adopted the exposed revisions to Section 2, Section 3 and Section 5 of Model #785 on a joint conference call with the Financial Condition (E) Committee on Jan. 6, 2016.

On Jan. 8, 2016, the Executive (EX) and Plenary adopted these revisions to Model #785, which provide the commissioner authority to adopt regulations with respect to: 1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; 2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; 3) variable annuities with guaranteed death or living benefits; 4) long-term care insurance policies; and 5) other life and health insurance

and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. They also provide for a "professional reinsurer" exemption to the regulation.

XXX/AXXX Model Regulation

The Reinsurance (E) Task Force next directed NAIC staff and Consultants to consider the comments received from the 2015 Summer National Meeting with respect to the Aug. 16, 2015, exposure of the proposed XXX/AXXX Model Regulation, as well as the discussion and actions taken by the Task Force since that time, and proceed with making changes to a revised draft of the XXX/AXXX Model Regulation. On its Oct. 26, 2015, conference call, the Task Force, through a majority vote, elected to proceed in drafting the XXX/AXXX Model Regulation using the consequence option which provides that if there is a shortfall in the required level of Primary or Other Security after the remediation period provided in the regulation, then no credit for reinsurance is allowed. Also discussed was an additional exemption for smaller reinsurers that meet a minimum RBC ratio. On Feb. 26, 2016, NAIC staff exposed the revised draft of the XXX/AXXX Model Regulation and the accompanying NAIC staff memorandum, which details the revisions made from the prior exposure draft, for a 30-day public comment period ending March 27, 2016. The Task Force received six comment letters and discussed these on April 4, 2016, at the Spring National Meeting, including the following issues: 1) affiliated reinsurance transactions; 2) a small professional reinsurer exemption; 3) remediation of a shortfall under the consequence option, including additional time to remediate; and 4) changes to the Actuarial Method used under AG 48 recommended by the Life Actuarial (A) Task Force. The Reinsurance (E) Task Force directed NAIC staff and Consultants to work with the Drafting Group on drafting a revised XXX/AXXX Model Regulation that considers the comments received and discussion held during the meeting.

On June 17, 2016, the Drafting Group completed its work on a revised XXX/AXXX Model Regulation, and the Reinsurance (E) Task Force exposed it for a public comment period ending July 20. The key considerations and topics discussed and actions taken by the Drafting Group in development of the revised XXX/AXXX Model Regulation included: 1) modification to the consequence option to allow the reporting entity to take reinsurance credit for the amount of Primary Security held if any shortfall in Primary Security or Other Security is not remediated by the March 1 annual statement filing date; 2) an additional exemption for reinsurers that have material permitted practices, but that have more than 500% RBC after the permitted practices are removed; 3) removal of the Section 2 drafting note and creation of a new Section 9; 4) maintaining the current list of assets allowed as Primary Security, thereby not incorporating real estate as an allowable Primary Security asset; 5) discussion on whether the XXX/AXXX Model Regulation should contain references to "before the operative date of the *Valuation Manual*," given the improbability that a state would adopt both the January 2016 revisions to Model #785 and the XXX/AXXX Model Regulation prior to the operative date of the *Valuation Manual*, which the NAIC has recommended to be Jan. 1, 2017; and 6) recommended language by the Life Actuarial (A) Task Force AG 48 Drafting Group (LATF Drafting Group) for Section 4A and Section 6 of the XXX/AXXX Model Regulation. The Reinsurance (E) Task Force received six comment letters, in which a common theme focused on the commissioner's discretion under the XXX/AXXX Model Regulation to allow recapture as a form of remediation, allow for additional time to remediate any shortfall in Primary or Other Security and allow for a stronger consequence option for non-compliance.

On July 28, 2016, the Reinsurance (E) Task Force met via conference call to discuss the most recent draft of the XXX/AXXX Model Regulation. The Task Force agreed to remove recapture as an acceptable form of remediation in the XXX/AXXX Model Regulation, clarifying that if commissioner discretion is used, then this information would be captured as a prescribed or permitted practice under the provisions of statutory accounting prescribed in the *Accounting Practices and Procedures Manual* (AP&P Manual), and to develop a drafting note to capture the discussion on commissioner discretion and permitted practices. The Task Force further voted to remove the references to "before the operative date of the *Valuation Manual*" from the XXX/AXXX Model Regulation, and directed NAIC staff and Consultants to work with members of the Drafting Group and the LATF Drafting Group on reviewing the comments received and developing a single option for Section 4A and Section 6 of the XXX/AXXX Model Regulation.

On Aug. 4, 2016, the Reinsurance (E) Task Force exposed the revised XXX/AXXX Model Regulation and the Summary of Changes Memorandum for a public comment period ending Aug. 22, 2016. The Task Force received four comment letters on the proposed revisions. The following information on Section 4A and Section 6 of the XXX/AXXX Model Regulation was provided by the LATF Drafting Group:

> There are two types of policies that are exempt from the scope of AG 48 that the LATF Drafting Group believes should not be exempt from the scope of the XXX/AXXX Model Regulation: 1) attained-age-based yearly renewable term (YRT) life insurance policies (subject to Section 6F of the *Valuation of Life Insurance Policies Model Regulation* (# 830); and 2) Certain n-year renewable term life insurance policies (subject to Section 6G of Model #830). Additionally, while YRT reinsurance is currently exempt from the scope of AG 48 (subject to Section 6E of Model #830), the LATF Drafting Group believes that it should not be exempt from the scope of the XXX/AXXX Model Regulation.

On Aug. 27, 2016, at the Summer National Meeting, the Reinsurance (E) Task Force unanimously adopted the XXX/AXXX Model Regulation as exposed, with the technical edits agreed upon by the Task Force and interested parties. As part of this motion, the Task Force agreed to send the adopted XXX/AXXX Model Regulation to the NAIC Legal Division for a review to include reference checks and grammatical correctness, and to ensure consistency with the NAIC model law style. On Sept. 23, 2016, the adopted XXX/AXXX Model Regulation and a project history document were referred for consideration to the Financial Condition (E) Committee, which subsequently distributed the items as materials for its Sept. 30, 2016, conference call.

On Sept. 30, 2016, the Financial Condition (E) Committee discussed the proposed XXX/AXXX Model Regulation as adopted by the Reinsurance (E) Task Force. A concern raised by a member of the Committee related to the drafting note for remediation using a disclosed permitted practice. After discussion of this concern, and recognition of existing tools that commissioners currently possess, the Committee unanimously adopted a motion to remove the drafting note and subsequently unanimously adopted the XXX/AXXX Model Regulation.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The following significant issues were discussed extensively with regulators and interested parties during the process.

Consequence Options for Non-Compliance with the XXX/AXXX Model Regulation

AG 48 provides that the consequence for a shortfall of Primary Security in accordance with the XXX/AXXX Reinsurance Framework is a qualified actuarial opinion, unless the ceding insurer remediates the shortfall in the time frame and manner provided for in AG 48. In Section 6A(3) of AG 48, there are two ways to remediate this shortfall: 1) by adding additional Primary Security on or before March 1 of the year in which the actuarial opinion is being filed in an amount that would have caused the Primary Security held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, Trust, or modified coinsurance basis, to equal or exceed the Required Level of Primary Security on the valuation date; or 2) by establishing a liability equal to the difference between the Primary Security and the Required Level of Primary Security. AG 48 also provides a similar remediation process for shortfalls in Other Security.

Consistent with the Framework, the XXX/AXXX Model Regulation provides that the consequence for a shortfall is the loss of credit for reinsurance, unless the ceding insurer remediates the shortfall in the time frame and manner provided for in the regulation. The process and time frame for remediation, as well as the extent of loss of credit (total or partial), were the subject of extensive discussion. The Drafting Group members proposed several potential credit for reinsurance "consequences" for ceding insurers that have a shortfall in either Primary Security or Other Security. These options include: 1) complete loss of credit unless the shortfall is remediated in full; 2) dollar-for-dollar reduction in credit for reinsurance for any shortfall; 3) percentage reduction in credit for reinsurance for any shortfall and 4) Primary Security limitation, which would allow credit for reinsurance up to the amount of Primary Security held.

At the 2015 Summer National Meeting, the Drafting Group advised the Reinsurance (E) Task Force that it decided to draft the XXX/AXXX Model Regulation under the first option (complete loss of credit unless the shortfall is remediated in full by the annual statement filing date), but the Task Force encouraged state insurance regulators and interested parties to review the four consequence options with respect to the XXX/AXXX Model Regulation and to provide any comments or suggested language. On its Oct. 26, 2015, conference call, the Task Force, through a majority vote, elected to proceed in drafting the XXX/AXXX Model Regulation using the first consequence option. At the Task Force meeting on April 4, 2016, there was discussion that state insurance regulators need flexibility to work with a company on the remediation process, specifically noting that 15 days (the period between the valuation date of Feb. 15 and the remediation date of March 1) may not be a sufficient amount of time for remediation. It was also noted that the consequence option under AG 48 was different than the consequence option agreed upon by the Task Force.

After consideration of these issues, on June 17, 2016, the Drafting Group recommended: 1) adoption of consequence option 4 above (the Primary Security limitation, under which, in the case of an unremediated shortfall of Primary Security or Other Security, credit is permitted only up to the amount of Primary Security held; 2) that the remediation process occur quarterly rather than annually; and 3) that the annual remediation process deadline remain March 1. This approach was adopted by the Reinsurance (E) Task Force at the 2016 Summer National Meeting.

On its July 28, 2016, conference call, the Reinsurance (E) Task Force opposed including recapture as an acceptable form of remediation in the XXX/AXXX Model Regulation, and provided that it should not be an automatic option for remediation and should only occur if the reinsurance treaty allows for the ceded reinsurance to be recaptured.

Drafting Note to Remediation on Commissioner Discretion

On its July 28, 2016, conference call, the Reinsurance (E) Task Force discussed whether the commissioner should have the discretion to lengthen the remediation period beyond the current March 1 and/or provide a different form of remediation in the event of non-compliance with the XXX/AXXX Model Regulation. With respect to the XXX/AXXX Model Regulation's consequence option and remediation provisions, a common theme expressed in the comment letters was commissioner discretion under the XXX/AXXX Model Regulation to allow for additional time to remediate any shortfall in Primary or Other Security and to allow for a different form of remediation for non-compliance. One reason for developing the XXX/AXXX Model Regulation was the inconsistencies experienced as a result of commissioner discretion. The Task Force directed NAIC staff and Consultants to prepare a drafting note to the remediation section clarifying that commissioner discretion is limited to the authority existing under applicable state law, should be exercised only in extraordinary circumstances, and would be captured as a prescribed or permitted practice under the provisions of statutory accounting prescribed in the AP&P Manual. The following drafting note was included in the final version of the regulation:

> Drafting Note: Nothing in this Regulation should be construed to prohibit the commissioner, under limited and extraordinary circumstances and for good cause shown, from granting a disclosed permitted practice by extending the period of time to remediate or by permitting recapture of the ceded business as an alternative form of remediation to any company to the extent that the commissioner has such authority under applicable state law and provided the permitted practice complies with the procedures outlined in the NAIC Accounting Practices and Procedures Manual, and any extension of the time deadline complies with NAIC annual and quarterly statement filing requirements.

On a Sept. 30, 2016, conference call of the Financial Condition (E) Committee, a concern was raised by a member of the Committee related to the drafting note. The primary concern raised was that because the remediation requirement was not an accounting practice or principle, but rather a requirement of a regulation derived from state law, there was uncertainty regarding how a disclosed permitted practice would comply with the procedures outlined in the AP&P Manual, and, moreover, a commissioner should not be allowed to exceed his or her legislative authority. In considering this issue, the Committee agreed that under unusual circumstances, for example, if markets froze similar to the 2008 financial crisis, the commissioner could work with the company to

remedy the shortfall, even if it is beyond the date the annual financial statement is filed. Also considered in this issue was that, similar to the 2008 financial crisis, it would be reasonable for systemic problems such as this unusual circumstance to be considered on a national coordinated basis. Considering these points, the Committee unanimously agreed to remove the drafting note.

Section 4A and Section 6

Throughout the drafting of the XXX/AXXX Model Regulation, there were several discussions and comments received on the scope of the regulation and on the provisions of Section 6—The Actuarial Method. Subsequent to the 2016 Spring National Meeting, the Drafting Group requested input from the LATF Drafting Group on the language within Section 4A and Section 6 of the XXX/AXXX Model Regulation. Various versions of Section 4A and Section 6 were exposed and discussed. The final versions of Section 4A and Section 6 are very similar to their counterparts in AG 48, with a few exceptions. For additional information, see the Aug. 27 and July 28 minutes of the Reinsurance (E) Task Force.

The Reinsurance (E) Task Force also directed NAIC staff to develop a referral to the Financial Analysis Handbook (E) Working Group, requesting it consider adding guidance advising analysts of the need for additional scrutiny during review of security for reinsurance of grandfathered policies.

Small Reinsurer Exemption

The 2016 revisions to Model #785 created a new exemption (sometimes referred to as the "professional reinsurer exemption") that would apply to business ceded to a reinsurer that: 1) maintains at least $250 million in capital and surplus determined in accordance with statutory accounting principles, without deviation; and 2) either a) is licensed in at least 26 states or b) is licensed or accredited in at least 35 states with a minimum of 10 licenses. The ACLI requested an additional exemption to be placed in the regulation that would exempt reinsurance ceded to reinsurers that, while not captives engaged in financing transactions, could not meet the size and licensing requirements of the so-called professional reinsurer exemption. After extensive discussion, the Drafting Group recommended, and the Reinsurance (E) Task Force approved, a new "small reinsurer exemption" available for business ceded to a reinsurer that: 1) is not an affiliate of the ceding company; 2) is not licensed as a captive or similar entity in any state; 3) is licensed or accredited in at least 10 states; and 4) has an RBC of at least 500% after ignoring the financial impact of any permitted accounting practices. Thus, the XXX/AXXX Model Regulation now has at least three exemption provisions that can be used in connection with reinsurance ceded to professional reinsurers: 1) Section 4C, which pertains to professional reinsurers (and others) that do not have material permitted practices; 2) Section 4D, which pertains to professional reinsurers (and others) that have material permitted practices, but that have more than 500% RBC after those permitted practices are removed; and 3) Section 4E, which pertains to professional reinsurers (and others) that meet the criteria in Model #785.

7. Any Other Important Information (e.g., amending an accreditation standard)

The revisions to Model #785 will be considered by the Financial Regulation Standards and Accreditation (F) Committee as an amendment to the existing standard for Reinsurance Ceded. In addition, it is intended under the XXX/AXXX Reinsurance Framework that these revisions, in addition to the proposed XXX/AXXX Model Regulation, would become a new accreditation standard.

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT

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Section 1. Purpose

This Act provides for the creation of Special Purpose Reinsurance Vehicles ("SPRVs") exclusively to facilitate the securitization of one or more ceding insurers' risk as a means of accessing alternative sources of capital and achieving the benefits of securitization. Investors in fully funded insurance securitization transactions provide funds that are available to the SPRV to secure the aggregate limit under an SPRV contract that provides coverage against the occurrence of a triggering event. The creation of SPRVs is intended to achieve greater efficiencies in conducting insurance securitizations, to diversify and broaden insurers' access to sources of risk bearing capital and to make insurance securitization generally available on reasonable terms to as many U.S. insurers as possible.

Drafting Note: Under the terms of the typical securities underlying an insurance securitization transaction, proceeds from the issuance of securities are repaid to the investor on a specified maturity date with interest or dividends unless a triggering event occurs. The insurance securitization proceeds are available to pay the SPRV's obligations to the ceding insurer if a triggering event occurs, as well as being available to satisfy the SPRV's obligation to repay the insurance securitization investors if a triggering event does not occur. Insurance securitization transactions have been performed by alien companies to utilize efficiencies available to alien companies that are not currently available to domestic companies. This Act allows more efficiency in conducting insurance securitizations, allows domestic ceding insurers easier access to alternative sources of risk bearing capital, and promotes the benefits of insurance securitization to U.S. insurers.

Section 2. Exemption from Insurance Laws within Limitations

A. An SPRV is subject to the following sections of [insert state's insurance code]: [insert sections of code providing commissioner's general powers, including power to investigate insurance law violations, subpoena and examine documents and witnesses, conduct hearings, institute other legal action to enforce laws or orders, issue cease and desist orders, impose fines, handle documents and records, suspend or revoke licenses or certificates of authority, impose fees and other charges; and reference state's examination law for enforcement of the act].

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. No other provisions of this [insert state's insurance code] shall be applicable to a SPRV organized under this Act, except as provided in this Act.

Section 3. Definitions

For purposes of this Act, the following terms have the indicated meanings:

A. "Aggregate limit" means the maximum sum payable to the ceding insurer under an SPRV contract.

B. "Ceding insurer" means one or more insurers or reinsurers under common control that enters into an SPRV contract with an SPRV.

C. "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not, in fact, exist. Notwithstanding the foregoing, for purposes of this Act, the fact that an SPRV exclusively provides reinsurance to a ceding insurer under an SPRV contract shall not by itself be sufficient grounds for a finding that the SPRV or the SPRV Organizer or owner is controlled by or under common control with the ceding insurer.

D. "Fair value" means:

(1) As to cash, the amount thereof; and

(2) As to an asset other than cash:

(a) The amount at which that asset could be bought or sold in a current transaction between arms-length, willing parties;

(b) The quoted market price for the asset in active markets should be used if available; and

(c) If quoted market prices are not available, a value determined using the best information available considering values of like assets and other valuation methods, such as present value of future cash flows, historical value of the same or similar assets or comparison to values of other asset classes the value of which have been historically related to the subject asset.

E. "Fully funded" means that, with respect to an SPRV contract, the fair value of the assets held in trust by or on behalf of the SPRV under the SPRV contract on the date on which the SPRV contract is effected, equals or exceeds the aggregate limit as defined in this Act.

F. "Indemnity trigger" means a transaction term by which the SPRV's obligation to pay the ceding insurer for losses covered by an SPRV contract is triggered by the ceding insurer incurring a specified level of losses.

G. "Insolvency" or "insolvent" means that the SPRV is unable to pay its obligations when they are due, unless the obligations are the subject of a bona fide dispute.

H. "Non-indemnity trigger" means a transaction term by which the SPRV's obligation to pay the ceding insurer under an SPRV contract arises from the occurrence or existence of some event or condition other than the ceding insurer incurring a specified level of losses under its insurance or reinsurance contracts.

I. "Permitted investments" means those investments that meet the qualifications set forth in Section 17 of this Act.

J. "Qualified U.S. financial institution" means, for purposes of meeting the requirements of a trustee as specified in Section 6, a financial institution that is eligible to act as a fiduciary of a trust, and:

(1) Is organized, or, in the case of a U.S. branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof, and

(2) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

Drafting Note: Because assets held in a fiduciary capacity are not subject to the claims of the trustee's creditors, and because the trust departments of all U.S. financial institutions (including U.S. branch or agency offices of foreign banking organizations having fiduciary powers in the U.S.) are regulated, supervised and examined by the institution's primary U.S. bank regulatory authority (federal or state), there is no need to apply additional standards measuring the financial condition or standing of the institution.

K. "Special Purpose Reinsurance Vehicle" or "SPRV" means an entity domiciled in and organized under the laws of this state, which has received a Limited Certificate of Authority from the commissioner under this Act exclusively for the limited purpose of entering into and effectuating SPRV insurance securitizations, SPRV contracts and other related transactions permitted by this Act.

L. "SPRV contract" means a contract between the SPRV and the ceding insurer pursuant to which the SPRV agrees to pay the ceding insurer an agreed amount upon the occurrence of a triggering event.

M. "SPRV insurance securitization" means a package of related risk transfer instruments and facilitating administrative agreements by which proceeds are obtained by an SPRV through the issuance of securities, which proceeds are held in trust pursuant to the requirements of this Act to secure the obligations of the SPRV under an SPRV contract with one or more ceding insurers, wherein the SPRV's obligation to return the full initial investment to the holders of such securities, pursuant to the transaction terms, is contingent upon the funds not being used to pay the obligations of the SPRV to the ceding insurers under the SPRV contract.

N. "SPRV organizer" means one or more persons that have organized or intend to organize an SPRV, under authority obtained as specified in this Act.

O. "SPRV securities" means the securities issued by an SPRV.

P. "Triggering event" means an event or condition that, if and when it occurs or exists, obligates the SPRV to make a payment to the ceding insurer under the provisions of an SPRV contract.

Section 4. Limited Certificate of Authority Required

A. In order to securitize one or more ceding insurers' risks, an SPRV shall obtain a limited certificate of authority from the commissioner according to the provisions of this section.

B. An SPRV organizer seeking to obtain a limited certificate of authority for a SPRV shall file an application with the commissioner. A complete application shall include the following:

(1) An affidavit verifying that each prospective SPRV organizer meets the requirements of this Act;

(2) A representation that the prospective SPRV organizer intends to form an SPRV that shall operate in accordance with the requirements set forth in this Act;

(3) The proposed name of the SPRV;

(4) Biographical affidavits of all SPRV organizers setting forth their legal names, any names under which they have or are conducting their affairs, and any affiliations with other persons as defined in [insert a citation to the state insurance holding company system act], together with such other biographical information as the commissioner may request;

(5) The source and form of the minimum capital to be contributed to the SPRV;

(6) Any persons with which the SPRV is or upon formation will be affiliated as defined in [insert the state's insurance holding company system act];

(7) The names and biographical affidavits of the proposed members of the board of directors and principal officers of the SPRV, setting forth their legal names, any names under which they have or are conducting their affairs and any affiliations with other persons as defined in [insert the name of the state insurance holding company system act], together with such other biographical information as the commissioner may request;

(8) A plan of operation, consisting of a description of the contemplated insurance securitization, the SPRV contract and related transactions, which shall include:

(a) Draft documentation or, at the discretion of the commissioner, a written summary, of all material agreements that will be entered into to effectuate the insurance securitization and the related SPRV contract, to include the names of the ceding insurers, the nature of the risks being assumed, and the maximum amounts, purpose and nature and the interrelationships of the various transactions required to effectuate the insurance securitization;

(b) The investment strategy of the SPRV and a representation that the investment strategy complies with the investment requirements set forth in this Act and that the strategy will include investment practices or other provisions to preserve asset values, which will facilitate attainment of full funding during the term of the securitization with assets that can be monetized in response to a triggering event without a substantial loss in value; and

(c) A description of the method by which losses covered by the SPRV contract that may develop after the termination of the contract period are to be addressed under the provisions of the SPRV contract; and

(d) A representation that the trust agreement and the trusts holding assets that secure the obligations of the SPRV under the SPRV contract and the SPRV contract with the ceding insurers in connection with the contemplated insurance securitization will be structured in accordance with the requirements set forth in this act.

C. The commissioner shall approve the application and issue a limited certificate of authority upon a finding that (1) the proposed plan of operation provides a reasonable expectation of a successful operation, (2) the terms of the SPRV contract and related transactions comply with this Act, (3) the proposed plan of operation is not hazardous to any ceding insurer or to policyholders and (4) the commissioner of the state of domicile of each ceding insurer has notified the commissioner in writing that it has not disapproved the transaction. In evaluating the expectation of a successful operation, the commissioner shall consider, among other factors, whether the proposed SPRV organizer, directors and officers are of known good character and not reasonably believed to be affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions or other insurance or business relations, with any person known to have been involved in the improper manipulation of assets, accounts or reinsurance. If the commissioner denies the application, he or she shall grant the prospective SPRV organizer a hearing upon request.

Drafting Note: Each state should review its legislative authority to ensure that its commissioner has the necessary jurisdiction to review and approve or disapprove proposed SPRV transactions by its domestic ceding insurers to non-domestic SPRVs.

D. Upon approval by the commissioner of the application and the issuance of a limited certificate of authority, the SPRV may be acquired or formed and, in accordance with the approved plan of operation, the SPRV may enter into contracts and conduct other activities within the scope of the filed plan of operation.

E. The limited certificate of authority shall state that the SPRV's authorization to be involved in the business of reinsurance shall be limited only to the reinsurance activities that the SPRV is allowed to conduct pursuant to this Act.

F. The SPRV organizer shall provide a complete set of the documentation of the insurance securitization to the commissioner upon closing of the transactions, including an opinion of legal counsel with respect to compliance with this Act and any other applicable laws as of the effective date of the transaction. Any material change of the SPRV's plan of operation described in Subsection B of this section, including but not limited to the issuance of new securities to continue the securitization activities of the SPRV pursuant to this Act after expiration and full satisfaction of the initial securitization transactions, shall require prior approval of the commissioner, provided that a change in the counterparty to swap transactions for an existing securitization as allowed under this Act shall not be deemed a material change.

Section 5. Limited Purpose of SPRV

SPRVs authorized under this Act are created for the limited purpose of entering into insurance securitization transactions with investors and related agreements to pay one or more ceding insurers agreed upon amounts under a SPRV contract upon the occurrence of triggering events related to the insurance business of the ceding insurer. A SPRV may not issue a contract for assumption of risk or indemnification of loss other than a SPRV contract.

Drafting Note: States may consider either authorizing, either directly by statute, or by providing rule-making authority, specific lines of business that may be ceded to a SPRV or restricting specific lines of business from being ceded to a SPRV.

Section 6. Approved Transactions and Operation of SPRVs

A. SPRVs authorized under this Act may at any given time enter into and effectuate SPRV contracts with one or more ceding insurers, provided that the SPRV contracts obligate the SPRV to indemnify the ceding insurer for losses and that contingent obligations of the SPRV under the SPRV contracts are securitized in full through a single SPRV insurance securitization and are fully funded and secured with assets held in trust in accordance with the requirements included herein pursuant to agreements contemplated by this Act and invested in a manner that meets the criteria set forth in Section 17.

Drafting Note: The requirement that a SPRV indemnify the ceding insurer against losses may be expanded to allow an SPRV to enter into non-indemnity transactions with ceding insurers pursuant to regulations issued by the commissioner addressing the treatment of the portion of the risk that is not indemnity based, accounting, disclosure, risk based capital treatment, and assessing risks associated with such SPRV contract governing credit for these transactions.

B. An SPRV may enter into agreements with third parties and conduct business necessary to fulfill its obligations and administrative duties incident to the insurance securitization and the SPRV contract. The agreements may include entering into swap agreements or other transactions that have the objective of leveling timing differences in funding up-front or ongoing transaction expenses or managing credit or interest rate risk of the investments in trust to assure that the assets held in trust will be sufficient to satisfy payment or repayment of the securities issued pursuant to an insurance securitization transaction or the obligations of the SPRV under the SPRV contract. In fulfilling its function, the SPRV shall adhere to the following requirements and shall, to the extent of its powers, ensure that contracts obligating other parties to perform certain functions incident to its operations are substantively and materially consistent with the following requirements and guidelines:

(1) An SPRV shall have a distinct name, which shall include the designation "SPRV." The name of the SPRV shall not be deceptively similar to, or likely to be confused with or mistaken for, any other existing business name registered in this state.

(2) Unless otherwise provided in the plan of operation, the principal place of business and office of any SPRV organized under this Act shall be located in this state.

(3) The assets of an SPRV shall be preserved and administered by or on behalf of the SPRV to satisfy the liabilities and obligations of the SPRV incident to the insurance securitization and other related agreements, including the SPRV contract.

(4) Assets of the SPRV that are pledged to secure obligations of the SPRV to a ceding insurer under an SPRV contract shall be held in trust and administered by a qualified U.S. financial institution. The qualified U.S. financial institution shall not control, be controlled by, or be under common control with, the SPRV or the ceding insurers.

(5) The agreement governing any such trust shall create one or more trust accounts into which all pledged assets shall be deposited and held until distributed in accordance with the trust agreement. The pledged assets shall be held by the trustee at the trustee's office in the United States and may be held in certificated or electronic form.

(6) The provisions for withdrawal by ceding insurers of assets from the trust shall be clean and unconditional, subject only to the following requirements:

(a) The ceding insurer shall have the right to withdraw assets from the trust account at any time, without notice to the SPRV, subject only to written notice to the trustee from the ceding insurer that funds in the amount requested are due and payable by the SPRV;

(b) No other statement or document need be presented in order to withdraw assets, except the ceding insurer may be required to acknowledge receipt of withdrawn assets;

(c) The trust agreement shall indicate that it is not subject to any conditions or qualifications outside of the trust agreement;

(d) The trust agreement shall not contain references to any other agreements or documents; and

(e) No reference shall be made to the fact that these funds may represent reinsurance premiums or that the funds have been deposited for any specific purpose.

(7) The trust agreement shall be established for the sole use and benefit of the ceding insurer at least to the full extent of the SPRV's obligations to the ceding insurer under the SPRV contract. In the case of more than one ceding insurer, a separate trust agreement shall be entered into with each ceding insurer and a separate trust account shall be maintained for each ceding insurer.

(8) The trust agreement shall provide for the trustee to:

(a) Receive assets and hold all assets in a safe place;

(b) Determine that all assets are in a form that the ceding insurer or the trustee, upon direction by the ceding insurer may, whenever necessary, negotiate the assets, without consent or signature from the SPRV or any other person or entity;

(c) Furnish to the SPRV, the commissioner and the ceding insurer a statement of all assets in the trust account reported at fair value upon its inception and at intervals no less frequent than the end of each calendar quarter;

(d) Notify the SPRV and the ceding insurer, within ten (10) days, of any deposits to or withdrawals from the trust account;

(e) Upon written demand of the ceding insurer, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the ceding insurer and deliver physical custody of the assets to the ceding insurer; and

(f) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the ceding insurer.

(9) The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the ceding insurer.

(10) The trust agreement may be made subject to and governed by the laws of any state, in addition to the requirements for the trust as provided in this Act, provided that the state is disclosed in the plan of operation filed with and approved, or deemed approved, by the commissioner.

(11) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(12) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

(a) Notwithstanding the provisions of Subsection B(6)(c), (d) and (e) or B(14)(e) of this section, when a trust agreement is established in conjunction with an SPRV contract, then the trust agreement may provide that the ceding insurer shall undertake to use and apply any amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the SPRV, for the following purposes:

(i) To pay or reimburse the ceding insurer amounts due to the ceding insurer under the specific SPRV contract, including but not limited to unearned premiums due to the ceding insurer, if not otherwise paid by the SPRV in accordance with the terms of such agreement; or

(ii) Where the ceding insurer has received notification of termination of the trust account, and where the SPRV's entire "obligations" under the specific SPRV contract remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit the amounts in a separate account, in the name of the ceding insurer, in any qualified U.S. financial institution, apart from its general assets, in trust for uses and purposes specified in Subparagraph (a) of this paragraph as may remain executory after the withdrawal and for any period after the termination date. "Obligations" within the meaning of this subparagraph may, without duplication, include:

(I) Losses and loss expenses paid by the ceding insurer, but not recovered from the SPRV;

(II) Reserves for losses reported and outstanding;

(III) Reserves for losses incurred but not reported;

(IV) Reserves for loss expenses;

(V) Reserves for unearned premiums;

(VI) Any other amounts that, together with Items (I) to (V) of this subparagraph, represent the aggregate limit remaining under the SPRV contract if the period of coverage or the agreed upon period of loss development has yet to expire.

(b) The provisions to be included in the trust agreement pursuant to this paragraph may instead be included in the underlying SPRV contract.

(13) An SPRV contract shall contain provisions that:

(a) Require the SPRV to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what recoverables or reserves, or both, the agreement is to cover;

(b) Stipulate that assets deposited in the trust account shall be valued according to their current fair value, and shall consist only of permitted investments;

(c) Require the SPRV, prior to depositing assets with the trustee, to execute assignments, endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate any such assets without consent or signature from the SPRV or any other entity;

(d) Require that all settlements of account between the ceding insurer and the SPRV be made in cash or its equivalent; and

(e) Stipulate that the SPRV and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the SPRV contract, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the SPRV contract, and shall be utilized and applied by the ceding insurer or any successor by operation of law of the ceding insurer, including (subject to the provisions of Section 16), but without further limitation, any liquidator, rehabilitator, receiver or conservator of the ceding insurer, without diminution because of insolvency on the part of the ceding insurer or the SPRV, only for the following purposes:

(i) To transfer all such assets into one or more trust accounts for the benefit of the ceding insurer pursuant to the terms of the SPRV contract and in compliance with this Act; and

(ii) To pay any other amounts that the ceding insurer claims are due under the SPRV contract.

(14) The SPRV contract entered into by the SPRV may contain provisions that give the SPRV the right to seek approval from the ceding insurer to withdraw from the trust all or part of the assets contained in the trust and to transfer the assets to the SPRV, provided:

(a) The SPRV shall, at the time of the withdrawal, replace the withdrawn assets with other qualified assets having a fair value equal to the fair value of the assets withdrawn and that meet the requirements of Section 17; and

(b) After the withdrawals and transfer, the fair value of the assets in trust securing the obligations of the SPRV under the SPRV contract is no less than an amount needed to satisfy the fully funded requirement of the SPRV contract. The ceding insurer shall be the sole judge as to the application of these provisions, but shall not unreasonably nor arbitrarily withhold its approval.

(15) The contract shall provide that investors in the SPRV agree that any obligation to repay principal, interest or dividends on the securities issued by the SPRV shall be reduced upon the occurrence of a triggering event, to the extent that the assets of the SPRV held in trust for the benefit of the ceding insurer are remitted to the ceding insurer in fulfillment of the obligations of the SPRV under the SPRV contract.

(16) Assets held by an SPRV in trust shall be valued at their fair value.

(17) The proceeds from the sale of securities by the SPRV to investors shall be deposited with the trustee as contemplated by this Act, and shall be held or invested by the trustee in accordance with the requirements of Section 17.

(18) An SPRV organized under this Act shall engage only in fully funded indemnity triggered SPRV contracts to support in full the ceding insurers' exposures assumed by the SPRV. However, an SPRV may engage in an SPRV contract that is non-indemnity triggered only after the commissioner, in accordance with the authority granted under Section 20 of this Act, adopts regulations addressing the treatment of the portion of the risk that is not indemnity based, to include accounting, disclosure, risk based capital treatment, and the manner in which risks associated with a non-indemnity based SPRV contract may be evaluated and managed. At no time may an SPRV enter into an SPRV contract that is not fully funded, whether indemnity triggered or non-indemnity triggered. Assets of the SPRV may be used to pay interest or other consideration on any outstanding debt or other obligation of the SPRV, and nothing in this paragraph shall be construed or interpreted to prevent an SPRV from entering into a swap agreement or other transaction that has the effect of guaranteeing interest or other consideration.

(19) In the SPRV insurance securitization, the contracts or other relating documentation shall contain provisions identifying the SPRV that will enter into the special purpose reinsurance securitization and the contracts or other documentation shall clearly disclose that the assets of the SPRV, and only those assets, are available to pay the obligations of that SPRV. Notwithstanding the foregoing, and subject to the provisions of this Act and any other applicable law or regulation, the failure to include such language in the contracts or other documentation shall not be used as the sole basis by creditors, reinsurers or other claimants to circumvent the provisions of this Act.

(20) Under no circumstances shall an SPRV be authorized to:

(a) Issue or otherwise administer primary insurance policies;

(b) Have any obligation to the policyholders or reinsureds of the ceding insurer;

(c) Enter into an SPRV contract with a person that is not licensed or otherwise authorized to conduct the business of insurance or reinsurance in at least its state or country of domicile; or

(d) Assume or retain exposure to insurance or reinsurance losses for its own account that is not initially fully funded by proceeds from an SPRV securitization that meets the requirements of this Act.

(21) At the cessation of business of an SPRV, the limited certificate of authority granted by the commissioner shall expire and the SPRV shall no longer be authorized to conduct activities pursuant to this Act unless and until a new certificate of authority is issued pursuant to a new filing in accordance with Section 4.

(22) It shall be unlawful for an SPRV to loan or otherwise invest, or place in custody, trust or under management any of its assets with, or to borrow money or receive a loan from (other than by issuance of the securities pursuant to an insurance securitization), or advance from, anyone convicted of a felony, anyone who is untrustworthy or of known bad character or anyone convicted of a criminal offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation or corruption.

Section 7. Powers

A. An SPRV authorized under this Act shall have the necessary powers to enter into contracts and to conduct other commercial activities necessary to fulfill the purposes of this Act. These activities may include, but are not limited to, entering into SPRV contracts, issuing securities of the SPRV and complying with the terms thereof, entering into trust, swap and other agreements necessary to effectuate an insurance securitization in compliance with the limitations and pursuant to the authorities granted to the SPRV under this Act or the plan of operation approved or deemed approved by the commissioner.

B. An SPRV organized or doing business under this Act shall be capable of suing or being sued, and may make or enforce contracts in relation to the business of the SPRV; may have and use a common seal, and in the name of the SPRV or by a trustee chosen by the board of directors, shall be capable of taking, purchasing, holding and disposing of real and personal property for carrying into effect the purposes of its organization; and may by its board of directors, trustees, officers or managers, make bylaws and amendments thereto not inconsistent with the laws or the constitution of this state or of the United States. The bylaws shall define the manner of electing directors, trustees or managers and officers of the SPRV, together with their qualifications and duties and fixing the term of office.

Section 8. Affiliation

Notwithstanding the provisions of the [insert citation to insurance holding company system act] the SPRV, the SPRV organizer, or subsequent debt or equity investors in SPRV securities shall not be deemed affiliates of the ceding insurer by virtue of the SPRV contract between the ceding insurer and the SPRV, the securities of the SPRV or related agreements necessary to implement the SPRV insurance securitization. The SPRV may not be controlled by, may not control, or may not be under common control with, any ceding insurer that is a party to an SPRV contract.

Section 9. Capitalization

An SPRV shall have minimum initial capital of not less than $5,000. All of the initial capital shall be received by the SPRV in cash. The minimum initial capital required and all other funds of the SPRV in excess of its minimum initial capital, including funds held in trust to secure the obligations of the SPRV pursuant to its obligations under the SPRV contracts, shall be invested as provided in Section 17.

Section 10. Dividends

The SPRV may not declare or pay dividends in any form to its owners unless the dividends do not decrease the capital of the SPRV below $5,000 and, after giving effect to the dividends, the assets of the SPRV, including assets held in trust pursuant to the terms of the insurance securitization, shall be sufficient to meet its obligations. The dividends may be declared by the board of directors of the SPRV if the dividends would not violate the provisions of this Act or jeopardize the fulfillment of the obligations of the SPRV or the trustee pursuant to the SPRV insurance securitization, the SPRV contract or any related transaction. The provisions of [insert reference to the insurance holding company system act of the state of the SPRV's domicile] pertaining to dividends do not apply to such dividends.

Section 11. Records and Financial Reports

A. The records of the SPRV shall be maintained in this state and shall be available for examination by the commissioner at any time. No later than five (5) months after the fiscal year end of the SPRV, the SPRV shall file with the commissioner an audit by a certified public accounting firm of the financial statements of the SPRV and the trust accounts.

B. Each SPRV organized under this Act shall file with the commissioner not later than March 1 a statement of operations, to include a statement of income, a balance sheet and a detailed listing of invested assets, including identification of assets held in trust to secure the SPRV's obligations under the SPRV contract, for the year ending the prior December 31. The statements shall be prepared in accordance with [insert reference to applicable statutory accounting guidance for reinsurers adopted by this state] on forms required by the commissioner.

C. The SPRV shall keep its books and records in such manner that its financial condition, affairs and operations can be ascertained and so that its financial statements filed with the commissioner can be readily verified and its compliance with the provisions of this Act determined. The books or records may be photographed, reproduced on film or stored and reproduced electronically.

D. All books, records, documents, accounts and vouchers shall be preserved and kept available in this state for the purpose of examination and until authority to destroy or otherwise dispose of the records is secured from the commissioner. The original records may, however, be kept and maintained outside this state if, according to a plan adopted by the SPRV's board of directors and approved by the commissioner, it maintains suitable records in lieu thereof.

Section 12. Officers and Directors

The directors of an SPRV shall elect officers that they deem necessary to carry out the purposes of the SPRV pursuant to this Act. The provisions of [insert the insurance code or relevant business corporation act, limited liability corporation act, limited partnership act, etc.] relating to the indemnification of officers and directors apply to and govern SPRVs organized under this Act.

A. Each SPRV authorized to do business in this state shall notify the commissioner within thirty (30) days of the appointment or election of any new officers or directors.

B. In cases where the commissioner deems that an officer or director does not meet the standards set forth in this section, he shall, after notice and hearing afforded to the officer or director, and after a finding that the officer or director is incompetent or untrustworthy or of known bad character, order the removal of the person. If the SPRV does not comply with a removal order within thirty (30) days, the commissioner may suspend that SPRV's limited certificate of authority until such time as the order is complied with.

C. The SPRV shall make no loans to any SPRV organizer, owner, director, officer, manager or affiliate of the SPRV.

Section 13. Fees and Taxes

The commissioner may charge fees to reimburse the commissioner for expenses and costs incurred by the department of insurance incident to the examination of financial statements, review of the plan of operation and to reimburse other such activities of the commissioner related to the formation and ongoing operation of the SPRV. The SPRV shall not be subject to state premium or other taxes incidental to the operation of its business as long as the business remains within the limitations of this Act.

Section 14. Dissolution

An SPRV operating under this Act may be dissolved at any time by a vote of its board of directors, and after the action has been approved by the commissioner. No voluntary dissolution shall be effected or allowed until and unless all of the obligations of the SPRV pursuant to the insurance securitization have been fully and finally satisfied pursuant to their terms. In the case of voluntary dissolution, the disposition of the affairs of the SPRV (including the settlement of all outstanding obligations), shall be made by the officers or directors of the SPRV and when the liquidation has been completed and a final statement, in acceptable form, filed with and approved, or deemed approved, by the commissioner, the provisions for voluntary dissolution under the [insert reference to section of the state's insurance code or general business law that provides for and governs dissolution of insurers or other entities as appropriate] shall be followed to dissolve the SPRV.

Section 15. Conservation, Rehabilitation or Liquidation

A. The provisions of [insert reference to the conservation, rehabilitation and liquidation statute] apply to an SPRV, except to the extent modified below.

B. (1) Notwithstanding the provisions of [insert reference to the state's conservation, rehabilitation and liquidation act that is consistent with Section 16 of the NAIC Insurers Rehabilitation and Liquidation Model Act], the commissioner may apply by petition to the [insert reference to appropriate court of jurisdiction] for an order authorizing the commissioner to conserve, rehabilitate or liquidate an SPRV domiciled in this state solely on one or more of the following grounds:

(a) There has been embezzlement, wrongful sequestration, dissipation, or diversion of the assets of the SPRV intended to be used to pay amounts owed to the ceding insurer or the holders of SPRV securities; or

(b) The SPRV is insolvent and the holders of a majority in outstanding principal amount of each class of SPRV securities request or consent to conservation, rehabilitation or liquidation under this Act.

(2) The court shall not grant relief under Paragraph (1)(a) of this subsection unless, after notice and a hearing, the commissioner, who shall have the burden of proof, establishes by clear and convincing evidence that relief should be granted.

C. Notwithstanding any contrary provision in the insurance code of this state, the regulations promulgated under the insurance code of this state, or any other applicable law or regulation, upon any order of conservation, rehabilitation or liquidation of the SPRV, the receiver shall be bound to deal with the SPRV's assets and liabilities, in accordance with the requirements set forth in this Act.

D. With respect to amounts recoverable under an SPRV contract, the amount recoverable by the receiver shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation or liquidation with respect to the ceding insurer, notwithstanding any provisions to the contrary in the contracts or other documentation governing the SPRV insurance securitization.

(1) Notwithstanding the provisions of [insert reference to the conservation, rehabilitation and liquidation act consistent with Section 5 of the NAIC Rehabilitation and Liquidation Model Act] or any other Section of the [insert reference to the conservation, rehabilitation and liquidation act], an application or petition under Section [insert conservation, rehabilitation and liquidation act provisions consistent with Sections 10, 11, 17, 20, 55, 58 or 59 of the NAIC Insurers Rehabilitation and Liquidation Model Act], or any temporary restraining order or injunction issued under any such section, with respect to a ceding insurer shall not prohibit the transaction of any business by an SPRV, including any payment by an SPRV made pursuant to an SPRV security, or any action or proceeding against an SPRV or its assets.

(2) Notwithstanding the provisions of [insert reference to the section of the conservation, rehabilitation and liquidation act that is consistent with Section 10 of the NAIC Insurers Rehabilitation and Liquidation Model Act], the commencement of a summary proceeding or other interim proceeding commenced prior to a formal delinquency proceeding with respect to an SPRV, and any order issued by the court thereunder, shall not prohibit the payment by an SPRV made pursuant to an SPRV security or SPRV contract or the SPRV from taking any action required to make the payment.

E. Notwithstanding any other provision of [insert reference to the state's conservation, rehabilitation and liquidation act] or other state law:

(1) A receiver of a ceding insurer may not avoid a non-fraudulent transfer by a ceding insurer to an SPRV of money or other property made pursuant to an SPRV contract; and

(2) A receiver of an SPRV may not void a non-fraudulent transfer by the SPRV of money or other property made to a ceding insurer pursuant to an SPRV contract or made to or for the benefit of any holder of an SPRV security on account of the SPRV security.

F. With the exception of the fulfillment of the obligations under an SPRV contract, and notwithstanding any other provisions of this Act or other law of this state to the contrary, the assets of an SPRV, including assets held in trust, shall not be consolidated with or included in the estate of a ceding insurer in any delinquency proceeding against the ceding insurer under this Act for any purpose, including, without limitation, distribution to creditors of the ceding insurer.

G. Notwithstanding any other provision of this Act:

(1) The domiciliary receiver of an SPRV domiciled in another state shall be vested by operation of law with the title to all of the assets, property, contracts and rights of action, and all of the books, accounts and other records of the SPRV located in this state. The domiciliary receiver shall have the immediate right to recover all such vested property, assets, and causes of action of the SPRV located in this state.

(2) No ancillary proceeding may be commenced or prosecuted in this state against an SPRV domiciled in another state.

Drafting Note: The state should amend its conservation, rehabilitation and liquidation law to include an SPRV as a "person covered" as defined in the Section 2 of the NAIC Insurers Rehabilitation and Liquidation Model Act].

Drafting Note: A number of states require a liquidator to cancel policies within a pre-specified time period in the event of a liquidation. While reviewing the Plan of Operation, commissioners should consider the termination provisions, if any, of the securitization instruments in the event of the cancellation of all of the insurance policies underlying the securitization in order to assess whether any portion of the risk premium relating to those underlying policies should equitably be returned to the ceding insurer.

Section 16. Not Subject to Guaranty Funds, Residual Market or Similar Arrangements

A. The SPRV or the activities, assets and obligations relating to the SPRV are not subject to the provisions of [insert reference to sections of the insurance code addressing life and health and property and casualty guaranty or insolvency funds], and an SPRV shall not be assessed by or otherwise be required to contribute to any guaranty fund or guaranty association in this state with respect to the activities, assets or obligations of an SPRV or the ceding insurer.

B. The SPRV shall not be required to participate in residual market, FAIR plan or other similar plans to provide insurance coverage, take out policies, assume risks, make capital contributions, pay or be otherwise obligated for assessments, surcharges or fees, or otherwise support or participate in such plans or arrangements.

Section 17. Asset and Investment Limitations

A. Assets of the SPRV held in trust to secure obligations under the SPRV contract shall at all times be held in:

(1) Cash; and cash equivalents;

(2) Securities listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets under statutory accounting convention in its state of domicile; or

(3) Any other form of security acceptable to the commissioner.

B. In addition, the SPRV may enter into swap agreements or other transactions that have the objective of leveling timing differences in funding of up-front or ongoing transaction expenses or managing credit or interest rate risk of the investments in the trust to ensure that the investments are sufficient to assure payment or repayment of the securities (and related interest or principal payments) issued pursuant to an SPRV insurance securitization transaction or the SPRV's obligations under the SPRV contract.

Section 18. Credit for Reinsurance for the SPRV Contract

An SPRV contract meeting the requirements under this Act shall be granted credit for reinsurance treatment or shall otherwise qualify as an asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer under the (insert reference to the state's equivalent of Section 3 of the NAIC Credit for Reinsurance Model Act) for the benefit of the ceding insurer, provided and only to the extent that:

A. The fair value of the assets held in trust for the benefit of the ceding insurer equal or exceed the obligations due and payable to the ceding insurer by the SPRV under the SPRV contract;

B. The assets are held in trust in accordance with the requirements set forth in this Act;

C. The assets are administered in the manner and pursuant to arrangements as set forth in this Act; and

D. The assets are held or invested in one or more of the forms allowed in Section 17.

Section 19. No Transaction of an Insurance Business by Investors in Securities

The securities issued by the SPRV pursuant to an SPRV insurance securitization shall not be deemed to be insurance or reinsurance contracts. An investor in such securities issued pursuant to an SPRV insurance securitization or any holder of such securities shall not, by sole means of this investment or holding, be deemed to be transacting an insurance business in this state. The underwriters or selling agents (and their partners, directors, officers, members, managers, employees, agents, representatives and advisors) involved in an SPRV insurance securitization shall not be deemed to be conducting an insurance or reinsurance agency, brokerage, intermediary, advisory or consulting business by virtue of their activities in connection therewith.

Section 20. Authority to Adopt Regulations

The commissioner may adopt regulations necessary to effectuate the purposes of this Act. Any regulations so adopted will not affect a SPRV insurance securitization in effect at the time of adoption.

Section 21. Effective Date

This Act shall become effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2001 Proc. 3rd Quarter (adopted).

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Illinois	215 ILL. COMP. STAT. §§ 5/179E-1 to 5/179E-100 (2001).		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. § 22:1727 (2011).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 781 to 798 (2003/2007).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. §§ 38-14-10 to 38-14-200 (2002).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2001

SPECIAL PURPOSE REINSURANCE VEHICLE MODEL ACT (#789)

1. Project Description

This model provides a basis for the creation of Special Purpose Reinsurance Vehicles ("SPRVs") exclusively to facilitate the securitization of one or more ceding insurers' risk. At present, insurers have been using offshore SPRVs to effectuate securitizations, often using Bermuda or Cayman Island domiciles. Domestic insurers cede reinsurance to the offshore SPRV, which then securitizes the risk and thereby retains none of it. These SPRVs are sometimes referred to as 'transformers' because they transform a reinsurance transaction into a capital markets transaction. The purpose of the SPRV model is to enable those transactions to take place onshore.

2. Group Responsible for Drafting the Act

The project was assigned to the Insurance Securitization Working Group of the Financial Condition (E) Committee. The members of the working group were: Arnie Dutcher (IL), Chair, Greg Serio (NY), Vice-Chair, Woody Girion (CA), Al Franz (DE), Kevin McCarty (FL), Don Roof (GA), Craig Gardner (LA), Alessandro Iuppa (ME), Steve Johnson (PA), Joe Torti (RI), Ernst Csiszar (SC), and Jose Montemayor (TX).

3. Charge Authorizing the Project

Extract: "The Insurance Securitization Working Group will investigate whether there needs to be a regulatory response to continuing developments in insurance securitization, including the use of non-U.S. special purpose vehicles…". This charge was first given to the group in 1998. The response decided upon at the October 22, 1998, meeting by the group was to facilitate onshore as opposed to offshore SPRVs.

4. General Description of the Drafting Process and Due Process

Interested parties performed much of the original drafting of the act, with representatives of USAA, a current user of offshore SPRVs, providing much input. The act was extensively modified in a series of meetings spanning from October 1999 through July 2001.

The first significant discussion of a SPRV model was at the Atlanta National Meeting on October 4, 1999, where the first industry interested parties' draft of a model was presented to the group. The model was extensively discussed and revised on November 10, 1999, and a new draft was received by the working group and discussed further on December 6, 1999. There was then a significant amount of discussion regarding the public policy issues surrounding SPRVs at a two-day public hearing in May 2000 with position papers presented by industry interested parties in support of and opposed to SPRVs. Subsequent to this, an academic paper was presented to the working group in June 2000 and considered in more detail at an interim meeting on August 30, 2000, where a new draft of the model act was also presented. The academic paper was then modified in March 2001 by its authors. The draft act was modified again and discussed at an interim meeting on November 15, 2000, and a further draft was prepared for a full day interim meeting on February 6, 2001, at which regulators found compromise solutions for numerous areas, and voted 11-0 to adopt the act. Changes were discussed at a conference call on March 16, 2001, to consider the final drafting from the February meeting, but none were agreed upon. Some minor changes were agreed at its March 24, 2001, meeting and all twelve working group members voted unanimously to adopt the model.

Following the adoption of the model by the Insurance Securitization Working Group on March 24, 2001, the Financial Condition (E) Committee requested additional comment from regulators and interested parties for discussion during a June 9, 2001, public hearing in New Orleans. At the June 9, 2001, hearing, oral and written comments were considered, and the draft act was modified and released once again for public comment. The Committee considered comments received during a July 26, 2001, conference call and agreed to additional revisions. Finally, the Committee voted 10-2 to adopt the act.

5. Discussion of Key Issues

Tax: Although the income statement of an SPRV would be a wash, its viability does depend critically on being able to deduct the interest payments to securitization investors as interest. There is some concern that there could be reclassification of the interest to dividends under some IRS interpretations, and hence the proponents of onshore SPRVs would intend to ask Congress to provide the same certainty that pass-through tax treatment would be allowed as Congress has done with mortgage securitizations. This would of course require an act in Congress. The Reinsurance Association of America (RAA)

is very opposed to such potential legislation claiming that it provides a tax advantage and that it is inherently unfair. The proponents' viewpoint is that it provides no advantage, merely guarantees against a disadvantage. In fact, they say that were a domestic reinsurer to do exactly what an SPRV is expected to do, the reinsurer would already receive the tax treatment that the SPRVs want to receive. The academic paper regarding onshore SPRVs concluded, inter alia, that "the issues involved with the proposed federal tax treatment of onshore SPRVs should not be used to impede the development and use of these vehicles" and that the authors did "not believe that proposed tax treatment of onshore SPRV transactions would have a detrimental impact on other forms of and vehicles for risk transfer."

Competition: Major industry associations of direct and primary insurers are firmly supportive of the act, while the RAA is opposed, presumably mostly from a competitive standpoint. Together with the tax issue mentioned above, the RAA would prefer that SPRVs be limited to catastrophic risk only and that any multiple cedent situation only apply to small companies. The RAA's position is that the SPRV program creates incentives that promote on-shore securitizations while doing nothing to promote utilization of on-shore reinsurance.

REINSURANCE INTERMEDIARY MODEL ACT

Table of Contents

Section 1. Short Title

This Act may be cited as the Reinsurance Intermediary Act.

Section 2. Definitions

As used in this Act:

A. "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

B. "Controlling person" means a person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary.

C. "Insurer" means a person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

D. "Licensed producer" means a person licensed under [insert reference to state producer licensing law] to sell, solicit or negotiate insurance.

E. "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in Subsections F and G of this section.

F. "Reinsurance intermediary-broker" (RB) means a person, other than an officer or employee of the ceding insurer, firm, association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without acting as a RM on behalf of the insurer.

G. "Reinsurance intermediary-manager" (RM) means a person, firm, association or corporation, whether known as a RM, manager or other similar term, who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department or underwriting office) and acts as an agent for the reinsurer except the following:

(1) An employee of the reinsurer;

(2) A U.S. manager of the U. S. branch of an alien reinsurer;

(3) An underwriting manager that, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the Holding Company Act, and that is not compensated based on the volume of premiums written.

(4) The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance but only if the group association, pool or organization of insurers (as distinguished from its members) is subject to examination by the [Insurance Commissioner] of the state in which the manager's principal business office is located.

H. "Reinsurer" means a person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer with the authority to assume reinsurance.

I. "To be in violation" means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this Act.

J. Qualified U. S. financial institutions:

For purposes of this Act, a "qualified U. S. financial institution" means an institution that:

(1) Is organized or (in the case of a U.S. office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(2) Is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

Section 3. Licensure

A. No person, firm, association or corporation shall act as a RB in this state if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

(1) In this state, unless the RB is a licensed producer or reinsurance intermediary in this state; or

(2) In another state, unless the RB is a licensed producer or reinsurance intermediary in this state or another state having a law substantially similar to this law.

B. No person, firm, association or corporation shall act as a RM:

(1) For a reinsurer domiciled in this state, unless the RM is a licensed producer or reinsurance intermediary in this state;

(2) In this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless the RM is a licensed producer or reinsurance intermediary in this state.

C. The commissioner may require a resident RM subject to Subsection B to:

(1) File a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

Drafting Note: It is contemplated that one bond per reinsurer represented would be required.

(2) Maintain an errors and omissions policy in an amount acceptable to the commissioner.

D. (1) The commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation that has complied with the requirements of this Act. A license issued to a firm or association will authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. A license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation, and all such persons shall be named in the application and any supplements thereto.

(2) The commissioner shall issue a nonresident reinsurance intermediary license if:

(a) The person is currently licensed as a resident reinsurance intermediary or insurance producer and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];

(c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of that application, a completed application deemed appropriate by the commissioner; and

(d) The person's home state awards nonresident licenses to residents of this state on the same basis.

Drafting Note: In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act"), states should not require an applicant for a non-resident license to satisfy any additional requirements for a license except as allowed by the Act. Incorporation into this model law of the Gramm-Leach-Bliley Act provisions with respect to non-resident administrative licensing procedures should not be read to imply that corrective action was required to bring this model law into compliance with the Gramm-Leach-Bliley Act. The changes were made solely to ensure and to clarify that the licensing provisions of this model law are consistent with the language of the Gramm-Leach-Bliley Act.

E. The commissioner may refuse to issue a reinsurance intermediary license if, in his or her judgment, the applicant, any one named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the commissioner will furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to [cite applicable freedom of information law].

F. Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from this section.

Section 4. Required Contract Provisions—Reinsurance Intermediary—Brokers

Transactions between a RB and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

A. The insurer may terminate the RB's authority at any time.

B. The RB will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing, to the RB, and remit all funds due to the insurer within thirty (30) days of receipt.

C. All funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank that is a qualified U.S. financial institution as defined herein.

D. The RB will comply with Section 5 of this Act.

E. The RB will comply with the written standards established by the insurer for the cession or retrocession of all risks.

F. The RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Section 5. Books and Records—Reinsurance Intermediary Brokers

A. For at least ten (10) years after expiration of each contract of reinsurance transacted by the RB, the RB will keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RB;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the RB including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including but not limited to, premium and loss accounts; and

(11) When the RB procures a reinsurance contract on behalf of a licensed ceding insurer:

(a) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(b) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

Drafting Note: States may wish to bifurcate this subsection, shortening the required retention period for contracts limited to first-party property coverages and lengthening the period for certain third-party liability coverages (e.g., medical malpractice).

B. The insurer will have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

Section 6. Duties of Insurers Utilizing the Services of a Reinsurance Intermediary—Broker

A. An insurer shall not engage the services of any person, firm, association or corporation to act as a RB on its behalf unless the person is licensed as required by Section 3A of this Act.

B. An insurer may not employ an individual who is employed by a RB with which it transacts business, unless the RB is under common control with the insurer and subject to the [insert citation to the Holding Company Act].

C. The insurer shall annually obtain a copy of statements of the financial condition of each RB with which it transacts business.

Section 7. Required Contract Provisions—Reinsurance Intermediary—Managers

Transactions between a RM and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's Board of Directors. At least thirty (30) days before the reinsurer assumes or cedes business through the producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, provide that:

A. The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may immediately suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

B. The RM will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

C. All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank that is a qualified U.S. financial institution as defined herein. The RM may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that it represents.

D. For at least ten (10) years after expiration of each contract of reinsurance transacted by the RM, the RM will keep a complete record for each transactions showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the RM, as permitted by Section 9D of this Act, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including but not limited to, premium and loss accounts; and

(11) When the RM places a reinsurance contract on behalf of a ceding insurer:

(a) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(b) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

Drafting Note: States may wish to bifurcate this subsection, shortening the required retention period for contracts limited to first-party property coverages and lengthening the period for certain third-party liability coverages (e.g., medical malpractice).

E. The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

F. The contract cannot be assigned in whole or in part by the RM.

G. The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

H. Rates, terms and purposes of commissions, charges and other fees which the RM may levy against the reinsurer are set forth.

I. If the contract permits the RM to settle claims on behalf of the reinsurer:

(1) All claims will be reported to the reinsurer in a timely manner;

(2) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(a) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(b) Involves a coverage dispute;

(c) May exceed the RM's claims settlement authority;

(d) Is open for more than six (6) months; or

(e) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(3) All claim files will be the joint property of the reinsurer and RM. However, upon an order of liquidation of the reinsurer the files shall become the sole property of the reinsurer or its estate; the RM shall have reasonable access to and the right to copy the files on a timely basis;

(4) Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

J. If the contract provides for a sharing of interim profits by the RM, interim profits will not be paid until one year after the end of each underwriting period for property business and five (5) years after the end of each underwriting period for casualty business (or a later period set by the commissioner for specified lines of insurance) and not until the adequacy of reserves on remaining claims has been verified pursuant to Section 9C of this Act.

K. The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

L. The reinsurer shall periodically (at least semi-annually) conduct an on-site review of the underwriting and claims processing operations of the RM.

M. The RM will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract.

N. Within the scope of its actual or apparent authority the acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

Section 8. Prohibited Acts

The RM shall not:

A. Cede retrocessions on behalf of the reinsurer, except that the RM may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. The guidelines shall include a list of reinsurers with which automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

B. Commit the reinsurer to participate in reinsurance syndicates;

C. Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

D. Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

E. Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

F. Jointly employ an individual who is employed by the reinsurer unless such RM is under common control with the reinsurer subject to the [insert citation for Holding Company Act]; or

G. Appoint a sub-RM.

Section 9. Duties of Reinsurers Utilizing the Services of a Reinsurance Intermediary—Manager

A. A reinsurer shall not engage the services of any person, firm, association or corporation to act as a RM on its behalf unless the person is licensed as required by Section 3B of this Act.

B. The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which the reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the commissioner.

C. If a RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

D. Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

E. Within thirty (30) days of termination of a contract with a RM, the reinsurer shall provide written notification of termination to the commissioner.

F. A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its RM. This subsection shall not apply to relationships governed by the [insert citation to Holding Company Act] or, if applicable, [insert citation to state law equivalent to the Broker Controlled Insurer Act].

Section 10. Examination Authority

A. A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the commissioner.

B. A RM may be examined as if it were the reinsurer.

Section 11. Compliance with Orders

A. A RB or RM shall comply with any order of a court of competent jurisdiction or a duly constituted arbitration panel requiring the production of non-privileged documents by the RB or RM, or the testimony of an employee or other individual otherwise under the control of the RB or RM with respect to any reinsurance transaction for which it acted as a RB or RM.

B. Compliance shall be subject to the right of the RB or RM, and the parties to the reinsurance transaction, to object to the court or arbitration panel concerning the nature or scope of the documents or testimony or the time within which it must comply with the order. Failure to comply with the order shall be deemed to be a material non-compliance with this Act. However, in no event shall this section be construed to require more than one appearance by the same witness in a single action or arbitration.

Section 12. Penalties and Liabilities

A. If the commissioner determines that the reinsurance intermediary or any other person has not materially complied with this Act, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the commissioner may order:

(1) For each separate violation, a penalty in an amount not exceeding $5,000;

(2) Revocation or suspension of the reinsurance intermediary's license; and

(3) If it was found that because of such material non-compliance that the insurer or reinsurer has suffered any loss or damage, the commissioner may maintain a civil action brought by or on behalf of the reinsurer or insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the reinsurer or insurer and its policyholders and creditors or seek other appropriate relief.

B. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to [insert state's rehabilitation or liquidation statute], and the receiver appointed under that order determines that the reinsurance intermediary or any other person has not materially complied with this Act, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

Drafting Note: If state law does not otherwise provide, amend the bracketed citation in the preceding paragraph to include the rehabilitation or liquidation statute of any reciprocal state. This is intended to codify the standing of a receiver to maintain a civil action in a reciprocal state.

C. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance law.

D. Nothing contained in this Act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

Section 13. Reciprocity

A. The insurance commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by Section 3 of this Act, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

B. A nonresident reinsurance intermediary's satisfaction of any applicable home state continuing education requirements, if any, for licenses insurance producers or reinsurance intermediaries shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers or reinsurance intermediaries from this state on the same basis.

Drafting Note: States are encouraged to eliminate any licensing and appointment retaliatory fees. In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act"), states should not require nonresident fees that are so disparate from the resident fees that they impose a barrier to entry. Such fees would be prohibited under Public Law 106-102.

Section 14. Service of Process

A reinsurance intermediary, by accepting licensure in this state, is deemed to have consented to the jurisdiction of the commissioner and of the courts of this state with respect to all activities conducted under the license, and to have designated the commissioner as its agent for service of process. Each licensed reinsurance intermediary shall furnish the commissioner with the name and address of a designated contact resident of this state to whom notices or orders of the commissioner or process affecting the reinsurance intermediary may be forwarded. The licensee shall promptly notify the commissioner in writing of every change in its designated contact for services of process, and such changes shall not become effective until acknowledged by the commissioner.

Section 15. Rules and Regulations

The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this Act.

Drafting Note: This section may be omitted if state's insurance law contains general rule-making provision.

Section 16. Effective Date

This Act shall take effect on [insert date]. No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary on and after [insert date] unless utilization is in compliance with this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. I 6, 30, 840, 844-850, 870-872 (adopted).
1990 Proc. II 7, 17-18, 748, 766, 770-775 (amended and reprinted).
1993 Proc. I 1128-1129, 1131, 1137-1138 (amended, reprinted and adopted by parent committee).
1993 Proc. 2nd Quarter 12, 102 (adopted by executive and plenary).
2001 Proc. 2nd Quarter 11, 14, 835, 943-944, 964-966 (amended).
2006 Proc. 2nd Quarter 40, 90 (amended).

REINSURANCE INTERMEDIARY MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

REINSURANCE INTERMEDIARY MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-5A-1 to 27-5A-13 (1993).		ALA. ADMIN. CODE r. 482-1-107 (1994).
Alaska	ALASKA STAT. §§ 21.27.670 to 21.27.770 (1992/2004) (portions of model).		ALASKA ADMIN. CODE tit. 3, § 23.140 (2009).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-486 to 20-486.11 (1991/1993).		
Arkansas	ARK. CODE ANN. §§ 23-62-401 to 23-62-413 (1993/1995).		
California	CAL. INS. CODE §§ 1781.1 to 1781.13 (1992/2004).		
Colorado	COLO. REV. STAT. §§ 10-2-901 to 10-2-912 (1992/2009).		3 COLO. CODE REGS. § 702-1:1-2-6 (1994/2003).
Connecticut	CONN. GEN. STAT. §§ 38a-760 to 38a-760J (1993/2012).		
Delaware	18 DEL. CODE ANN. § 1601 to 1613 (1991).		
District of Columbia	D.C. CODE §§ 31-1801 to 31-1810 (1993/2003).		

REINSURANCE INTERMEDIARY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. § 626.7492 (1992/1995).		
Georgia	GA. CODE ANN. §§ 33-49-1 to 33-49-11 (1991).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:9B-101 to 431:9B-111 (1992/2006).		HAW. CODE R. § 16-171-314 (2005/2012).
Idaho	IDAHO CODE ANN. §§ 41-5101 to 41-5111 (1992/1993).		
Illinois	215 ILL. COMP. STAT. 100/1 to 100/60 (1991/2003).		
Indiana	IND. CODE §§ 27-6-9-1 to 27-6-9-26 (1991).		760 IND. ADMIN. CODE 1-51-1 to 1-51-7 (1993/2013).
Iowa	IOWA CODE §§ 521C.1 to 521C.12 (1991/1994).		
Kansas	KAN. STAT. ANN. §§ 40-4501 to 40-4513 (1992/2005).		
Kentucky	KY. REV. STAT. ANN. §§ 304.9-700 to 304.9-759 (1992).		
Louisiana	LA. REV. STAT. ANN. §§ 22:1721 to 22:1732 (1992).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 741 to 754 (1993).		
Maryland	MD. CODE ANN., INS. 8-501 to 8-520 (1993/1997).		
Massachusetts	MASS. GEN. LAWS ch. 175, §§ 177M to 177W (1993).		
Michigan	MICH. COMP. LAWS §§ 500.1151 to 500.1171 (1994).		

REINSURANCE INTERMEDIARY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. §§ 60A.70 to 60A.756 (1991/1998).		
Mississippi	MISS. CODE ANN. §§ 83-19-201 to 83-19-221 (1992).		
Missouri	MO. REV. STAT. §§ 375.1110 to 375.1140 (1991).		MO. CODE REGS. ANN. tit. 20, § 700-7.100 (1992/2003).
Montana	MONT. CODE ANN. §§ 33-2-1701 to 33-2-1709 (1993).		
Nebraska	NEB. REV. STAT. §§ 44-5601 to 44-5613 (1993/2002).		
Nevada			NEV. REV. STAT. §§ 681A.260 to 681A.580 (1995/2003); NEV. ADMIN. CODE §§ 681A.050 to 681A.110 (1996).
New Hampshire	N.H. REV. STAT. ANN. §§ 402-F:1 to 402-F:12 (1992/1997).		
New Jersey	N.J. REV. STAT. §§ 17:22E-1 to 17:22E-23 (1993).		N.J. ADMIN. CODE §§ 11:17-7.1 to 11:17-7.7 (1993/2003).
New Mexico	N.M. STAT. ANN. §§ 59A-12D-1 to 59A-12D-12 (1993/1999).		
New York			N.Y. INS. LAW §§ 2101 to 2139 (1984/2013) (reinsurance intermediary provisions in agents licensing law); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 32.0 to 32.4 (Regulation 98) (1982).
North Carolina	N.C. GEN. STAT. §§ 58-9-2 to 58-9-26 (1993/2001).		BULLETIN 94-B-3 (1994).

REINSURANCE INTERMEDIARY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota	N.D. CENT. CODE §§ 26.1-31.1-01 to 26.1-31.1-12 (1991/1993).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-3-09 (1993).		
Oklahoma	OKLA. STAT. tit. 36, §§ 5101 to 5113 (1992).		
Oregon	OR. REV. STAT. §§ 744.800 to 744.820 (1993/2003).		
Pennsylvania	40 PA. STAT. ANN. §§ 321.1 to 321.10 (1992).		
Puerto Rico	P.R. REG. 9071 (2015).		
Rhode Island	R.I. GEN. LAWS §§ 27-52-1 to 27-52-12 (1992/1999).		
South Carolina	S.C. CODE ANN. §§ 38-46-10 to 38-46-120 (1992).		
South Dakota	S.D. CODIFIED LAWS §§ 58-14-24 to 58-14-42 (1993/1994).		
Tennessee	TENN. CODE ANN. §§ 56-6-801 to 56-6-812 (1993).		
Texas	TEX. INS. CODE ANN. §§ 4152.001 to 4152.302 (2005).		
Utah	UTAH CODE ANN. §§ 31A-23a-801 to 31A-23a-809 (1992/2003).		
Vermont	VT. STAT. ANN. tit. 8, §§ 4815 to 4824 (1992).		VT. STAT. ANN. tit. 8, §§ 6070 to 6075 (1994) (reinsurance intermediaries for RRGs); VT. ADMIN. CODE 4-3-25:1 (REG. 94-2) (1994).

REINSURANCE INTERMEDIARY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. §§ 38.2-1347 to 38.2-1357 (1992/2001).		ADMIN. LETTER 2002-10 (2002).
Washington	WASH. REV. CODE ANN. §§ 48.94.005 to 48.94.901 (1993/2005).		WASH. ADMIN. CODE 284-13-700 to 284-13-863 (1993/2010).
West Virginia	W. VA. CODE §§ 33-38-1 to 33-38-14 (1994/2005).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 47.01 to 47.10 (1993/2006).		WIS. ADMIN. CODE INS. §§ 6.58 to 6.61 (1977/1996).
Wyoming	WYO. STAT. ANN. §§ 26-47-101 to 26-47-113 (1992).		

PROJECT HISTORY - 2006

REINSURANCE INTERMEDIARY MODEL ACT (#790)

1. Project Description

The Reinsurance (G) Task Force was charged with reviewing the Reinsurance Intermediary Model Act. The purpose of these amendments is to ensure that a reinsurance broker or manager be required to comply with the order of a court or arbitration panel requiring the production of non-privileged documents or the testimony of an employee or other individual otherwise under the control of the intermediary with respect to reinsurance transactions for which the intermediary provided services. The language provides for safeguards with respect to the nature or scope of the requested documents or testimony, penalties in the event of a violation, and safeguards with respect to multiple appearances by the same witness.

2. Group Responsible for the Report

The project was assigned to the Reinsurance (G) Task Force. The members of the task force at the time were: Julie Bowler (MA), Chair; John Oxendine (GA), Vice-Chair; Walter Bell (AL); John Garamendi (CA); Susan Cogswell (CT); Matthew Denn (DE); Thomas Hampton (DC); Kevin McCarty (FL); Michael McRaith (IL); Martin Koetters (KY); Alessandro Iuppa (ME); Glenn Wilson (MN); Alice Molasky-Arman (NV); Roger Sevigny (NH); Steven Goldman (NJ); Howard Mills (NY); Jim Poolman (ND); Diane Koken (PA); Dorelisse Juarbe Jimenez (PR); Mike Geeslin (TX); Alfred Gross (VA); Mike Kriedler (WA) and Jorge Gomez (WI).

3. Charge Authorizing the Project

As part of the NAIC 2006 Model Law Review, changes were proposed to the Reinsurance Intermediary Model Act.

4. General Description of the Drafting Process and Discussion of Key Issues

Most reinsurance contracts are conceived, negotiated and drafted by reinsurance intermediaries and that most such contracts contain arbitration clauses. When disputes arise between the parties to the reinsurance contract, arbitrators often look to intermediaries for background documentation and testimony concerning the intentions of the parties, representations made and the course of conduct during the operation of contract. All too often, however, intermediaries refuse to provide this information leaving the arbitrators to evaluate the transaction created and documented by intermediaries without their assistance.

Due to a gap in the Federal Arbitration Act, an arbitration panel lacks the authority to order a pre-hearing deposition or production of documents. The issue is not just one of facilitating the conflict resolution method of choice between insurers and reinsurers. The issue is also whether an intermediary is "fit and proper" from a regulatory standpoint, if it refuses to cooperate with efforts to resolve problems growing out of the contracts it conceived, negotiated and drafted.

During an August 17, 2005, conference call, the Interested Persons reviewed the recommended amendments to the Intermediary Act that reflected agreed language worked out between several interested parties. The task force then exposed those amendments for comment from interested parties and regulators. Receiving no additional comments or disagreement with the proposal, the task force adopted amendments during the NAIC 2006 Spring National Meeting.

PROJECT HISTORY - 2001

REINSURANCE INTERMEDIARY MODEL ACT (#790)

1. Project Description

The Reinsurance (G) Task Force was charged with reviewing the Reinsurance Intermediary Model Act to clarify non-resident reciprocity provisions for reinsurance intermediaries consistent with the Gramm-Leach-Bliley Act. The charge was proposed by the NARAB Working Group after the NAIC 2000 Winter National Meeting.

2. Group Responsible for the Report

The project was assigned to the Reinsurance (G) Task Force. The members of the task force at that time were: John Oxendine (GA), Chair; Alessandro Iuppa (ME), David Parsons (AL); Elisara Togiai (AS); Harry Low (CA), Donna Lee Williams (DE), Nathaniel Shapo (IL), Greg Serio (NY), and Jose Montemayor (TX).

3. Charge Authorizing the Project

At the NAIC 2000 Winter National Meeting, Nicole Allen, Council of Insurance Agents and Brokers, alerted the task force of an issue surrounding the possible applicability of the NARAB reciprocity standards to non-resident licensure for reinsurance intermediaries. Ms. Allen recommended that the task force review the NAIC Reinsurance Intermediary Model Act to ensure that appropriate reciprocity requirements are in place for reinsurance intermediaries.

4. General Description of the Drafting Process and Discussion of Key Issues

A draft of revisions to the Reinsurance Intermediary Model Act was prepared on January 16, 2001, by NAIC Staff. The task force then exposed those amendments for comment from interested parties after a January 25, 2001, conference call. The task force adopted amendments during the NAIC 2001 Spring National Meeting, which were finalized during a May 22, 2001, conference call. The adopted amendments redefine licensed producers as persons required to be licensed under the laws to sell, solicit or negotiate insurance. The Model Act was further revised to include new language concerning non-resident reinsurance intermediaries, which advise that a license shall be granted if: 1) the person is currently licensed as a resident reinsurance intermediary or insurance producer and in good standing in his or her home state; 2) the person has submitted the proper request for licensure and has paid the fees required; 3) the person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of that application, a completed application deemed appropriate by the commissioner; and 4) the person's home state awards nonresident licenses to residents of this state on the same basis. The existing service of process provision was amended to preclude any condition precedent being established before the Commissioner would be designated as agent for service of process. Language was also included at the request of the Underwriting and Reinsurance Pools Working Group to clarify the scope of the "Pool Manager" exemption from licensure.

The Regulation was presented and adopted by the Task Force at the NAIC 2001 Summer National Meeting.

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

Table of Contents:

Section 1. Authority [Optional]

This regulation is adopted and promulgated by the commissioner pursuant to Section [applicable section] of the [name of state] Insurance Law [or Code].

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.

Section 2. Preamble

A. The [name of state] Insurance Department recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

B. However, it is improper for a licensed insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival. The terms of such agreements referred to herein and described in Section 4 violate:

(1) Section [insert applicable section] relating to financial statements which do not properly reflect the financial condition of the ceding insurer;

(2) Section [insert applicable section] relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and

(3) Section [insert applicable section] relating to creating a situation that may be hazardous to policyholders and the people of this State.

Section 3. Scope

This regulation shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar regulation in their domiciliary state. This regulation shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This regulation shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

Section 4. Accounting Requirements

A. No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(1) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured;

(2) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

(3) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

(4) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

(5) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

(6) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk categories:

(a) Morbidity

(b) Mortality

(c) Lapse

This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(d) Credit Quality (C1)

This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

(e) Reinvestment (C3)

This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(f) Disintermediation (C3)

This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

\+ - Significant 0 - Insignificant

RISK CATEGORY

	a b c d e f
Health Insurance - other than LTC/LTD*	+ 0 + 0 0 0
Health Insurance - LTC/LTD*	+ 0 + + + 0
Immediate Annuities	0 + 0 + + 0
Single Premium Deferred Annuities	0 0 + + + +
Flexible Premium Deferred Annuities	0 0 + + + +
Guaranteed Interest Contracts	0 0 0 + + +
Other Annuity Deposit Business	0 0 + + + +
Single Premium Whole Life	0 + + + + +
Traditional Non-Par Permanent	0 + + + + +
Traditional Non-Par Term	0 + + 0 0 0
Traditional Par Permanent	0 + + + + +
Traditional Par Term	0 + + 0 0 0
Adjustable Premium Permanent	0 + + + + +
Indeterminate Premium Permanent	0 + + + + +
Universal Life Flexible Premium	0 + + + + +
Universal Life Fixed Premium	0 + + + + +
Universal Life Fixed Premium dump-in premiums allowed	0 + + + + +

*LTC = Long Term Care Insurance

LTD = Long Term Disability Insurance

(7) (a) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in Paragraph (7)(b)) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(b) Notwithstanding the requirements of Paragraph (7)(a), the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

- Health Insurance - LTC/LTD
- Traditional Non-Par Permanent
- Traditional Par Permanent
- Adjustable Premium Permanent
- Indeterminate Premium Permanent
- Universal Life Fixed Premium
  (no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

Where: I is the net investment income (Exhibit 2, Line 16, Column 7)

CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6)

X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1)

Y is the same as X but for the prior year

Drafting Note: Line references are for the 1992 annual statement. Line references may be deleted or should be updated if regulation is adopted after calendar year 1992. Be aware that annual statement line references may change from year to year.

(8) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date.

(9) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(10) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(11) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

B. Notwithstanding Subsection A, an insurer subject to this regulation may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner may deem consistent with the Insurance Law [or Code], Rules or Regulations, including actuarial interpretations or standards adopted by the Department.

C. (1) Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty (30) days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

(2) Any increase in surplus net of federal income tax resulting from arrangements described in Subsection C(1) shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

{For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

At the end of year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66% of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.}

Section 5. Written Agreements

A. No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

B. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

C. The reinsurance agreement shall contain provisions which provide that:

(1) The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(2) Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

Section 6. Existing Agreements

Insurers subject to this regulation shall reduce to zero by December 31, 19[ ] any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which, under the provisions of this regulation would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

Drafting Note: While each jurisdiction has short time period discretion, the latest date to be inserted must be no later than three (3) years from the date this amended model regulation was adopted by the NAIC.

Section 7. Effective Date

This regulation shall become effective [date].

Chronological Summary of Actions (All references are to the Proceedings of the NAIC).

1986 Proc. I 9-10, 22, 149, 240, 243-245 (adopted).
1992 Proc. II 8, 11-12, 159, 162-167 (amended and reprinted).

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-085 (1988/1997).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.600 to 21.695 (1992/1997).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-307 (1993/1996).		
Arkansas	ARK. CODE R. 054.00.51 (1991/1996).		
California	BULLETIN 97-5 (1992).		
Colorado	3 COLO. CODE REGS. § 702-3:3-3-4 (2016).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-72a-1 to 38a-72a-5 (1993/2014).		
Delaware	18 DEL. CODE REGS. § 1002 (1995/2003).		
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 2300 to 2304 (1995).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-144.010 (1991/1996).		

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. COMP. R. & REGS. 120-2-61 (1993).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-20-1 to 16-20-5 (1994).		
Idaho	IDAHO ADMIN. CODE 18.07.06 (1993).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1103.10 to 1103.50 (1994/2011).		
Indiana	760 IND. ADMIN. CODE 1-55-1 to 1-55-6 (2007/2013).		
Iowa	IOWA ADMIN. CODE r. 191-17.1 to 191-17.5 (1989/1993).		
Kansas	KAN. ADMIN. REGS. § 40-2-24 (1997) (adopted by reference with modification).		
Kentucky	806 KY. ADMIN. REGS. 3:160 (1991/1996).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.3701 to XIII.3711 (Regulation 57) (1995).		
Maine	CODE ME. R. tit. 02-031 Ch. 760 (1993).		
Maryland	MD. CODE REGS. 31.05.07.01 to 31.05.07.09 (1993).		
Massachusetts	211 MASS. CODE REGS. 129.01 to 129.04 (1993/2015).		
Michigan	MICH. ADMIN. CODE r. 500.1122 to 500.1127 (1994).		
Minnesota	MINN. STAT. § 60A.803 (1994).		
Mississippi	MISS. CODE R. 92-102 (1992/1996).		

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-2.300 (1990/1993).		
Montana	MONT. ADMIN. R. 6.6.3601 to 6.6.3604 (1993).		
Nebraska	210 NEB. ADMIN. CODE § 57 (1991/2000).		
Nevada	NEV. ADMIN. CODE §§ 681A.150 to 681A.190 (1996).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 308.01 to 308.06 (1992/2012).		
New Jersey	N.J. ADMIN. CODE §§ 11:2-40.1 to 11:2-40.8 (1993/2001).		
New Mexico	N.M. ADMIN. CODE 13.2.7.1 to 13.2.7.14 (1997).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 127.1 to 127.4 (Regulation 102) (1993).		
North Carolina	N.C. GEN. STAT. § 58-7-31 (1993).		
North Dakota	N.D. ADMIN. CODE 45-03-07.2-01 to 45-03-07.2-04 (1995/2001).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-3-07 (1991/1995).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:25-7-50 to 365:25-7-53 (1992/1994).		
Oregon	OR. ADMIN. R. 836-012-0300 to 836-012-0332 (1993/2010).		
Pennsylvania	31 PA. CODE §§ 162.1 to 162.9 (1993).		

LIFE AND HEALTH REINSURANCE AGREEMENTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-4.2-1 to 27-4.2-7 (1992/2011); 230 R.I. Code R. 20-45-8.1 to 20-45-8.6 (2001).		
South Carolina	S.C. CODE ANN. REGS. 69-48 (1991/1994).		
South Dakota	S.D. ADMIN. R. 20:06:30 (1995/2003).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-62 (1994).		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE r. 590-143 (1991/2012).		
Vermont	4-3 VT. CODE R. § 20 (REGULATION 93-1) (1993/1994).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-280-10 to 5-280-70 (1991/2013).		
Washington	WASH. ADMIN. CODE 284-13-850 to 284-13-863 (1995).		
West Virginia	W. VA. CODE § 33-4-15b (1992/1995) (also applies to P/C insurers); W. VA. CODE R. §§ 114-48-1 to 114-48-6 (1996).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 55.01 to 55.05 (1993).		
Wyoming	WYO. STAT. ANN. §to 26-5-119 (1992/1993).		

ASSUMPTION REINSURANCE MODEL ACT

Table of Contents

Section 1. Purpose

This Act provides for the regulation of the transfer and novation of contracts of insurance by way of assumption reinsurance. It defines assumption reinsurance and establishes notice and disclosure requirements which protect and define the rights and obligations of policyholders, regulators and the parties to assumption reinsurance agreements.

Section 2. Scope

A. This Act applies to any insurer authorized in this state which either assumes or transfers the obligations or risks, or both, on contracts of insurance pursuant to an assumption reinsurance agreement.

Drafting Note: Certain other transactions may result in a substantive assumption or transfer of obligations or risks, or both, under contracts of insurance. For example, some state statutes permit transactions in which affiliated insurers isolate certain obligations under existing insurance policies, in whole or in part, from other insurance operations (so-called "division statutes"). States desiring to assure their jurisdiction over assumptions of this type should consider including the following in their statutes:

1. Add "or other agreement, plan or arrangement whose effect on policyholder rights is substantially similar to an assumption reinsurance agreement" after "assumption reinsurance agreement" in Section 2A.

2. Insert ", or other agreement, plan or arrangement" after "contract" in Section 3B.

3. Insert ", or" after "extinguished" in Section 3B(2).

4. Insert a new Paragraph (3) in Section 3B that would read as follows: "Whose effect on policyholder rights is substantially similar to transactions meeting the conditions set forth in Paragraphs (1) and (2) of this subsection and that have not been specifically excluded from the application of this Act by Section 2B."

B. This Act does not apply to:

(1) Any reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks, or both, under the contracts of insurance subject to the reinsurance agreement;

(2) The substitution of one insurer for another upon the expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new contract of insurance by another insurer;

(3) The transfer of contracts of insurance pursuant to mergers or consolidations of two (2) or more insurers to the extent that those transactions are regulated by statute;

(4) Any insurer subject to a judicial order of liquidation or rehabilitation;

Drafting Note: This section is intended to apply to any similar proceedings under court order.

(5) Any reinsurance agreement or transaction to which a state insurance guaranty association is a party, provided that policyholders do not lose any rights or claims afforded under their original policies pursuant to [cite applicable state guaranty fund laws]; or

(6) The transfer of liabilities from one insurer to another under a single group policy upon the request of the group policyholder.

Section 3. Definitions

A. "Assuming insurer" means the insurer that acquires an insurance obligation or risk, or both, from the transferring insurer pursuant to an assumption reinsurance agreement.

B. "Assumption reinsurance agreement" means any contract that both:

Drafting Note: See notes after Section 2A for suggested additional language.

(1) Transfers insurance obligations or risks, or both, of existing or in-force contracts of insurance from a transferring insurer to an assuming insurer; and

(2) Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks, or both, under the contracts are extinguished.

C. "Contract of insurance" means any written agreement between an insurer and policyholder pursuant to which the insurer, in exchange for premium or other consideration, agrees to assume an obligation or risk, or both, of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries; it shall include all property, casualty, life, health, accident, surety, title and annuity business authorized to be written pursuant to the insurance laws of this state.

Drafting Note: Individual states may cite specific sections of their insurance laws regarding lines, classes or types of insurance to which this Act is applicable. If a state has a statutory definition of contract of insurance which is inconsistent with this definition, the state may want to consider using the statutory definition.

D. "Home service business" means insurance business on which premiums are collected on a weekly or monthly basis by an agent of the insurer.

E. "Notice of transfer" means the written notice to policyholders required by Section 4A.

F. "Policyholder" means any individual or entity which has the right to terminate or otherwise alter the terms of a contract of insurance. It includes any certificateholder whose certificate is in force on the proposed effective date of the assumption, if the certificateholder has the right to keep the certificate in force without change in benefit following termination of the group policy.

The right to keep the certificate in force referred to in this section shall not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act, ("COBRA") Section 601, *et seq*., of the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1161 *et seq*.).

G. "Transferring insurer" means the insurer which transfers an insurance obligation or risk, or both, to an assuming insurer pursuant to an assumption reinsurance agreement.

Section 4. Notice Requirements

A. Notice to Policyholders, Agents and Brokers

(1) The transferring insurer shall provide or cause to be provided to each policyholder a notice of transfer by first-class mail, addressed to the policyholder's last known address or to the address to which premium notices or other policy documents are sent or, with respect to home service business, by personal delivery with acknowledged receipt. A notice of transfer shall also be sent to the transferring insurer's agents or brokers of record on the affected policies.

(2) The notice of transfer shall state or provide:

(a) The date the transfer and novation of the policyholder's contract of insurance is proposed to take place;

(b) The name, address and telephone number of the assuming and transferring insurer;

(c) That the policyholder has the right to either consent to or reject the transfer and novation;

(d) The procedures and time limit for consenting to or rejecting the transfer and novation;

(e) A summary of any effect that consenting to or rejecting the transfer and novation will have on the policyholder's rights;

(f) A statement that the assuming insurer is licensed to write the type of business being assumed in the state where the policyholder resides, or is otherwise authorized, as provided herein, to assume such business;

(g) The name and address of the person at the transferring insurer to whom the policyholder should send its written statement of acceptance or rejection of the transfer and novation; and

(h) The address and phone number of the insurance department where the policyholder resides so that the policyholder may write or call the insurance department for further information regarding the financial condition of the assuming insurer.

(i) The following financial data for both companies:

(i) Ratings for the last five (5) years if available or for such lesser period as is available from two (2) nationally recognized insurance rating services acceptable to the commissioner including the rating service's explanation of the meaning of the ratings. If ratings are unavailable for any year of the five-year period, this shall also be disclosed;

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

(ii) A balance sheet as of December 31 for the previous three (3) years if available or for such lesser period as is available and as of the date of the most recent quarterly statement;

(iii) A copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(iv) An explanation of the reason for the transfer.

(3) Notice in a form identical or substantially similar to Appendix A attached shall be deemed to comply with the requirements of Section 4A(2).

(4) The notice of transfer shall include a pre-addressed, postage-paid response card which a policyholder may return as its written statement of acceptance or rejection of the transfer and novation.

(5) The notice of transfer shall be filed as part of the prior approval requirement set forth in Section 4B(1).

B. Notification and Prior Approval Requirements

(1) Prior approval by the commissioner is required for any transaction where an insurer domiciled in this state assumes or transfers obligations and/or risks on contracts of insurance under an assumption reinsurance agreement. No insurer licensed in this state shall transfer obligations and/or risks on contracts of insurance issued to or owned by residents of this state to any insurer that is not licensed in this state. An insurer domiciled in this state shall not assume obligations or risks, or both, on contracts of insurance issued to or owned by policyholders residing in any other state unless it is licensed in the other state, or the insurance regulatory official of that state has approved the assumption.

(2) Any licensed foreign insurer that enters into an assumption reinsurance agreement which transfers the obligations or risks, or both, on contracts of insurance issued to or owned by residents of this state, shall file or cause to be filed with the commissioner of insurance of this state the assumption certificate, a copy of the notice of transfer and an affidavit that the transaction is subject to substantially similar requirements in the state of domicile of both the transferring and assuming insurer. If no such requirements exist in the domicile of either the transferring or assuming insurers, then the requirements of Section 4B(3) shall apply.

Drafting Note: It is anticipated that the insurance department will review the filing in a manner consistent with the policy form review process applicable for the state which could include either prior approval or file and use.

(3) Any licensed foreign insurer that enters into an assumption reinsurance agreement which transfers the obligations or risks, or both, on contracts of insurance issued to or owned by residents of this state, shall obtain prior approval of the commissioner of insurance of this state and be subject to all other requirements of this Act with respect to residents of this state, unless the transferring and assuming insurers are subject to assumption reinsurance requirements adopted by statute or regulation in the jurisdiction of their domicile which are substantially similar to those contained herein.

(4) The following factors, along with such other factors as the commissioner deems appropriate under the circumstances, shall be considered by the commissioner in reviewing a request for approval:

(a) The financial condition of the transferring and assuming insurers and the effect the transaction will have on the financial condition of each company;

(b) The competence, experience and integrity of those persons who control the operation of the assuming insurer;

(c) The plans or proposals the assuming party has with respect to the administration of the policies subject to the proposed transfer;

(d) Whether the transfer is fair and reasonable to the policyholders of both companies; and

(e) Whether the notice of transfer to be provided by the insurer is fair, adequate and not misleading.

Section 5. Policyholder Rights

A. Policyholders shall have the right to reject the transfer and novation of their contracts of insurance. Policyholders electing to reject the assumption transaction shall return to the transferring insurer the pre-addressed, postage-paid response card or other written notice and indicate thereon that the assumption is rejected (collectively referred to as the "Response Card").

B. Payment of any premium to the assuming company during the twenty-four-month period after notice is received shall be deemed to indicate the policyholder's acceptance of the transfer to the assuming insurer and a novation shall be deemed to have been effected, provided that the premium notice clearly states that payment of the premium to the assuming insurer shall constitute acceptance of the transfer. However, the premium notice shall also provide a method for the policyholder to pay the premium while reserving the right to reject the transfer. With respect to any home service business or any other business not using premium notices, the disclosures and procedural requirements of this subsection are to be set forth in the Notice of Transfer required by Section 4 and in the assumption certificate.

C. After no fewer than twenty-four (24) months from the mailing of the initial notice of transfer required under section 4A, if positive consent to, or rejection of, the transfer and assumption has not been received or consent has not been deemed to have occurred under Subsection B of this section, the transferring company shall send to the policyholder a second and final notice of transfer as specified in Section 4A. If the policyholder does not accept or reject the transfer during the one month period immediately following the date on which the transferring insurer mails the second and final notice of transfer, the policyholder's consent will be deemed to have occurred and novation of the contract will be effected. With respect to the home service business, or any other business not using premium notices, the twenty-four and one month periods shall be measured from the date of delivery of the Notice of Transfer pursuant to Section 4A(1).

D. The transferring insurer will be deemed to have received the Response Card on the date it is postmarked. A policyholder may also send its Response Card by facsimile or other electronic transmission or by registered mail, express delivery or courier service, in which case the Response Card shall be deemed to have been received by the assuming insurer on the date of actual receipt by the transferring insurer.

Section 6. Effect of Consent

If a policyholder consents to the transfer pursuant to Section 5 or if the transfer is effected under Section 7, there shall be a novation of the contract of insurance subject to the assumption reinsurance agreement with the result that the transferring insurer shall thereby be relieved of all insurance obligations or risks, or both, transferred under the assumption reinsurance agreement and the assuming insurer shall become directly and solely liable to the policyholder for those insurance obligations or risks, or both.

Section 7. Commissioner's Discretion

If an insurer domiciled in this state or in a jurisdiction having a substantially similar law is deemed by the domiciliary commissioner to be in hazardous financial condition or an administrative proceeding has been instituted against it for the purpose of reorganizing or conserving the insurer, and the transfer of the contracts of insurance is in the best interest of the policyholders, as determined by the domiciliary commissioner, a transfer and novation may be effected notwithstanding the provisions of this Act. This may include a form of implied consent and adequate notification to the policyholder of the circumstances requiring the transfer as approved by the commissioner.

Drafting Note: States must amend their guaranty association law to specify that residents whose policies are transferred to an unlicensed insurer pursuant to this section are entitled to continued guaranty association protection.

Section 8. Effective Date

This Act shall take effect six (6) months after the date it is enacted and shall apply to all assumption reinsurance agreements entered into on or after that effective date.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. 3rd Quarter 7, 29, 650, 670-674 (adopted).
1999 Proc. 1st Quarter 8, 9, 755, 757-758 (amended).

Appendix A

NOTICE OF TRANSFER

IMPORTANT: THIS NOTICE AFFECTS YOUR CONTRACT RIGHTS. PLEASE READ IT CAREFULLY.

Transfer of Policy

The [ABC Insurance Company] has agreed to replace us as your insurer under [insert policy/certificate name and number] effective [insert date]. The [ABC Insurance Company's] principal place of business is [insert address] and certain financial information concerning both companies is attached, including (1) ratings for the last five years, if available, or for such lesser period as is available from two nationally recognized insurance rating services; (2) balance sheets for the previous three years, if available, or for such lesser period as is available and as of the date of the most recent quarterly statement; (3) a copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and (4) an explanation of the reason for the transfer. You may obtain additional information concerning [ABC Insurance Company] from reference materials in your local library or by contacting your Insurance Commissioner at [insert address and phone number].

The [ABC Insurance Company] is licensed to write this coverage in your state. The Commissioner of Insurance in your state has reviewed the potential effect of the proposed transaction, and has approved the transaction.

Your Rights

You may choose to consent to or reject the transfer of your policy to [ABC Insurance Company]. If you want your policy transferred, you may notify us in writing by signing and returning the enclosed pre-addressed, postage-paid card or by writing to us at:

[Insert name, address and facsimile number of contact person.]

Payment of your premium to the assuming company will also constitute acceptance of the transaction. However, a method will be provided to allow you to pay the premium while reserving the right to reject the transfer.

If you reject the transfer, you may keep your policy with us or exercise any option under your policy. If we do not receive a written rejection you will, as a matter of law, have consented to the transfer. However, before this consent is final you will be provided a second notice of the transfer twenty-four months from now. After the second notice is provided, you will have one month to reply. If you have paid your premium to the [ABC Insurance Company], without reserving your right to reject the transfer, you will not receive a second notice.

Drafting Note: The second and final notice to the policyholders should include a date by which the policyholder should respond. The date should be one month after the date on which the notice was mailed to the policyholder.

Effect of Transfer

If you accept this transfer, [ABC Insurance Company] will be your insurer. It will have direct responsibility to you for the payment of all claims, benefits and for all other policy obligations. We will no longer have any obligations to you.

If you accept this transfer, you should make all premium payments and claims submissions to [ABC Insurance Company] and direct all questions to [ABC Insurance Company].

If you have any further questions about this agreement, you may contact [XYZ Insurance] or [ABC Insurance].

Sincerely,

_____

[XYZ Insurance Company
111 No Street
Smithville, USA
555/555-5555]

[ABC Insurance Company
222 No Street
Jonesville, USA
333/333-3333]

For your convenience, we have enclosed a pre-addressed postage-paid response card. Please take time now to read the enclosed notice and complete and return the response card to us.

[Notice Date]

RESPONSE CARD

____ Yes, I accept the transfer of my policy from [name of transferring company] to [name of assuming company].

____ No, I reject the proposed transfer of my policy from [name of transferring company] to [name of assuming company] and wish to retain my policy with [name of transferring company].

_____ _____
Date Signature

Name:_____

Street Address:_____

City, State, Zip: _____

ASSUMPTION REINSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ASSUMPTION REINSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.12.025 (2004).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-736 (1997).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	3 COLO. CODE REGS. § 702-3:3-3-1 (1990/2012).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	GA. CODE ANN. §§ 33-52-1 to 33-52-6 (1992).		GA. COMP. R. & REGS. 120-2-62 (1995).
Guam	NO CURRENT ACTIVITY		

ASSUMPTION REINSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE § 515.68A (1997).
Kansas	KAN. STAT. ANN. §§ 40-5201 to 40-5210 (2004).		BULLETIN 1993-21 (1993).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 761 to 766 (1994).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. REV. STAT. §§ 375.1280 to 375.1295 (1993).		
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. REV. STAT. §§ 44-6201 to 44-6211 (1993); BULLETIN CB-85 (1993) (appendix of model).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		

ASSUMPTION REINSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico	NO CURRENT ACTIVITY		
New York			GEN. COUNS. OPIN. 7-21-2008 (#2) (2008).
North Carolina	N.C. GEN. STAT. §§ 58-10-20 to 58-10-45 (1996).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	OR. REV. STAT. §§ 742.150 to 742.162 (1995); OR. ADMIN. R. 836-050-0000 to 836-050-0020 (1996/2006).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-53.1 to 27-53.1-8 (1996).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	VT. STAT. ANN. tit. 8, §§ 8201 to 8208 (1994).		
Virgin Islands	NO CURRENT ACTIVITY		

ASSUMPTION REINSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	NO CURRENT ACTIVITY		
Washington			WASH. ADMIN. CODE 284-95-010 to 284-95-080 (1991).
West Virginia			W. VA. CODE § 33-4-15 (1957/2005).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

Table of Contents

Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

B Sections 3 through 8 shall not apply to contingent deferred annuities.

C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than $20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection B;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in Subsection B;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection B; and

Drafting Note: The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken.

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(1) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);

(2) Reduced by 125 basis points;

(3) Where the resulting interest rate is not less than 15 basis points (0.15%); and

(4) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

C. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

D. The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1977 Proc. I 26, 28, 317, 479, 484-487 (adopted).
1977 Proc. II 555-557 (corrected).
2003 Proc. 1st Quarter15-17, 113-114, 965, 970-973 (amended and reprinted).
2017 3rd Quarter (amended).
Fall 2020 (amended).

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama		ALA. CODE §§ 27-15-28.1 to 27-15-28.2 (1981/2004).	
Alaska		ALASKA STAT. § 21.45.305 (1966/2006).	
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. § 20-1232 (1977/2007).	
Arkansas		ARK. CODE ANN. §§ 23-81-301 to 23-81-313 (1981/2005).	
California		CAL. INS. CODE §§ 10168 to 10168.10 (1979/2018).	
Colorado		COLO. REV. STAT. §§ 10-7-501 to 10-7-511 (1977/2004).	
Connecticut		CONN. GEN. STAT. § 38a-440 (1978/2018).	
Delaware		DEL. CODE ANN. tit. 18, § 2929A (1980/2004).	
District of Columbia		D.C. MUN. REGS. tit. 26, § 5100 (2004).	D.C. CODE § 31-4705.03 (1978/2003).

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia		GA. CODE ANN. § 33-28-3 (1979/2019).	
Guam	NO CURRENT ACTIVITY		
Hawaii		HAW. REV. STAT. § 431:10D-107 (1988/2004).	
Idaho		IDAHO CODE ANN. § 41-1927A (1977/2004).	
Illinois		215 ILL. COMP. STAT. 5/229.4(a) (2004/2006).	
Indiana		IND. CODE §§ 27-1-12.5-1 to 27-1-12.5-11 (1977/2011).	
Iowa		IOWA CODE § 508.38 (1979/2016).	
Kansas		KAN. STAT. ANN. §§ 40-4,101 to 40-4,113 (1978/2004).	
Kentucky		KY. REV. STAT. § 304.15-315 (1978/2010).	
Louisiana		LA. REV. STAT. ANN. § 22:952 (1979/2012).	
Maine		ME. REV. STAT. ANN. tit. 24-A §§ 2541 to 2551 (1979/2018).	
Maryland		MD. ANN. CODE INS. §§ 16-501 to 16-510 (1980/2006).	
Massachusetts			
Michigan		MASS. GEN. LAWS ch. 175, § 144A 1/2 (2004).	
Minnesota		MICH. COMP. LAWS § 500.4072 (1980/2003).	
Mississippi	NO CURRENT ACTIVITY	MINN. STAT. § 61A.245 (1978/2011).	

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri		MO. REV. STAT. §§ 376.669 to 376.671 (1979/2015).	
Montana		MONT. CODE ANN. §§ 33-20-501 to 33-20-513 (1979/2005).	
Nebraska		NEB. REV. STAT. §§ 44-407.10 to 44-407.23 (1979/2014).	
Nevada		NEV. ADMIN. CODE §§ 688A.200 to 688A.210 (2003).	NEV. REV. STAT. §§ 688A.361 to 688A.369 (1977/2011) (authority to adopt indexed rate by regulation); BULLETIN 2011-007 (2011).
New Hampshire		N.H. REV. STAT. ANN. §§ 409-A:1 to 409A:10 (1979/2004).	
New Jersey		N.J. REV. STAT. §§ 17B:25-20 to 17B:25-33 (1981/2006).	BULLETIN 2002-10 (2002); BULLETIN 2003-22.
New Mexico			N.M. STAT. ANN. § 59A-20-33 (1985/2019).
New York		N.Y. INS. LAW § 4223 (1984/2008).	N. Y. ADMIN. CODE tit. 11 §§ 44.0 to 44.12 (Regulation 127) (1986/2013).
North Carolina		N.C. GEN. STAT. § 58-58-61 (2003); BULLETIN 2003-B-4 (1979/2003).	
North Dakota		N.D. CENT. CODE §§ 26.1-34-01 to 26.1-34-11 (1985/2003).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO REV. CODE ANN. § 3915.073 (1983/2004).	
Oklahoma		OKLA. STAT. tit. 36 §§ 4030.2 to 4030.13 (2000/2014).	
Oregon		OR. REV. STAT. §§ 743.275 to 743.298 (1977/2016).	

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania			40 PA. CONS. STAT. § 510b (1980/2004).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island		R.I. GEN. LAWS §§ 27-4.4-1 to 27-4.4-12 (1994/2008).	
South Carolina			S.C. CODE ANN. §§ 38-69-210 to 38-69-330 (1988/2005).
South Dakota		S. D. CODIFIED LAWS ANN. §§ 58-15-83 to 58-15-93 (2004/2006).	
Tennessee		TENN. CODE ANN. §§ 56-36-101 to 56-36-113 (1978/2016).	
Texas		TEX. CODE ANN. INS. §§ 1107.001 to 1107.108 (1977/2015).	
Utah		UTAH CODE ANN § 31A-22-409 (1986/2008).	
Vermont		VT. STAT. ANN. tit. 8, § 3750 (1981/2003).	
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 970 to 975 (1968).
Virginia		VA. CODE § 38.2-3220 to 38.2-3229 (1986/2004).	
Washington		WASH. REV. CODE ANN. §§ 48.23.410 to 48.23.520 (1982/20017.)	
West Virginia		W. VA. CODE § 33-13-30A (1977/2004).	
Wisconsin		WIS. STAT. § 632.435 (1977/2004).	
Wyoming		WYO. STAT. §§ 26-16-401 to 26-16-411 (1981/2006).	

PROJECT HISTORY - 2020

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES (#805)

1. Description of the Project, Issues Addressed, etc.

In late 2012, the Life Insurance and Annuities (A) Committee charged the Contingent Deferred Annuity (A) Working Group with evaluating the adequacy of existing laws and regulations as applied to contingent deferred annuities (CDAs) and whether additional solvency and consumer protection standards are required. The Working Group submitted its report, findings and recommendations to the Committee at the 2013 Spring National Meeting. Among its findings, the Working Group found that: 1) CDAs do not easily fit into the category of fixed or variable annuity; 2) review of solvency and consumer protection standards are necessary; and 3) tools to assist states in reviewing CDA product filings and solvency oversight of CDAs should be established. The Working Group also identified issues that would be more appropriately addressed by other existing NAIC groups with the specific subject-matter expertise.

At the 2013 Fall National Meeting, the Life Insurance and Annuities (A) Committee gave the Life Actuarial (A) Task Force a charge to recommend a manner to specifically exempt CDAs from the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805). The Executive (EX) Committee approved the Request for NAIC Model Law Development to Model #805 at the 2016 Summer National Meeting.

At the 2016 Fall National Meeting, the Life Insurance and Annuities (A) Committee adopted amendments to Model #805 recommended by the Life Actuarial (A) Task Force to exempt CDAs from certain sections of Model #805, with which, due to their structure, they cannot comply. The revisions to Model #805 exempt CDAs from the sections of the Model #805 that prescribe computational methods and minimum nonforfeiture values for deferred annuities, but would allow the insurance commissioner to specify separate nonforfeiture standards, if needed, at a later time.

In November 2020, the Life Insurance and Annuities (A) Committee adopted an amendment to Model #805 recommended by the Life Actuarial (A) Task Force to reduce the nonforfeiture interest rate floor from 1% to 15 basis points (bps) (0.15%) in response to the historic low interest rate environment.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Life Actuarial (A) Task Force. The following states participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Tynesia Dorsey, Vice Chair, represented by Peter Weber (OH); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Russell Toal (NM); Linda A. Lacewell represented by Bill Carmello and Mona Bhalla (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

3. Project Authorized by What Charge and Date First Given to the Group.

The Life Actuarial (A) Task Force charges require the group to provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues. The recommendation to reduce the minimum nonforfeiture interest rate floor was provide in response to the low interest rates for five-year constant maturity treasuries, which was as low as 25 bps during the period of Task Force deliberations. The Executive (EX) Committee approved the Request for NAIC Model Law Development to Model #805 at the 2020 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Life Actuarial (A) Task Force, chaired by Mr. Boerner, drafted the change to Model #805.

The following interested parties participated: American Council of Life Insurers (ACLI); American Academy of Actuaries (Academy); Allianz Life Insurance Company of North America (Allianz); and the Interstate Insurance Product Regulation Commission (Compact).

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

The Task Force began working on the charge during open meetings beginning in the summer of 2020. The initial Request for NAIC Model Law Development submitted to the Life Insurance and Annuities (A) Committee recommended reduction of the minimum nonforfeiture interest rate floor from 1% to 0%. When approving the request, the Committee asked the Task Force to consider rates between 0% and 50 bps, inclusive. At the Summer National Meeting, the Task Force voted to expose a revision to the model for public comment. The revision asked stakeholders to provide comments on potential rates of 0.15%, 0.25%, 0.35% and 0.50%, in addition to the originally proposed 0% with approved the request The Task Force held public discussions on the potential revision on Oct. 8, Oct. 1 and Sept. 24. The Task Force adopted the proposed revision, which recommended reducing the Model #805 minimum nonforfeiture interest rate to 15 bps, on Oct. 8. The Life Insurance and Annuities (A) Committee adopted the revisions to the model on Nov. 10.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

The revision is intended to provide companies relief from a minimum nonforfeiture interest rate floor that was considered unsupportable in the environment of historically low interest rates. The feedback received from commenters was that retaining with the 1% minimum nonforfeiture interest rate floor would likely result in the limited availability of indexed annuity products or possibly an exodus of companies from the indexed annuity market. The Task Force members, with the exception of Missouri, New York and Oklahoma, agreed that a significant reduction in the minimum nonforfeiture interest rate floor was warranted.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2017

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES (#805)

1. Description of the Project, Issues Addressed, etc.

In late 2012, the Life Insurance and Annuities (A) Committee charged the Contingent Deferred Annuity (A) Working Group with evaluating the adequacy of existing laws and regulations as applied to contingent deferred annuities (CDAs) and whether additional solvency and consumer protection standards are required. The Working Group submitted its report, findings and recommendations to the Committee at the 2013 Spring National Meeting. Among its findings, the Working Group found that: 1) CDAs do not easily fit into the category of fixed or variable annuity; 2) review of solvency and consumer protection standards are necessary; and 3) tools to assist states in reviewing CDA product filings and solvency oversight of CDAs should be established. The Working Group also identified issues that would be more appropriately addressed by other existing NAIC groups with the specific subject-matter expertise.

During the 2013 Fall National Meeting, the Life Insurance and Annuities (A) Committee gave the Life Actuarial (A) Task Force a charge to recommend a manner to specifically exempt CDAs from the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805). The Executive (EX) Committee approved the request for model law development to Model #805 at the 2016 Summer National Meeting.

At the 2016 Fall National Meeting, the Life Insurance and Annuities (A) Committee adopted amendments to Model #805 recommended by the Life Actuarial (A) Task Force to exempt CDAs from certain sections of Model #805, with which, due to their structure, they cannot comply. The revisions to Model #805 exempt CDAs from the sections of the Model #805 that prescribe computational methods and minimum nonforfeiture values for deferred annuities, but would allow the insurance commissioner to specify separate nonforfeiture standards, if needed, at a later time.

2. Name of Group Responsible for Drafting the Model and States Participating.

Contingent Deferred Annuity (A) Working Group of the Life Actuarial (A) Task Force. The following states participated: Tomasz Serbinowski (UT), Chair; Perry Kupferman (CA); Bob Chester (CT); Nicole Boyd (KS); Felix Schirripa (NJ); Mike Boerner, Jan Graeber and Phil Reyna (TX); and Craig Chupp and Ern Johnson (VA).

3. Project Authorized by What Charge and Date First Given to the Group.

The charge was given to the Life Actuarial (A) Task Force at the 2013 Fall National Meeting to recommend a manner to specifically exempt CDAs from Model 805. The Task Force appointed the Contingent Deferred Annuity (A) Working Group to complete the charge. The Executive (EX) Committee approved the request for model law development to Model #805 at the 2016 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Contingent Deferred Annuity (A) Working Group, chaired by Mr. Serbinowski, completed the charge to exclude CDAs from the scope of Model #805.

In addition to the Working Group members, the following interested state insurance regulators participated: Mike Yanacheak (IA); Rhonda Ahrens (NE); and Pete Weber (OH).

The following interested parties participated: American Council of Life Insurers (ACLI); Center for Economic Justice (CEJ); American Academy of Actuaries (Academy); and Lewis & Ellis Inc.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

The Working Group began working on the charge in open conference calls beginning in the spring of 2014. Draft recommendations were posted on the Working Group's web page, and comments were solicited. Draft revisions to Model #805 were adopted by the Life Insurance and Annuities (A) Committee at the 2016 Fall National Meeting.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

The revisions sought to achieve two objectives: 1) exempt CDAs from the current nonforfeiture requirements; and 2) preserve state insurance commissioners' authority to prescribe CDA-specific nonforfeiture requirements in the future.

The Life Actuarial (A) Task Force received multiple comments to the effect that the revisions to Model #805 would likely result in a non-uniform treatment of CDAs across the country, with individual states establishing different nonforfeiture standards for CDAs. The Task Force noted that many NAIC model laws grant state insurance commissioners' rulemaking authority and that this has never been viewed as contrary to the NAIC's stated mission of encouraging uniformity.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2003

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES (#805)

1. What issues was the project intended to address?

At the Executive Committee and Plenary Meeting in San Antonio, Texas, on February 8, 2002, the issue of the appropriate interest rate to incorporate into Section 4 of the Model was discussed. The following excerpt from the minutes summarizes that discussion:

> Commissioner Koken, vice chair of the Life Insurance and Annuities (A) Committee, stated that the A Committee has been reviewing the issue of the minimum nonforfeiture rate on annuities. It is currently 3%, which in the current economic climate means that companies may have to take some products off the market because they can't invest at that rate, or there will be real solvency concerns. The recommendation from the A Committee is to support the industry in their efforts to go to the legislatures and ask for a reduction in the nonforfeiture rate to 1.5% and to give a charge to the Life and Health Actuarial Task Force to develop a long-term solution to this issue. The group believes that ultimately an indexed rate is the best response so that as the economy changes it will not be necessary to go back to the legislatures.

The minutes of that meeting further show that the following motion was adopted: "Recommend that the states support a 1.5% nonforfeiture with a sunset of July 1, 2004 and a charge to develop an indexed rate." In a subsequent discussion of the Task Force, the project was defined to include the following general scope (as captured in the Life and Health Actuarial Task Force minutes from March 14-15, 2002):

> William Schreiner (ACLI) reported that the ACLI has a committee studying this matter, and that committee is looking for the Task Force's input on areas to study. He said "it is fair that you will want to look at more than just the interest rate." A lengthy, wide-ranging discussion ensued on how to proceed. Mr. Hartnedy summarized the discussion by saying that three potential areas of inquiry had been identified: 1) "You've got to carefully consider in the change of any minimum guarantees the surrender charge;" 2) "We're very interested in a dynamic or, if you will, index rate"; and 3) "We want pros and cons as to impact on people in different circumstances by doing this." Mr. Gorski suggested "maybe there is a need to think about disclosure at the same time." Mr. Schreiner added that "all the elements of the (nonforfeiture) 'formula' will be in play."

2. What states participated in drafting the model?

The following states are currently members of the Task Force: New Mexico (Chair), Arkansas (Vice-Chair), California, Connecticut, Florida, Illinois, Minnesota, Nebraska, New York, Oklahoma, Pennsylvania, Texas, Utah, and Vermont.

3. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?

The efforts of the Task Force were closely coordinated with all industry interested parties. In addition to open sessions at the quarterly meetings of the NAIC, seven conference calls were held over the last year to discuss the various submissions and drafts of the Model. Notice of those conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 200 regulators and interested parties, including representatives of the American Council of Life Insurers, the National Alliance of Life Companies, the National Fraternal Congress of America, and the American Academy of Actuaries (AAA).

4. What significant issues were raised during the drafting process, and how were those issues resolved?

Given this complexity of this topic and the myriad of opinions, it is impossible to put together a brief description which captures a) all of the issues raised and b) all of the detail underlying those issues. Any summary will of necessity be a broad overview and will omit numerous particulars of the project. However, I believe that the items below represent the major points of discussion:

A) Is there really a need to change the Model?

Many regulators expressed doubts regarding whether there was a need to change the Model. This excerpt from Frank Dino's (Florida Department of Financial Services) summary of the October 10, 2002, conference call of the Task Force summarized the basic nature of those concerns:

> Some of the previously expressed doubts regarding whether a problem actually exists in the current nonforfeiture law were repeated. It was noted that the current law allows initial expense loads of 35% and 10% for flexible premium and single premium products, respectively. Even ignoring annual expense charges, it would take fifteen years and four years, respectively, for the minimum values to match the original deposit, assuming the minimum 3% were credited each year. It was also noted almost all states interpret the existing law as imposing a cumulative standard, rather than requiring that a minimum interest credit of 3% be applied each year. This gives companies the ability to credit less than 3% some years (provided they can still meet the cumulative requirement).

Ultimately, a consensus emerged on the Task Force that changes to the Model should be made. The distinct expense loads for flexible premium and single premium products were eliminated, and replaced by a single standard of 12.5%. In its first draft Model submitted on August 22, 2002, the ACLI suggested 15%. However, subsequent discussions resulted in the compromise figure of halfway between the existing 10% standard for single premium annuities and the ACLI's proposed 15%.

B) What should be the basis of the index used in establishing the minimum nonforfeiture interest rate?

Early on in this project, it became clear that there is no economic or actuarial theory that makes any one index the obvious choice over another. The following suggestions were among the many received:

In correspondence received on May 24, 2002, the ACLI suggested the following:

> Proposal: five-year constant maturity treasuries (CMT) is proposed as the basis of required minimum interest rate credits.
>
> Rationale: the use of a CMT basis has the virtue of expected continuous availability, while the choice of a five-year basis lies between short and longer-term maturities.

The ACLI provided this commentary with the submission of their initial proposal for actual draft language on August 22, 2002: "The interest rate proposed is the Five-Year Constant Maturity Treasury rate (CMT) as of June 30 of the preceding calendar year minus two and one-half percent (2.5%), but not greater than four percent (4%) nor less than one percent (1%)."

In a submission dated November 13, 2002, the ACLI modified its proposal as follows: "Index Basis: 3 Year Constant Maturity Treasury (monthly) rate – minus 150 basis points, but not less than 1%."

In a submission dated January 22, 2003, the ACLI made the following recommendation: "Therefore, we urge that the index basis in the proposed model Individual Deferred Annuity Nonforfeiture Law be changed to the three-year CMT reduced by 125 bps."

In a submission labeled "Preliminary Draft" dated September 10, 2002, the AAA stated that "an index rate for the annuity non-forfeiture value can be based on either the Treasury Curve, The Swap Curve (or) somewhere on any myriad of credit curves." The submission includes a description of how LIBOR swap rates might be used:

> Under this approach we define the Non-Forfeiture Interest Rate (NIR) as equal to the Applicable Swap Rate less X. The Applicable Swap Rate is the monthly average swap rate for a swap whose term is equal to the term of the guarantee period for the premium/renewal (rounded up to the next whole year) during the month the premium is received or the renewal rate is set.

Many other comments were provided relative to the appropriate choice of an index, as well as a) what reductions to the index should be made to recognize company expenses and b) maximum and minimum limits on the interest rates.

In a reaching a decision, the Life and Health Actuarial Task Force concluded that the Five-Year CMT less 125 basis points provides a reasonable balance between 1) giving companies relief in times of low interest rates and 2) providing an appropriate minimum guarantee for the consumer. Also, a consensus seemed to emerge on the Task Force in agreement with the position expressed in the January 22, 2003, submission from the ACLI: "The primary goal of the law's revision is to provide a means to permit lower interest rate guarantees than the current law allows in low interest rate environments." Accordingly, a cap equal to the existing 3% interest rate was established. However, in order to provide some minimum level of guarantee to the consumer, a floor of 1% was also established. Finally, flexibility was provided to the companies by allowing for the redetermination of the minimum interest guarantees on a periodic basis.

C) Should a lower minimum nonforfeiture interest rate be allowed for equity-indexed annuities?

This matter was not raised in a substantive way by any of the interested parties until the Task Force meeting in December 2002. Subsequently, a report was received from the AAA (dated January 27, 2003) that recommended the following: "The Academy of Actuaries recommends that an offset for Equity Indexed Annuities be allowed. The Academy strongly believes there is a need for an offset as long as the product provides a meaningful equity participation guarantee."

The Task Force agreed with this recommendation, and inserted the following language into the Model:

> During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.
>
> The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Several members of the Task Force expressed a desire that a model regulation be developed to assist the states in implementing this provision.

5. What are the implications of this project for accreditation and codification?

Since this project does not deal with solvency monitoring, there is no impact for accreditation and codification.

ANNUITY NONFORFEITURE MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to Sections [insert applicable references to Section 12 of the Standard Nonforfeiture Law for Individual Deferred Annuities] of the [insert jurisdiction] Insurance Laws.

Section 2. Purpose

The purpose of this regulation is to adopt rules to implement the provisions of [insert applicable references to Section 4 of the Standard Nonforfeiture Law for Individual Deferred Annuities].

Section 3. Definitions

A. "Basis" carries two meanings.

(1) When used in the context of an initial or redetermination method, "basis" means the specified period over which an average is computed that produces the value of the five-year Constant Maturity Treasury (CMT) rate. The "specified period" could be as short as a single day. The same basis shall apply to all equity-indexed benefits and the non equity-indexed benefit, if any.

(a) The basis may also use a specified period that is determined by the level of change in the CMT rate, or any other date dependent methodology adopted by the NAIC and approved by the commissioner. A specifically excluded method is one that defines the nonforfeiture rate as the lowest rate in a specified time period. A method based upon changes in CMT levels must move up or down in an identical manner with changes in interest rates, subject to statutory minimums and maximums.

(b) If the basis uses a specified period determined by the level of change in the CMT rate:

(i) The nonforfeiture rate applicable at the time this subsection is first utilized for a contract form shall be determined by a method using a specified period or another approved date dependent methodology.

(ii) A symmetrical range shall be defined that will determine when the rate shall be updated. The maximum allowable range shall be plus or minus fifty (50) basis points.

(iii) At the beginning of each modal period (e.g., monthly, quarterly, etc), a potential nonforfeiture rate shall be calculated using the method in (i), without incorporating any caps or floors. The "modal period" is the period the company specifies during which the current nonforfeiture rate will remain fixed.

(iv) If the difference between the potential nonforfeiture rate and the current initial nonforfeiture rate is less than or equal to the range, the current nonforfeiture rate shall not be updated.

(v) If the difference between the potential nonforfeiture rate and the current nonforfeiture rate is more than the range, the current nonforfeiture rate shall be updated to be equal to the potential nonforfeiture rate adjusted for rounding and any caps or floors.

(vi) See the attached examples in Appendix A.

(2) When used in the context of equity-indexed benefits, "basis" means the point in time used for establishing the parameters incorporated into the calculation of the value of the equity-indexed options. These parameters include the risk free rate, dividend yield, index volatility, prior index values if the option is path dependent, and any other relevant parameters.

B. "Equity-indexed benefits" means a benefit in an annuity contract in which the value of the benefit is determined using an interest crediting rate based on the performance on an equity-based index and contract parameters. Excluded from this definition are variable benefits of separate account variable annuities and indexed guaranteed separate account contracts purchased by institutional buyers.

C. "Index term" means each period of time until the next indexed interest crediting date.

D. "Initial method" means the basis upon which the initial nonforfeiture rate is established and the period for which it applies. The period may last for the entire duration of the contract.

E. "Initial nonforfeiture rate" means the nonforfeiture rate applicable at contract issue.

F. "Minimum nonforfeiture amount" means the minimum value required under the [insert applicable references to Section 4B of the Standard Nonforfeiture Law for Individual Deferred Annuities] of the [insert jurisdiction] Insurance Laws. It reflects net considerations, the nonforfeiture rate, and other items as specified in [insert applicable references to Section 4A of the Standard Nonforfeiture Law for Individual Deferred Annuities] of the [insert jurisdiction] Insurance Laws.

G. "Nonforfeiture rate" means the interest rate used in determining the minimum nonforfeiture amount. This will be determined at issue (initial nonforfeiture rate) and, if applicable, each subsequent redetermination period (redetermination nonforfeiture rate).

H. "Redetermination method" means the redetermination date, basis and period for all future redetermination nonforfeiture rates.

I. "Redetermination nonforfeiture rate" means the nonforfeiture rate applicable at redetermination.

Section 4. Initial Method

A. The initial method shall be filed with the commissioner in accordance with jurisdictional filing and approval requirements.

B. Changes to the initial method are allowed once per calendar year. Any changes to the initial method shall be filed with the commissioner in accordance with jurisdictional filing and approval requirements. A change in initial method would be applicable only to new contracts (or new certificates) issued subsequent to the effective date of the change in method.

Drafting Note: States may consider adopting a deemer provision such that the change in initial method could be deemed approved after an appropriate waiting period, such as 30 or 60 days.

C. The initial method is not required to be disclosed in the contract form.

D. The initial nonforfeiture rate is not required to be disclosed in the contract form, unless redetermination is used.

E. The minimum nonforfeiture parameters (e.g., load, interest rate, expenses) need not be disclosed in the contract unless they are utilized in the calculation of the guaranteed minimum value of the contract as required under [insert applicable reference to section 3A(3) of the Standard Nonforfeiture Law for Individual Deferred Annuities].

Section 5. Redetermination Method

A. If redetermination is used, the method shall be disclosed in the contract form (or certificate).

B. Changes in the redetermination method for future issues (or certificates) are allowed at any time subject to jurisdictional filing and approval requirements.

Section 6. Nonforfeiture Rate and Minimum Nonforfeiture Amount

A. At any point in time, an annuity contract (or certificate) without an equity-indexed benefit will have one nonforfeiture rate and one nonforfeiture amount applicable to the entire contract that is determined in compliance with [insert applicable reference to Section 4B of the Standard Nonforfeiture Law for Individual Deferred Annuities].

B. For an annuity contract (or certificate) in which equity-indexed benefits are available the annuity contract (or certificate) may have more than one nonforfeiture rate applicable to the contract (or certificate) subject to the following:

(1) If the contract has a non equity-indexed benefit, the nonforfeiture interest rate applicable to the non equity-indexed benefit shall be determined in compliance with [insert applicable reference to Section 4B of the Standard Nonforfeiture Law for Individual Deferred Annuities].

(2) If an additional reduction is elected for equity-indexed benefits, reduced nonforfeiture interest rates may apply to each equity-indexed benefit for which the additional reduction is elected in compliance with [insert applicable reference to Section 4C of the Standard Nonforfeiture Law for Individual Deferred Annuities] and Section 7 of this regulation.

(3) The minimum nonforfeiture amount for the contract is determined by calculating a nonforfeiture amount, without any reduction for indebtedness to the company on the contract including interest due and accrued on the indebtedness, for each equity-indexed and non equity-indexed benefit using the nonforfeiture interest rates described in this subsection, summing the results, and then deducting any indebtedness to the company on the contract including interest due and accrued on the indebtedness.

(4) When contract value is transferred (see examples in Appendix B)

(a) From a benefit, the benefit's minimum nonforfeiture amount is reduced by the benefit's minimum nonforfeiture amount prior to the transfer multiplied by the proportion of the benefit's contract value that is transferred;

(b) To a benefit, the benefit's minimum nonforfeiture amount is increased by the sum of all reductions in minimum nonforfeiture amounts determined under Subparagraph (a) multiplied by the proportion of total contract value that is transferred to that benefit;

(c) For purposes of the calculations specified in Subparagraphs (a) and (b) above, the contract value must first be reduced by any fees associated with the transfer.

(5) In the case of a withdrawal from a benefit in which the amount of withdrawal exceeds the benefit's nonforfeiture amount, the insurer shall treat the excess withdrawal in a manner at least as favorable to the contractholder as deducting the excess withdrawal from the nonforfeiture amounts of other benefits in order from lowest to highest nonforfeiture interest rate.

(6) Any contract charge or premium taxes paid by the company must be allocated to a benefit's minimum nonforfeiture amount based on the percentage of that benefit's contract value to the total contract value.

Section 7. Equity-Indexed Benefits

A. If a company chooses to take the additional reduction for an equity-indexed benefit as provided under [insert applicable references to Section 4C of the Standard Nonforfeiture Law for Individual Deferred Annuities], the company shall prepare a demonstration showing compliance with the requirements in [insert applicable references to Section 4C of the Standard Nonforfeiture Law for Individual Deferred Annuities].

B. To demonstrate compliance, utilize the following steps:

(1) Calculate the annualized option cost for the equity-indexed benefit in the form of basis points for the entire Index Term as of the beginning of the Index Term.

(a) Use the equity-indexed benefit's guaranteed product features, such as the guaranteed participation rate, guaranteed caps, etc.

(b) For the option cost, use a basis representative of the point in time at the beginning of the current index term. The company cannot change this basis during the index term.

(c) Make no adjustments for persistency, death, utilization, etc.

(d) The method and parameters for the option cost shall be calibrated to capital markets based option pricing.

(2) If the annualized option cost for the equity-indexed benefit is twenty-five (25) basis points or more, then the equity-indexed benefit provides substantive participation under [insert applicable references to Section 4C of the Standard Nonforfeiture Law for Individual Deferred Annuities] and the company may take a reduction equal to the lesser of 100 basis points and the annual cost basis value.

(3) The company shall prepare an actuarial certification (see Appendix C), signed by a member of the American Academy of Actuaries that the reduction complies with requirements [insert reference] at the time that the contract form is filed and submit it according to the requirements of the jurisdiction.

Drafting Note: This information shall be filed with the commissioner if a jurisdiction requires the submission of an actuarial memorandum demonstrating compliance with the jurisdiction's version of the Standard Nonforfeiture Law for Individual Deferred Annuities.

(4) The company shall also annually prepare an actuarial certification (see Appendix D) [insert reference], signed by a member of the American Academy of Actuaries with regard to ongoing compliance and submit it in conjunction with the filing of the annual statement.

Drafting Note: The company should maintain demonstrations and work papers to be submitted if requested.

C. If the commissioner determines that the additional reduction of up to 100 basis points for equity-indexed benefits has been inappropriately taken, the commissioner may require the recalculation of all values for all affected policyholders without all or part of such additional reduction.

Section 8. Effective Date

The effective date of this regulation is [insert date].

Appendix A

Illustrations of indexing methods dependent upon changes in CMT levels

Example 1: Method—For each calendar year, the rate is set based on the monthly average from November of the preceding year. Each month, a potential rate will be calculated based upon the previous month's CMT average. If the potential rate differs from the actual rate by more than 25 bps, the actual rate will be updated. This continues until the end of the calendar year, when the rate is automatically reset based upon the monthly average from November again.

Date	5 Year CMT Monthly Average	Potential NF rate	Actual NF Rate	Comments
Nov. 2003	3.0%	N/a	N/a	Monthly rate for Jan. 2004—1.75% (3.0%—125 bps)
Dec. 2003	3.0%	N/a	N/a	
Jan. 2004	3.1%	N/a	1.75%	Based on Nov. 2003
Feb. 2004	3.2%	1.85% (3.1%—125 bps)	1.75%	No change since difference between actual rate and potential rate is less than 25 bps
March 2004	3.3%	1.95%	1.75%	No change since difference is only 20 bps. Note that result of March CMT means April actual rate will change.
April 2004	3.3%	2.05%	2.05%	Potential rate (2.05%) differs from actual rate (1.75%) by more than 25 bps, so update actual rate.
May 2004	3.1%	2.05%	2.05%	
June 2004	3.1%	1.85%	2.05%	
July 2004	2.6%	1.85%	2.05%	5 year CMT dropped this month, so next month potential NF rate will drop. Since more than 25 bps change, actual NF rate changes.
Aug. 2004	2.6%	1.35%	1.35%	
Sept. 2004	2.6%	1.35%	1.35%	
Oct. 2004	2.6%	1.35%	1.35%	
Nov. 2004	2.7%	1.35%	1.35%	Monthly rate for Jan. 2005—1.45% (2.7%—125 bps)
Dec. 2004	3.0%	1.45%	1.35%	Less than 25 bps change
Jan. 2005	2.8%	N/a	1.45%	Based on Nov. 2004
Feb. 2005	2.8%	1.55%	1.45%	Less than 25 bps change
March 2005	2.8%	1.55%	1.45%	
April 2005	2.8%	1.55%	1.45%	
May 2005	3.25%	1.55%	1.45%	
June 2005	3.25%	2.0%	2.0%	Update rate since more than 25 bps change from potential rate to actual rate.
July 2005	3.25%	2.0%	2.0%	

Example 2: relatively level interest rate environment. Method—This example starts with an initial NF rate based on a single point in time. Once this initial rate is determined, it is in effect until the potential rate differs from the actual rate by more than 25 bps. This example does not automatically set each calendar year from a set month. For this example, the initial rate is set for the contract form based off a one month average with a one month lag for a contract form that will launch in January 2004. March potential rate is based off of January CMT rates, April potential rate is determined from February CMT rates and so on. So for issues in January 2004, the rate is based on November 2003 monthly average. For all issues after January 2004, the actual rate will change only if it differs from the potential rate by more than 25 bps. These examples will look at what happens in relatively level interest rate environment—keeping in mind that the NF rate MUST be updated so all 5 year CMT rates upon which the nonforfeiture rate is based occur within 15 months from contract issue date.

Date	5 Year CMT Monthly Average	Potential NF rate	Actual NF Rate	Comments
Nov. 2003	3.0%	N/a	N/a	Month for base rate—"sets a starting peg in the ground"
Dec. 2003	3.1%	N/a	N/a	One month lag
Jan. 2004	3.1%	1.75%	1.75%	Initial rate for block
Feb. 2004	**3.3%**	1.85%	1.75%	
March 2004	**3.5%**	1.85%	1.75%	
April 2004	3.5%	2.05%	2.05%	
May 2004	3.5%	2.25%	2.05%	
June 2004	3.5%	2.25%	2.05%	
July 2004	3.5%	2.25%	2.05%	
Aug. 2004	3.5%	2.25%	2.05%	
Sept. 2004	3.5%	2.25%	2.05%	
Oct. 2004	3.5%	2.25%	2.05%	
Nov. 2004	3.5%	2.25%	2.05%	
Dec. 2004	3.5%	2.25%	2.05%	
Jan. 2005	3.5%	2.25%	2.05%	
Feb. 2005	3.5%	2.25%	2.05%	
March 2005	3.5%	2.25%	2.05%	
April 2005	3.5%	2.25%	2.05%	
May 2005	3.5%	2.25%	2.25%	Since CMT rate that determined actual NF rate of 2.05% occurred more than 15 months ago, the actual rate MUST be updated. Given the method, this means this rate is based on March CMT rate (monthly average with a one month lag—see description in method for this example).
June 2005	3.5%	2.25%	2.25%	
July 2005	3.5%	2.25%	2.25%	

Example 3: Shows what to do when 1% floor comes into play. Method—This example starts with an initial NF rate based on a single point in time. The potential rate is determined based on the preceding month CMT average. If the potential rate differs from the actual rate by more than 25 bps, the actual rate is updated. This example shows how to handle statutory minimums (use the same logic for maximums).

Date	5 Year CMT Monthly Average	Potential NF rate	Actual NF Rate	Comments
Dec. 2003	2.4%	N/a	N/a	Starting month for the block—this sets the "peg in the ground"
Jan. 2004	2.3%	1.15%	1.15%	Initial rate for block
Feb. 2004	2.3%	1.05%	1.15%	
March 2004	2.25%	1.05%	1.15%	
April 2004	2.25%	1.0%	1.15%	
June 2004	2.1%	0.85%	1.0%	The potential rate is not subject to statutory minimums and maximums. It must be unbounded in order to determine if a change of more than 25 bps has occurred. In this case, it has, so the actual rate is updated, factoring in statutory minimums and maximums.
July 2004	2.1%	0.85%	1.0%	
Aug. 2004	2.1%	0.85%	1.0%	

Example 4: real life 5 year CMT averages. Method—Monthly average 5 year CMT with a one month lag time. NF rate is held constant as long as the potential nonforfeiture rate is within a range of plus or minus 50 bps from the current nonforfeiture rate.

http://www.federalreserve.gov/releases/h15/current/h15.pdf and
Http://www.treas.gov/offices/domestic-finance/debt-management/interest-rate/index.html

	(1) CMT Rate	(2) Potential NF Rate	(3) Actual NF Rate	
July 2002	3.81	N/a	2.95	Assumed as a given
Aug. 2002	3.29	2.55	2. 95	
Sept. 2002	2.94	2.05	2.05	
Oct. 2002	2.95	1.70	2.05	
Nov. 2002	3.05	1.70	2.05	
Dec. 2002	3.03	1.80	2.05	
Jan. 2003	3.05	1.80	2.05	
Feb. 2003	2.90	1.80	2.05	
March 2003	2.78	1.65	2.05	
April 2003	2.93	1.55	2.05	
May 2003	2.52	1.70	2.05	
June 2003	2.27	1.25	1.25	
July 2003	2.87	1.00	1.25	
Aug. 2003	3.37	1.60	1.25	

(1) = monthly average 5 year CMT from above named sources
(2) = monthly average minus 125 bps—"potential NF rate", then rounded
(3) = actual rate according to a value triggered method with range of plus or minus 50 bps

Note: the above examples are just that—examples. There are many more methods that could be used that may also be appropriate.

Appendix B

Transfer of minimum nonforfeiture amount for Section 6.

This example will show a simple demonstration of how the minimum nonforfeiture amount is to be transferred in an equity-indexed annuity under Section 6. Assume that the 5 year CMT is 3.75%. This results in a fixed annuity nonforfeiture rate of 2.5%. Further assume that the equity-indexed benefit receives the additional 100 bps reduction, so its nonforfeiture rate is 1.5%. This contract has a fixed interest option within an EIA. The policyholder may transfer money on any contract anniversary. Assuming there are transfers, the minimum nonforfeiture amount is path dependent. The minimum nonforfeiture amount will roll forward and get transferred back and forth at the benefit level, then added together to determine the minimum nonforfeiture amount for the contract. Note that there are slight rounding differences.

Year 1

Policyholder initially allocates 50% of premium each to fixed and equity-indexed benefits.

EIA benefit = 50% * (100,000 * 87.5%—$50) * 1.015 = 44,380.88
Fixed benefit = 50% * (100,000 * 87.5%—$50) * 1.025 = 44,818.13

The total minimum nonforfeiture amount is 44,380.88 + 44,818.13 = 89,199.00.

Year 2

At the end of year 1, assume that due to market performance, the *contract value* is now allocated 60% in the equity-indexed benefit and 40% in the fixed benefit. The policyholder decides to re-allocate his contract value so that it is again at 50% in the equity-indexed benefit and 50% in the fixed interest benefit. This means that $1/6^{th}$ (10% out of the 60%) of the equity-indexed contract value is transferred to the fixed interest contract value. Thus, $1/6^{th}$ of the equity-indexed nonforfeiture amount is transferred to the fixed nonforfeiture amount. The results follow:
EIA benefit = 44,380.88 — 7,396.81 = 36,984.06.
Fixed benefit = 44,818.13 + 7,396.81 = 52,214.94.
Note that the total minimum nonforfeiture amount remains level at 89,199.00.

Year 2 calculations are identical to year 1 with the adjusted starting values. Note that since contract value is again split 50% each, the contract charge is also allocated 50% to each benefit.

EIA benefit = (36,984.06—50% * $50)* 1.015 = 37,513.45
Fixed benefit = (52,214.94—50% * $50)* 1.025 = 53,494.68
Total = 91,008.13

With different starting allocations and re-allocations, all the calculations operate the same, but would be adjusted "accordingly."

Appendix C

Initial Actuarial Certification of Compliance for Equity Indexed Annuities with (identify state regulation that corresponds to the Annuity Nonforfeiture Model Regulation)

For use with Equity-Indexed Annuity contract forms at time of filing.

I, (state name and professional designation) am responsible for evaluating compliance with the (identify state law and regulation that corresponds to the Standard Nonforfeiture Law for Individual Deferred Annuities and the Annuity Nonforfeiture Model Regulation) for (name of insurance company). I have reviewed (identify contract form) and am familiar with the (identify state law and regulation that corresponds to the Standard Nonforfeiture Law for Individual Deferred Annuities and the Annuity Nonforfeiture Model Regulation) as they pertain to equity-indexed annuities. I have also reviewed the methodology that will be used in calculating and setting assumptions for the additional reduction in nonforfeiture rate for equity-indexed annuities. Based on my review, I certify that the methodology used for (identify contract form) meets the minimum requirements of the (identify state law and regulation that corresponds to the Standard Nonforfeiture Law for Individual Deferred Annuities and the Annuity Nonforfeiture Model Regulation).

_____
(Name of actuary)

_____
(Signature of actuary)

_____
(Date of certification)

Appendix D

Actuarial Certification of Compliance for Equity Indexed Annuities with (identify state regulation that corresponds to the Annuity Nonforfeiture Model Regulation)

For use in certifying compliance with the (identify state regulation that corresponds to the Annuity Nonforfeiture Model Regulation).

I, (state name and professional designation) am responsible for evaluating compliance with the (identify state law and regulation that corresponds to the Standard Nonforfeiture Law for Individual Deferred Annuities and the Annuity Nonforfeiture Model Regulation) for (name of insurance company). I am familiar with the (identify state law and regulation that corresponds to the Standard Nonforfeiture Law for Individual Deferred Annuities and the Annuity Nonforfeiture Model Regulation) as they pertain to equity-indexed annuities. I have reviewed the equity index features of (identify all contract forms covered by this certification) for ongoing compliance with the requirements of (identify state regulation that corresponds to the Annuity Nonforfeiture Model Regulation) that deal with the additional reduction relating to equity-indexed annuities. I have reviewed the assumptions used to support the additional reduction that is permitted to be used with equity-indexed annuities.

Based on my review, I certify that the additional reduction used to determine nonforfeiture values provided under the policy forms identified above met the requirements of (identify state regulation that corresponds to the Annuity Nonforfeiture Model Regulation) as it relates to equity-indexed annuities in force as of December 31, (previous calendar year).

_____
(Name of actuary)

_____
(Signature of actuary)

_____
(Date of certification)

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2005 Proc.3rd Quarter (adopted by parent committee)
2005 Proc. 4th Quarter 31, 34-46, 2713 (adopted by Plenary).

ANNUITY NONFORFEITURE MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ANNUITY NONFORFEITURE MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			BULLETIN 2006-16 (2006).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. CODE REGS. tit. 10, §§ 2523 to 2523.6 (2012).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia			BULLETIN 04-002-CO (2004).
Florida	NO CURRENT ACTIVITY		
Georgia			GA. COMP. R. §§ 120-2-91-.01 to 120-2-91-.05 (2004/2005).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

ANNUITY NONFORFEITURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois			BULLETIN 2004-2 (2004); BULLETIN 2005-5 (2005).
Indiana			760 IND. ADMIN. CODE 2-16.1 (2010).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	806 KY. ADMIN. REGS. 15:070 (2007).		
Louisiana			DIRECTIVE 138 (1996/2008).
Maine			BULLETIN 338 (2005/2007).
Maryland	NO CURRENT ACTIVITY		
Massachusetts			BULLETIN 2004-05 (2004).
Michigan	NO CURRENT ACTIVITY		
Minnesota			BULLETIN 2006-5 (2006).
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada			NEV. ADMIN. CODE 688A.200 (2003); BULLETIN 2011-007 (2011).
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			BULLETIN 2012-8 (2012).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		

ANNUITY NONFORFEITURE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO ADMIN. CODE 3901-6-16 (2012).
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2005

ANNUITY NONFORFEITURE MODEL REGULATION (#806)

1. Project Description

As described in the model, its purpose is to adopt rules to implement the provisions of Section 4 of the Standard Nonforfeiture Law for Individual Deferred Annuities. Revisions to Section 4 of the law were made in March 2003 which: (a) set the minimum nonforfeiture interest rate at a level which varies with the five-year constant maturity treasuries (CMT), subject to a 3% ceiling and a 1% floor; and (b) permits a lower minimum nonforfeiture interest rate for equity-indexed annuities (subject to the 3% ceiling and 1% floor).

2. Group Responsible for Drafting Model and States Participating

The 2005 members of the Life and Health Actuarial Task Force are: New Mexico (Chair), Minnesota (Vice-Chair), Alabama, Alaska, Arkansas, California, Connecticut, Florida, Kansas, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, and West Virginia.

3. General Description of Drafting Process

The matters described in Project Description were discussed by the Task Force at each quarterly meeting from June 2003 to June 2005. In addition, the Task Force held at least one conference call on this topic during each quarter over that period. Two conference calls were held subsequent to the June 2005 quarterly meeting, including one on September 20, 2005, on which the Task Force adopted the model. All quarterly meetings and conference calls were open to industry personnel. Notice of each conference call was posted on NAIC's Web site and e-mailed to approximately 300 interested parties, including representatives of the American Council of Life Insurers (ACLI).

4. Significant Issues Raised

Numerous contentious issues were debated during the more than two years of effort on this project. The following excerpt from the June 2003 Task Force minutes provides a sense of the wide range of issues addressed:

- Given that the Standard Nonforfeiture Law for Individual Deferred Annuities refers to the "market values" of equity-indexed benefits and not their theoretical costs, some means will need to be agreed upon to convert formulaic or modeling results to market values. Consideration will need to be given as to how to incorporate persistency into the determination of the market value of an equity-indexed benefit.

- How will a company demonstrate the appropriateness of a reduction in the nonforfeiture interest rate when the participation rate in the equity index can vary from one year to the next?

- From the American Academy of Actuaries report relative to equity indexed concerns: "Any additional issues if a company uses the redetermination feature for the minimum nonforfeiture rate?"

- How much variable language should be allowed in policy filings, i.e., to what extent should the specific nonforfeiture rate to be applied to the policy be left blank?

- Does a specific number need to be developed for what constitutes "substantive participation in an equity indexed benefit?"

- Several Task Force members expressed support for the position that the period over which the minimum nonforfeiture interest rate is determined should not be affected by the actual level of the five-year CMT. For example, a company could not use the lowest five-year CMT rate over the prior fifteen-month period. Rather, it would have to specify a specific date or period during the prior fifteen months over which the five-year CMT will be determined, regardless of the actual level of the CMT.

- How much detail should be disclosed to the consumer and included in the contract regarding how the initial and redetermined minimum nonforfeiture interest rates are determined? How much detail should be in the memorandum supporting the policy filing?

While all of the above and many more issues were addressed during the drafting of the model, the following two questions proved especially difficult to resolve, i.e., the extent to which differing minimum nonforfeiture interest rates should apply to (1) considerations (i.e., premium payments) paid at different times, and (2) the equity and non-equity components of the contract, i.e., one rate per contract.

Question #1: Does the Law bar the use of minimum nonforfeiture interest rates that vary according to the timing of the receipt of considerations (the so-called "premium bucket" approach)?

This question was discussed over a period of a year and one-half, and the Task Force reversed its position on more than one occasion during that period. The Task Force eventually decided to reject the "premium bucket" approach. The following excerpt from the minutes of the Task Force's October 14, 2004, conference call summarizes the extended debate:

> Mr. Dino moved, and Mr. Summers seconded a motion "for premium buckets to be excluded from the Annuity Nonforfeiture Model Regulation." A lengthy discussion ensued, during which the previously stated arguments for and against premium buckets were repeated.
>
> Opposed to premium buckets:
>
> - The literal wording of the Standard Nonforfeiture Law for Individual Deferred Annuities does not permit premium buckets in the determination of minimum nonforfeiture values.
> - Premium buckets will add complexity in verifying that minimum nonforfeiture standards are being met.
> - Premium buckets will make it more difficult for consumers to understand what the minimum nonforfeiture values are.
> - To the extent precise rules are not developed regarding how partial withdrawals affect minimum nonforfeiture values, there will be no true "minimum nonforfeiture standard."
>
> In favor of premium buckets:
>
> The arguments in favor of premium buckets are summarized in the Aug. 17, 2004, letter from William Schreiner (ACLI) (Note: the bullet points shown below are extracted from Mr. Schreiner's memo, and were not explicitly listed in the minutes).
>
> - The "premium bucket" approach permits the exact alignment of investment credit promises with available investment opportunities – a plus for both the contract owner and the insurer.
> - It permits the avoidance of situations in which insurer interest guarantees exceed the interest available to be earned in the current marketplace – a solvency concern – due to the existence of guarantees established in a more favorable environment.
> - It permits the avoidance of situations in which insurer interest guarantees are below the interest available to be earned in the current marketplace – a contract owner equity concern – due to the existence of guarantees established in a less favorable environment.
> - The premium bucket approach has long been available in the marketplace. Failure to include it in the model regulation, which is intended to clarify the operation of the new law, would effectively bar its use in low interest rate environments. Logic demands that if the new nonforfeiture law can coexist with premium buckets in high interest rate environments (and it can), the new law should not be used as a tool to eliminate its availability in low interest rate environments.
>
> The motion passed: Voting "yes" (7): Alaska, California, Florida, Minnesota, New Mexico, Ohio, and Texas; Voting "no" (5): Arkansas, Kansas, New York, Pennsylvania, and Utah; Abstain (2): Connecticut, South Carolina.

Question #2: Does the Law bar the use of different minimum nonforfeiture interest rates for the equity and non-equity components of the contract, i.e., should there be one minimum nonforfeiture interest rate per contract?

This issue was one of the last to be resolved, and the Task Force reversed its position on more than one occasion. On its call on July 18, 2005, it agreed to permit more than one rate per contract when the contract incorporates equity-indexed benefits,

and that was the position incorporated into the final document. The following excerpt from a prior discussion (the March 2005 Task Force minutes) summarizes the points raised during the ongoing debate:

> Some Task Force members questioned why there should be multiple nonforfeiture interest rates within a single contract. Mr. Dino said his preference "would be that we don't start separating and bifurcating components of a contract. Minimum values should be (for) the contract as a whole, and not looking at different benefit perspectives in the contract." Mr. Serbinowski disagreed "because if you have a contract that has both a fixed account and equity-indexed account, you have to deal with two rates." Mr. Bruning said, "Kansas reads the statute the same way Florida reads the statute; there's one rate per contract, and it either provides substantial equity participation or it doesn't." Mr. Dino moved, and Mr. Stone seconded a motion that Subsection 6B be modified as shown and Subsection 6C be eliminated: proposed Subsection 6B - At any point in time, each contract (or certificate) will have one nonforfeiture rate that is applicable to the entire contract. Mr. Summers stated he is opposed to the motion because difficulties will arise in determining if companies are inappropriately marketing equity-indexed annuities with fixed accounts in order to lower the minimum interest guarantee. Mr. Dino responded "if all he (i.e., the consumer) wanted was the fixed account, that's what he should have bought. And if the agent browbeat him into buying something he shouldn't have, give me the agent's name and phone number. I'll take care of that."

Adoption by the Task Force on its September 20, 2005, Conference Call

The Task Force adopted the model on a vote of five in favor, one opposed, and seven members abstaining. While there are undoubtedly multiple reasons for the unusually large number of abstentions, the primary reason appears to be uncertainty over the language in Subsection 6B. Among the matters addressed in that subsection is the determination of the minimum nonforfeiture benefit in the event of transfers and withdrawals for contracts with equity-indexed benefits. Comments were received from members of the industry that there are other methods of determination that are either simpler or equally as valid as that specified in Subsection 6B. Various options were discussed on the Sept. 20 call for providing more flexibility to companies, but no agreement could be reached regarding different language.

Implications of this Project for Accreditation and Codification

Since this project does not deal with solvency monitoring, there is no impact for accreditation and codification.

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

Table of Contents

Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Life Insurance.

Section 1a. Definitions

The term "operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual as defined in the [insert reference to the state's Standard Valuation Law incorporating the National Association of Insurance Commissioners' 2009 Amendments] is effective.

Section 2. Nonforfeiture Benefits

In the case of policies issued on and after the operative date of this Act as defined in Section 10, no policy of life insurance, except as stated in Section 9, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified here and are essentially in compliance with Section 8 of this law:

A. That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of such amount as may be hereinafter specified. In lieu of the stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

B. That, upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

C. That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make the election elects another available option not later than sixty (60) days after the due date of the premium in default.

D. That if the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

E. In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy; a statement of the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

F. A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and a paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

Section 3. Computation of Cash Surrender Value

A. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by Section 2, shall be an amount not less than the excess, if any, of the present value, on the anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(1) The then present value of the adjusted premiums as defined in Sections 5, 5a, 5b and 5c, corresponding to premiums which would have fallen due on and after the anniversary; and

(2) The amount of any indebtedness to the company on the policy.

B. Provided, however, that for any policy issued on or after the operative date of Section 5c, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in Subsection A of this section shall be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value as defined in Subsection A for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

C. Provided, further, that for any family policy issued on or after the operative date of Section 5c, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71), the cash surrender value referred to in Subsection A shall be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without term insurance on the life of the spouse and the cash surrender value as defined in Subsection A for a policy which provides only the benefits otherwise provided by term insurance on the life of the spouse.

D. Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by Section 2, shall be an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

Section 4. Computation of Paid-Up Nonforfeiture Benefits

Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this Act in the absence of the condition that premiums shall have been paid for at least a specified period.

Section 5. Calculation of Adjusted Premiums

A. This section shall not apply to policies issued on or after the operative date of Section 5c. Except as provided in Subsection C of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(1) The then present value of the future guaranteed benefits provided for by the policy;

(2) Two percent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy;

(3) Forty percent (40%) of the adjusted premium for the first policy year;

(4) Twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

Provided, however, that in applying the percentages specified in (3) and (4) above, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or level amount equivalent. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount for the purpose of this section shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the inception of the insurance as the benefits under the policy.

C. The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

(1) The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by

(2) The adjusted premiums for such term insurance,

the foregoing Paragraphs (1) and (2) being calculated separately and as specified in Subsections A and B except that, for the purposes of Subsection A(2), A(3) and A(4), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in Subsection A(2) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in Subsection C(1).

D. Except as otherwise provided in Sections 5a and 5b, all adjusted premiums and present values referred to in this Act shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to any age not more than three (3) years younger than the actual age of the insured and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3 1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred and thirty percent (130%) of the rates of mortality according to the applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

Section 5a. Calculation of Adjusted Premiums - Ordinary Policies

This section shall not apply to ordinary policies issued on or after the operative date of Section 5c. In the case of ordinary policies issued on or after the operative date of this section, all adjusted premiums and present values referred to in this Act shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after [insert effective date of 1972 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance] and prior to [insert effective date of 1976 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance] and a rate of interest not exceeding five and one-half percent (5 1/2%) per annum may be used; for policies issued on or after [insert effective date of 1976 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance], except that for any single premium whole life or endowment insurance policy, a rate of interest not exceeding six and one-half percent (6 1/2%) per annum may be used; and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1966. After the filing of such notice, upon the specified date (which shall be the operative date of this section for that company), this section shall become operative with respect to the ordinary policies thereafter issued by the company. If a company makes no election, the operative date of this section for the company shall be January 1, 1966.

Section 5b. Calculation of Adjusted Premiums - Industrial Policies

This section shall not apply to industrial policies issued on or after the operative date of Section 5c. In the case of industrial policies issued on or after the operative date of this section, all adjusted premiums and present values referred to in this Act shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after [insert effective date of 1972 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance] and prior to [insert effective date of 1976 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance] and a rate of interest not exceeding five and one-half percent (5 1/2%) per annum may be used for policies issued on or after [insert effective date of 1976 NAIC amendments to the Standard Nonforfeiture Law for Life Insurance], except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6 1/2%) per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1968. After the filing of such notice, upon the specified date (which shall be the operative date of this section for that company), this section shall become operative with respect to the industrial policies thereafter issued by the company. If a company makes no election, the operative date of this section for the company shall be January 1, 1968.

Section 5c. Calculations of Adjusted Premiums By the Nonforfeiture Net Level Premium Method

A. This section shall apply to all policies issued on or after the operative date of this section. Except as provided in Subsection G, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

(1) The then present value of the future guaranteed benefits provided for by the policy;

(2) One percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(3) One hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined.

Provided, however, that in applying the percentage specified in (3) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

C. In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums; or which provide an option for changes in benefits or premiums, other than a change to a new policy; the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

D. Except as otherwise provided in Subsection G, the recalculated future adjusted premiums for any policy shall be uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of:

(1) The sum of

(a) The then present value of the then future guaranteed benefits provided for by the policy, and

(b) The additional expense allowance, if any, over

(2) The then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under this policy.

E. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(1) One percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(2) One hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

F. The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (1) by (2) where

(1) Equals the sum of

(a) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and

(b) The present value of the increase in future guaranteed benefits provided for by the policy, and

(2) Equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

G. Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amount of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide higher uniform amounts of insurance on the standard basis.

H. All adjusted premiums and present values referred to in this Act shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1980 Standard Ordinary Mortality Table; or, at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section, for policies issued in that calendar year. Provided, however, that:

(1) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.

(2) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by Section 2, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(3) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(4) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(5) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(6) For policies issued prior to the operative date of the valuation manual, any Commissioners Standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by regulation any Commissioners Standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(7) For policies issued prior to the operative date of the valuation manual, any Commissioners Standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any Commissioners Standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

I. The nonforfeiture interest rate is defined below:

(1) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred and twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the *Standard Valuation Law*, rounded to the nearer one quarter of one percent (1/4 of 1%), provided, however, that the nonforfeiture interest rate shall not be less than four percent (4.00%).

Drafting Note: For flexible premium universal life insurance policices as defined in Section 3D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.

(2) For policies issued on and after the operative date of the valuation manual the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

J. Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

K. After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provision of this section after a specified date before January 1, 1989, which shall be the operative date of this section for the company. If a company makes no election, the operative date of this section for the company shall be January 1, 1989.

Section 6. Nonforfeiture Benefits for Indeterminate Premium Plans

In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in Sections 2, 3, 4, 5, 5a, 5b or 5c, then:

A. The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Sections 2, 3, 4, 5, 5a, 5b or 5c;

B. The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

C. The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by regulations promulgated by the commissioner;

Drafting Note: If desired the following provision may be added as Subsection D.

D. Notwithstanding any other provision in the laws of this state, any policy, contract or certificate providing life insurance under any plan must be affirmatively approved by the commissioner before it can be marketed, issued, delivered or used in this state.

Drafting Note: If Subsection D is enacted in a state where prior filing and approval of life insurance policy forms has not been previously required by statute, this subsection would mandate such action for plans requiring approval under Section 6. If Subsection D is enacted in a state where approval is deemed under certain circumstances, the deemer provision would be overridden by the terms of this section. In some states specific reference must be made to any statutory provision which is overridden.

Section 7. Proration of Values; Net Value of Paid-Up Additions

Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in Sections 3, 4, 5, 5a, 5b and 5c may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall not be less than the amounts used to provide such additions. Notwithstanding the provisions of Section 3, additional benefits payable:

A. In the event of death or dismemberment by accident or accidental means;

B. In the event of total and permanent disability;

C. As reversionary annuity or deferred reversionary annuity benefits;

D. As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this Act would not apply;

E. As term insurance in the life on a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child; and

F. As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits,shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this Act, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

Section 8. Consistency of Progression of Cash Surrender Values with Increasing Policy Duration

This section, in addition to all other applicable sections of this law, shall apply to all policies issued on or after January 1, 19[ ] [insert the fourth calendar year commencing after the effective date of the amendatory Act of 19--]. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of:

A. The greater of zero and the basic cash value hereinafter specified; and

B. The present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this Act, corresponding to premiums which would have fallen due on and after the anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in Section 3 or 5, whichever is applicable, shall be the same as the effects specified in Section 3 or 5, whichever is applicable, on the cash surrender values defined in that section.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in Section 5 or 5c, whichever is applicable. Except as is required by the next succeeding sentence of this section, the percentage:

A. Must be the same percentage for each policy year between the second policy anniversary and the later of:

(1) The fifth policy anniversary; and

(2) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

B. Must be such that no percentage after the later of the two policy anniversaries specified in Subsection A may apply to fewer than five (5) consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in Section 5c, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this law. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in Sections 2, 3, 4, 5c and 7. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as Section 7A through 7F shall conform with the principles of this section.

Section 9. Exceptions

This Act shall not apply to any of the following:

A. Reinsurance;

B. Group insurance;

C. Pure endowment;

D. Annuity or reversionary annuity contract;

E. A term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years of less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy;

F. A term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in Sections 5, 5a, 5b and 5c, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy;

G. A policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in Sections 3, 4, 5, 5a, 5b and 5c, exceeds two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the same policy year; nor

H. Policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of this Act, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

Section 10. Effective Date

After the effective date of this Act, any company may file with the commissioner a written notice of its election to comply with the provisions of this Act after a specified date before January 1, 1948. After the filing of such notice, then upon the specified date (which shall be the operative date for the company), this Act shall become operative with respect to the policies thereafter issued by such company. If a company makes no such election, the operative date of this Act for the company shall be January 1, 1948.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1942 Proc. Supp. 266-270 (text).
1943 Proc. 13 (adopted).
1947 Proc. 250, 253-254, 261 (amended).
1959 Proc. I 183, 193, 197-202, 294 (amended).
1960 Proc. II 518, 536-537, 538 (amended).
1962 Proc. I 140, 144, 145-146, 166 (amended).
1973 Proc. I 9, 11, 251, 277, 279, 284 (amended).
1973 Proc. II 533, 546-549 (reprinted).
1974 Proc. II 461-466 (reprinted).
1977 Proc. II, 19, 21, 432, 494, 560 (corrected).
1981 Proc. I 47, 51, 421, 517, 761, 774-782 (amended and reprinted).
1981 Proc. II 27, 35, 559, 793, 794 (amended).
2012 Proc. 2nd Quarter, Vol I, 121-133, 171, 391, 403 (amended).
2013 Proc. 3rd Quarter, Vol I, 121-124, 135-138, 159, 226, 319, 348, 362, 496, 505, 519 (amended).

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACITIVITY
Alabama	ALA. CODE r. §§ 27-15-70 to 27-15-83 (2016).		
Alaska	ALASKA STAT. § 21.45.300 (1966/2018).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1231 to 20-1231.01 (1955/2013).		
Arkansas	ARK. CODE ANN. §§ 23-81-201 to 23-81-213 (1959/2019).		
California	CAL. INS. CODE §§ 10159.1 to 10167.5 (1943/2017).		CAL. CODE REGS. tit. 10, § 2202 (1996/2016).
Colorado	COLO. REV. STAT. §§ 10-7-107; §§ 10-7-301 to 10-7-316 (1961/2015).		
Connecticut	CONN. GEN. STAT. §§ 38a-438 to 38a-439 (1978/2014).		
Delaware	DEL. CODE ANN. tit. 18, § 2929 (1953/2015).		
District of Columbia	D.C. CODE § 31-4705.02 (1934/2019).		

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACITIVITY
Florida	FLA. STAT. § 627.476 (1959/2014).		
Georgia	GA. CODE ANN. § 33-25-4 (1966/2018).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:10D-104 (1988/2014).		
Idaho	IDAHO CODE ANN. § 41-1927 (1963/2016).		
Illinois	215 ILL. COMP. STAT. 5/229.2 (1943/2015).		
Indiana	IND. CODE § 27-1-12-7 (1948/2018).		
Iowa	IOWA CODE § 508.37 (1963/2016).		
Kansas	KAN. STAT. ANN. § 40-428 (1947/2015).		
Kentucky	KY. REV. STAT. ANN. § 304.15-310; §§ 304.15-320 to 304.15-360 (1970/2015).		
Louisiana	LA. REV. STAT. ANN. § 22:936 (1960/2013).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2528 to 2534 (1969/2013) (portions of model).		
Maryland	MD. CODE ANN. INS. §§ 16-301 to 16-313 (1951/2015).		
Massachusetts	MASS. GEN. LAWS ch. 175, §§ 144 to 146A (1982/2018).		
Michigan	MICH. COMP. LAWS § 500.4060 (1943/2014).		

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACITIVITY
Minnesota	MINN. STAT. ANN.§ 61A.24 (1967/2016).		
Mississippi	MISS. CODE ANN. § 83-7-25 (1942/2014).		
Missouri	MO. REV. STAT. § 376.670 (1948/2015).		
Montana	MONT. CODE ANN. §§ 33-20-201 to 33-20-213 (1959/2015).		
Nebraska	NEB. REV. STAT. §§ 44-407 to 44-407.09; §§ 44-407.24 to 44-407.26 (1943/2014).		
Nevada	NEV. REV. STAT. §§ 688A.290 to 688A.360 (1962/2015).		
New Hampshire	N.H. REV. STAT. ANN. §§ 409:1 to 409:8 (1943/2013).		
New Jersey	N.J. REV. STAT. § 17B:25-19 (1971/2014).		BULLETIN 2015-1 (2015).
New Mexico	N.M. STAT. ANN. § 59A-20-31 (1985/2014).		
New York		N.Y. INS. LAW § 4221 (1984/2002).	
North Carolina	N.C. GEN. STAT. § 58-58-55 (1945/2015).		
North Dakota	N.D. CENT. CODE §§ 26.1-33-18 to 26.1-33-28 (1985/2015).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3915.07 (1957/1983); §§ 3915.071 to 3915.072 (1983/2014).		
Oklahoma	OKLA. STAT. tit. 36, § 4029 (1957/2014).		

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACITIVITY
Oregon	OR. REV. STAT. §§ 743.204 to 743.222 (1948/2015).		
Pennsylvania	40 PA. CONS. STAT. § 510.1 (2016); 40 PA. CONS. STAT. § 7151 (2016).		
Puerto Rico		P.R. RULE XLVIII (1984).	
Rhode Island	R.I. GEN. LAWS §§ 27-4.3-1 to 27-4.3-11 (1994/2014).		
South Carolina	S.C. CODE ANN. §§ 38-63-510 to 38-63-660 (1988/2016).		
South Dakota	S.D. CODIFIED LAWS §§ 58-15-31 to 58-15-43 (1966/2015).		
Tennessee	TENN. CODE ANN. § 56-7-401 (1945/2013).		
Texas	TEX. INS. CODE ANN. §§ 1105.001 to 1105.153 (2015).		
Utah	UTAH CODE ANN. § 31A-22-408 (1985/2016).		
Vermont	VT. STAT. ANN. tit. 8, §§ 3760 to 3773 (2015/2017).		
Virgin Islands		V.I. CODE INS. tit. 22, § 984 (1968).	
Virginia	VA. CODE ANN. §§ 38.2-3200 to 38.2-3229 (1986/2014).		
Washington	WASH. REV. CODE ANN. §§ 48.76.010 to 48.76.900 (1982/2016).		
West Virginia	W. VA. CODE § 33-13-30 (1957/2014).		

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACITIVITY
Wisconsin	WIS. STAT. § 632.43 (1943/2015).		
Wyoming	WYO. STAT. ANN. §§ 26-16-201 to 26-16-212 (1967/2017).		

PROJECT HISTORY - 2013

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE (#808)

1. Description of the Project, Issues Addressed, etc.

The project modified the *Standard Nonforfeiture Law for Life Insurance* (#808) to reflect changes necessitated by the protracted low interest environment. The nonforfeiture interest rate per annum for any policy issued in a particular calendar year is equal to 125% of the calendar-year statutory valuation interest rate for such policy as defined in the *Standard Valuation Law* (#820). A floor has been added to the calculation of the nonforfeiture interest rate equal to 4.00%, which is the annual effective rate used to determine the net single premium for purposes of the cash value accumulation test under Section 7702(b) of the Internal Revenue Code (IRC). The purpose of the floor is to ensure that, in a low-interest rate environment, traditional life insurance can continue to be issued in compliance with both state minimum nonforfeiture requirements and the maximum cash value requirements in Section 7702 of the IRC of 1986 (as amended). Life insurance contract holders that fail to comply with the requirements of IRC Section 7702 are subject to significant adverse federal income tax treatment, including current taxation of the gain on the contract.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2013 members of the Life Actuarial (A) Task Force are: Texas (Chair), Ohio (Vice Chair), Connecticut, Florida, Kansas, Minnesota, Missouri, Nebraska, New Jersey, New York, Oklahoma, Oregon and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

From 2002 to 2005, the Task Force was given the charge to review the *Standard Valuation Law* (#820) to determine if changes were necessary. In 2006, the charge was to review the *Standard Valuation Law*, related model regulations, and actuarial guidelines to determine if changes were necessary, particularly any that are needed to facilitate the implementation of a principle-based approach. In 2007, the request for model law development of the *Standard Nonforfeiture Law for Life* Insurance (#808) was approved. A subsequent request for model law development for the *Standard Nonforfeiture Law for Life Insurance* (#808) was approved in 2013.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

An amendment proposal, including draft language, was submitted to the Task Force by the interested parties. The Task Force reviewed the proposal and made minor modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force discussed the proposal April 4, 2013, at the NAIC Summer National Meeting. The Task Force held public conference calls on this topic Sept. 10, 2013, and Oct. 10, 2013. Notice of each of these conference calls was posted on the NAIC website and emailed to approximately 375 interested parties. A draft of the document was released for comment Sept. 10, 2013; no comments were submitted to the Task Force relative to this project.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Because of the protracted low-interest rate environment, there has been concern that the nonforfeiture interest rate would drop below 4%, resulting in traditional life insurance no longer continuing to be issued in compliance with both state minimum nonforfeiture requirements and the maximum cash value requirements in IRC Section 7702. During the Oct. 10, 2013, public conference call, a motion was made to adopt the revisions to the *Standard Nonforfeiture Law* (#). The motion passed unanimously by voice vote.

7. Any Other Important Information (e.g., amending an accreditation standard).

The *Standard Nonforfeiture Law for Life Insurance* (#808) is not an accreditation standard.

PROJECT HISTORY - 2012

STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE (#808)

1. Description of the Project, Issues Addressed, etc.

The project modified the *Standard Nonforfeiture Law for Life Insurance* to reflect changes made in 2009 to the *Standard Valuation Law* to enable a principle-based valuation methodology. The *Standard Nonforfeiture Law for Life Insurance* defines an interest rate and a mortality table to be used in the calculation of minimum nonforfeiture values. The nonforfeiture interest rate was defined with reference to an interest rate determined by a formula in the *Standard Valuation* Law, and the changes to the mortality table would be accomplished by regulation. Under principle-based reserving the interest rate formula will not be used, and mortality table changes will be made in the Valuation Manual. The modifications to the *Standard Nonforfeiture Law for Life Insurance* specify that the interest rate and the mortality table will be defined in the Valuation Manual on and after the manual is operative.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2012 members of the Life Actuarial (A) Task Force are: Texas (chair), Ohio (Vice Chair), Alabama, Connecticut, Florida, Kansas, Minnesota, Missouri, New Jersey, New York, Oklahoma, Oregon and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

From 2002 to 2005 the Task Force was given the charge to review the *Standard Valuation Law* to determine if changes were necessary. In 2006 the charge was to review the Standard Valuation Law, related model regulations, and actuarial guidelines to determine if changes are necessary, particularly any that are needed to facilitate the implementation of a principles-based approach. In 2007 the request for model law development of the *Standard Nonforfeiture Law for Life Insurance* was approved.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Several regulators developed drafts of the required modifications. A subgroup of the Task Force was formed to made changes and made a recommendation to the Task Force. The Task Force made several modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at public conference calls on this topic on the following dates: May 3, 2011; June 1, 2011; June 28, 2011; July 6, 2011; August 2, 2011; September 8, 2011; October 15, 2011; and December 13, 2011. The Task Force held public conference calls on this topic January 30, 2007; February 9, 2009; January 12, 2011; May 26, 2011; June 28, 2011; and August 30, 2011. The Task Force also discussed the modifications at National Meeting in December 2008; March, 2011; and March, 2012. Notice of each of these conference calls was posted on the NAIC home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment January 30, 2007; December 5, 2008; March 24, 2011; June 1, 2011; and August 2, 2011. Several memos and letters were submitted to the Task Force relative to this project.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Because of the current low interest rate environment there has been concern that traditional life insurance could not continue to be issued in compliance with both state minimum nonforfeiture requirements and the maximum cash value requirements in Internal Revenue Code (IRC) Section 7702. If the nonforfeiture interest rate would drop below 4% a traditional life insurance contract would not be able, in most cases, to comply with both state minimum nonforfeiture requirements and the maximum cash value requirements in Section 7702. The Task Force decided not to put in a requirement that the nonforfeiture interest rate could not be less than 4%.

At the Spring National Meeting in March 2012, a motion was made to adopt the revisions to the *Standard Nonforfeiture Law*. The motion passed with Alabama, Connecticut, Florida, Kansas, Minnesota, New York, New Jersey, Ohio, Oklahoma, Texas and Utah voting yes.

7. Any Other Important Information (e.g., amending an accreditation standard).

The *Standard Nonforfeiture Law for Life Insurance* is not an accreditation standard.

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND1980 CET MORTALITY TABLES

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Preamble

The U.S. Supreme Court in its decision in *Arizona Governing Committee v. Norris* makes it illegal for an employer to make contributions after August 1, 1983 to a defined contribution pension plan if the benefits derived from those contributions differ by sex. Although there is some uncertainty as to the breadth of the Supreme Court's decision, it would seem to require that after August 1, 1983 employer pension plans may need to be funded by life insurance products that have identical nonforfeiture values for men and women. Since the 1980 CSO and 1980 CET Mortality Tables contain mortality rates that vary by both age and sex, it is very difficult if not impossible for companies to determine actual nonforfeiture values that are identical for men and women and also satisfy a sex-differentiated minimum standard. For this reason, this regulation permits the same minimum nonforfeiture standard for men and women insureds under the 1980 CSO and 1980 CET Mortality Tables.

A few background comments may be helpful in understanding the intent of this regulation.

(1) No attempt was made to define which policies and situations are covered by the *Norris* decision and which are not. The breadth of the *Norris* decision is unclear and may ultimately have to be resolved by further court decisions or federal legislation.

(2) Insurers are given flexibility to use either:

(a) The existing tables with mortality rates that vary by age and sex; or

(b) Tables of mortality rates which are a blend of the male and female mortality rates.

(3) No change is made in minimum valuation standards, since these do not involve a contractual relationship between the insurer and its policyholder clients and the Supreme Court did not address state statutory valuation standards.

(4) Section 5 is included to make it clear that an insurer that issues the same kind of policy on a sex-distinct basis in some circumstances and on a sex-neutral basis in others shall not be deemed to be in violation of the state unfair discrimination laws.

(5) The effective date is August 1, 1983, the date the judgment in the *Norris* decision became effective.

Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to Section [insert reference to the Standard Nonforfeiture Law for Life Insurance] of the [insert state] Insurance Laws.

Section 2. Purpose

The purpose of the regulation is to permit individual life insurance policies to provide the same cash values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this regulation.

Section 3. Definition

A. As used in this regulation, "1980 CSO Table, with or without Ten-Year Select Mortality Factor" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 National Association of Insurance Commissioners (NAIC) amendments to the model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, With or Without Ten-Year Mortality Factors.

B. As used in this regulation, "1980 CSO Table (M), With or Without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, With or Without Ten-Year Select Mortality Factors.

C. As used in this regulation, "1980 CSO Table (F), With or Without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, With or Without Ten-Year Select Mortality Factors.

D. As used in this regulation, "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC amendments to the model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

E. As used in this regulation, "1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

F. As used in this regulation, "1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

G. As used in this regulation, "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

Section 4. Rule

A. For a policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of Section [insert applicable reference corresponding to Section 5cK of the NAIC model Standard Nonforfeiture Law for Life Insurance] for that policy form, for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits:

(1) A mortality table that is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) With or Without Ten-Year Select Mortality Factors may, at the option of the company, be substituted for the 1980 CSO Table, With or Without Ten-Year Select Mortality Factors; and

(2) A mortality table that is of the same blend as used in Paragraph (1) but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table.

B. The following tables will be considered as the basis for acceptable tables:

(1) 100% Male 0% Female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" tables.

(2) 80% Male 20% Female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" tables.

(3) 60% Male 40% Female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" tables.

(4) 50% Male 50% Female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" tables.

(5) 40% Male 60% Female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" tables.

(6) 20% Male 80% Female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" tables.

(7) 0% Male 100% Female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" tables.

Drafting Note: For blended tables, *see 1984 Proceedings of the NAIC*, Vol. I, pages 396 to 400.

C. Tables (1) and (7) are not to be used with respect to policies issued on or after January 1, 1985 except where the proportion of persons insured is anticipated to be ninety-percent (90%) or more of one sex or the other or except for certain policies converted from group insurance. Group conversions issued on or after January 1, 1986 must use mortality tables based on the blend of lives by sex expected for the policies if the group conversions are considered as extensions of the *Norris* decision. This consideration has not been clearly defined by court or legislative action in all jurisdictions.

Section 4A. Alternate Rule

A. In determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for a policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of Section [insert applicable reference corresponding to Section 5cK of the NAIC model Standard Nonforfeiture Law for Life Insurance] for that policy form, in addition to the mortality tables that may be used according to Section 4, the following may, at the option of the company, be substituted for the 1980 CET Table:

(1) A mortality table that is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, With or Without ten-year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, With or Without Ten-Year Select Mortality Factors; and

(2) A mortality table that is of the same blend as used in Paragraph (1) but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table.

B. The following blended mortality tables will be considered acceptable:

SA: 100% Male 0% Female smoker tables designated as "1980 CSO-SA" and "1980 CET-SA" Tables.

SB: 80% Male 20% Female smoker tables designated as "1980 CSO-SB" and "1980 CET-SB" Tables.

SC: 60% Male 40% Female smoker tables designated as "1980 CSO-SC" and "1980 CET-SC" Tables.

SD: 50% Male 50% Female smoker tables designated as "1980 CSO-SD" and "1980 CET-SD" Tables.

SE: 40% Male 60% Female smoker tables designated as "1980 CSO-SE" and "1980 CET-SE" Tables.

SF: 20% Male 80% Female smoker tables designated as "1980 CSO-SF" and "1980 CET-SF" Tables.

SG: 0% Male 100% Female smoker tables designated as "1980 CSO-SG" and "1980 CET-SG" Tables.

NA: 100% Male 0% Female nonsmoker tables designated as "1980 CSO-NA" and "1980 CET-NA" Tables.

NB: 80% Male 20% Female nonsmoker tables designated as "1980 CSO-NB" and "1980 CET-NB" Tables.

NC: 60% Male 40% Female nonsmoker tables designated as "1980 CSO-NC" and "1980 CET-NC" Tables.

ND: 50% Male 50% Female nonsmoker tables designated as "1980 CSO-ND" and "1980 CET-ND" Tables.

NE: 40% Male 60% Female nonsmoker tables designated as "1980 CSO-NE" and "1980 CET-NE" Tables.

NF: 20% Male 80% Female nonsmoker tables designated as "1980 CSO-NF" and "1980 CET-NF" Tables.

NG: 0% Male 100% Female nonsmoker tables designated as "1980 CSO-NG" and "1980 CET-NG" Tables.

C. Tables SA, SG, NA and NG are not acceptable as blended tables unless the proportion of persons insured is anticipated to be ninety-percent (90%) or more of one sex or the other.

Section 5. Unfair Discrimination

It shall not be a violation of [insert applicable reference to unfair trade practices statute] for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Section 6. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 7. Effective Date

The effective date of this regulation is August 1, 1983 to comply with the *Norris* decision.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1984 Proc. I 6, 31, 376, 395, 416-418 (adopted).
1986 Proc. II 12, 18, 538, 568-570, 646 (amended and reprinted).
1987 Proc. I 11, 19, 531-534, 610 (amended).

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND 1980 CET MORTALITY TABLES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND 1980 CET MORTALITY TABLES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-073 (1984/2003).		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	CODE ARK. R. 054.00.40 (1986/1988).		
California	BULLETIN 85-14 (1985) (adopted by reference).		BULLETIN 88-4 (1988).
Colorado	3 COLO. CODE REGS. § 702-4:4-1-5 (1985/2010).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-439-5 to 38a-439-15 (1985/1988).		
Delaware	18 DEL. CODE REGS. § 1206 (1984/2003).		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.476 (1959/1997).

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND 1980 CET MORTALITY TABLES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	GA. COMP. R. & REGS. 120-2-39-.02 (1987).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITYY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-42.1 to 191-42.6 (1984/2004) (use 2001 CSO Table).		
Kansas	NO CURRENT ACTIVITY		
Kentucky	806 KY. ADMIN. REGS. 12:110 (1984/1987).		
Louisiana	NO CURRENT ACTIVITY		
Maine	CODE ME. R. § 02-031 Ch. 340, Art. III (1984/2004).		
Maryland			MD. CODE REGS. 31.05.03.14 (2004).
Massachusetts	211 MASS. CODE REGS. §§ 32.01 to 32.08 (1985/1996).		
Michigan	MICH. ADMIN. CODE r. 500.1221 to 500.1225 (1985).		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	19 CODE MISS. R. Pt. 2, R. 6.01 to 6.08 (84-103) (1984/1988).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.110 (1985/1988).		

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND 1980 CET MORTALITY TABLES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. ADMIN. R. 6.6.1801 to 6.6.1805 (1983).		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN CODE. §§ 11:4-22.1 to 11:4-22.8 (1984/1996).		
New Mexico	N.M. ADMIN. CODE 13.9.9.1 to 13.9.9.10 (1985/1997).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 47.0 to 47.4 (Regulation 112) (1984/1986).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. ADMIN. CODE 45-04-07 (1985/1989).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-6-10.2 (2008).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-7-10 to 365:10-7-14 (1985/2002).		
Oregon	OR. ADMIN. R. 836-051-0110 (1985) (adopted by reference).		
Pennsylvania	31 PA. CODE § 84.5 (1985/1988).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		

NAIC PROCEDURE FOR PERMITTING SAME MINIMUM NONFORFEITURE STANDARDS FOR MEN AND WOMEN INSURED UNDER 1980 CSO AND 1980 CET MORTALITY TABLES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. REGS. 69-36 (1983/1988).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. COMP. R. & REGS. 0780-1-52-.03 (1985/2004).		
Texas			28 TEX. ADMIN. CODE §§ 3.1301 to 3.1307 (1984/2003).
Utah	UTAH ADMIN. CODE R590-95 (1985/2012).		
Vermont	VT. ADMIN. CODE 4-3-14:C 1 to 4-3-14:C 5 (Reg. 88-4) (1989/1999).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	WASH. ADMIN. CODE 284-74-200 (1988/1989).		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 2.20 (1984/1989).		
Wyoming	NO CURRENT ACTIVITY		

NAIC MODEL RULE (REGULATION) PERMITTING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

Table of Contents

Section 1. Authority

This rule is promulgated by the Commissioner of Insurance pursuant to Section [insert applicable reference to the Standard Nonforfeiture Law for Life Insurance] of the [insert state] Insurance Laws.

Section 2. Purpose

The purpose of the rule is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

Section 3. Definitions

A. As used in this rule, "1980 CSO Table, with or without Ten-Year Select Mortality Factor" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

B. As used in this rule, "1980 CET Table means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

C. As used in this rule, "1958 CSO Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

D. As used in this rule, "1958 CET Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Extended Term Insurance Table.

E. As used in this rule, the phrase "smoker and nonsmoker mortality tables" refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in A through D of this section which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance Department staff and recommended by the NAIC Technical Staff Actuarial Group.

F. As used in this rule, the phrase "composite mortality tables" refers to the mortality tables defined in A through D of this section as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

Note: See 1984 *Proceedings of the NAIC*, Vol. I, pages 402-413 for tables.

Section 4. Alternate Tables

A. For any policy of insurance delivered or issued for delivery in this state after the operative date of Section [insert applicable reference corresponding to 5cK of the NAIC Model Standard Nonforfeiture Law for Life Insurance] for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in Section 5 of this rule,

(1) The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Provided that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six (6) years younger than the actual age of the insured.

Provided further that the substitution of the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

B. For any policy of insurance delivered or issued for delivery in this state after the operative date of Section [insert applicable reference corresponding to 5cK of the NAIC Model Standard Nonforfeiture Law for Life Insurance] for that policy form, at the option of the company and subject to the conditions stated in Section 5 of this rule,

(1) The 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Section 5. Conditions

For each plan of insurance with separate rates for smokers and nonsmokers an insurer may

A. Use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

B. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Section [insert applicable reference corresponding to Section 7 of the NAIC Model Standard Valuation Law] and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

C. Use smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Section 6. Separability

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

Section 7. Effective Date

The effective date of this rule is January 1, 1984.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1984 Proc. I 6, 31, 376, 458-460 (adopted).

NAIC MODEL RULE (REGULATION) PERMITING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

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NAIC MODEL RULE (REGULATION) PERMITING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-075 (1985/2003).		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			CODE ARK. R. 054.00.92-5 (2008).
California	BULLETIN 85-14 (1985) (adopted by reference).		BULLETIN 88-4 (1988).
Colorado	3 COLO. CODE REGS. § 702-4:4-1-6 (1985/2010).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-17 to 38a-78-20 (1992).		
Delaware	18 DEL. CODE REGS. § 1207 (1984/2003).		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.476 (1959/1997).

NAIC MODEL RULE (REGULATION) PERMITING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO ADMIN. CODE 18.07.03.010 (2019).		
Illinois	ILL ADMIN. CODE. tit. 50, § 934 (1985).		
Indiana			760 IND. ADMIN. CODE 1-64-6 (2011).
Iowa	IOWA ADMIN. CODE r. 191-44.1 to 191-44.6 (1987/2004) (use CSO table).		
Kansas	KAN. ADMIN. REGS. § 40-2-17 (1986) (adopted by reference with exceptions).		
Kentucky	806 KY. ADMIN. REGS. 6:060 (1984/2005).		
Louisiana	NO CURRENT ACTIVITY		
Maine	CODE ME. R. § 02-031 Ch. 340, ART. VII (1984/2004).		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	211 MASS. CODE REGS. §§ 32.01 to 32.08 (1985/1996).		
Michigan	MICH. ADMIN. CODE r. 500.1281 to 500.1285 (1986).		
Minnesota	MINN. STAT. § 61A.255 (1984) (adopted by reference).		
Mississippi	19 CODE MISS. R. Pt. 2, R. 7.01 to 7.19 (84-104) (2012).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.120 (1986/1988).		

NAIC MODEL RULE (REGULATION) PERMITING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE §§ 11:4-24.1 to 11:4-24.5 (1985/2001).		BULLETIN 2012-8 (2012).
New Mexico	N.M. CODE R. §§ 13.9.10.1 to 13.9.10.9 (1985/1997).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 57.1 to 57.6 (Regulation 113) (1984/2013).		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	N.D. ADMIN. CODE 45-04-06 (1985).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO. ADMIN. CODE 3901-6-10.1 (2008).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-7-1 to 365:10-7-4 (1985/2002).		
Oregon	OR. ADMIN. R. 836-051-0115 (1985) (adopted by reference).		
Pennsylvania	31 PA. CODE §§ 84.5 to 84.6 (1986/1988).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		

NAIC MODEL RULE (REGULATION) PERMITING SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. REGS. 69-38 (1985).		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. COMP. R. & REGS. 0780-1-52-.02 (1985/2004).		
Texas	28 TEX. ADMIN. CODE §§ 3.1401 to 3.1406 (1984/2003) (use 2001 CSO table).		
Utah	UTAH ADMIN. CODE r. 590-94-1 to 590-94-6 (1985/2008).		
Vermont	VT. ADMIN. CODE 4-3-14:B 1 to 4-3-14:B 5 (1989/1999).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-60-10 to 5-60-60 (1987).		
Washington	WASH. ADMIN. CODE 284-74-100 (1987).		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 2.35 (1988).		
Wyoming	NO CURRENT ACTIVITY		

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated by the Commissioner of Insurance pursuant to Sections [insert applicable references to Section 4A(c) of the Standard Valuation Law and Section 5cH(6) of the Standard Nonforfeiture Law for Life Insurance] of the [insert state] Insurance Laws and Sections [insert applicable references to Sections 5A and 5B of the Valuation of Life Insurance Model Regulation] of the [insert state] Insurance Regulations.

Drafting Note: The reference to the Valuation of Life Insurance Policies Model Regulation should be omitted by states that have not adopted that model.

Section 2. Purpose

The purpose of this regulation is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with [insert applicable references to Section 4A(c) of the Standard Valuation Law and Section 5cH(6) of the Standard Nonforfeiture Law for Life Insurance] of the [insert state] Insurance Laws and Sections [insert applicable references to Sections 5A and 5B of the Valuation of Life Insurance Model Regulation] of the [insert state] Insurance Regulations.

Section 3. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

C. "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

D. "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

E. "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

Section 4. 2001 CSO Mortality Table

A. At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this regulation, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 200[_] [insert January 1 of the year next following or coincident with the effective date of this regulation] and before the date specified in Subsection B to which [insert applicable references to Section 4A(c) of the Standard Valuation Law, Section 5cH(6) of the Standard Nonforfeiture Law for Life Insurance, and Sections 5A and 5B of the Valuation of Life Insurance Policies Model Regulation] are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

B. Subject to the conditions stated in this regulation, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which [insert applicable references to Section 4A(c) of the Standard Valuation Law, Section 5cH(6) of the Standard Nonforfeiture Law for Life Insurance, and Sections 5A and 5B of the Valuation of Life Insurance Policies Model Regulation] are applicable.

Drafting Note: States should note that there is no new Commissioners Extended Term (CET) Table being proposed to replace the 1980 CET Table. Therefore, the new minimum basis for the computation of values related to extended term benefits will be the 2001 CSO Mortality Table.

Section 5. Conditions

A. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Section [insert applicable reference corresponding to Section 8 of the NAIC Model Standard Valuation Law] and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(3) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of Section 6 and [insert applicable reference to the Valuation of Life Insurance Policies Model Regulation] relative to use of the select and ultimate form.

D. When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in Sections [insert applicable references to Section 5A of the Actuarial Opinion and Memorandum Regulation] of the [insert state] Insurance Regulations. A commissioner may exempt a company from this requirement if it only does business in this state and in no other state.

Section 6. Applicability of the 2001 CSO Mortality Table to [insert applicable reference to the Valuation of Life Insurance Policies Model Regulation]

A. The 2001 CSO Mortality Table may be used in applying [insert applicable reference to the Valuation of Life Insurance Policies Model Regulation] in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in Section 4 of this regulation (unless otherwise noted, the references in this section are to the [insert applicable reference to the Valuation of Life Insurance Policies Model Regulation]):

(1) Section 3A(2)(b): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) Section 4B: All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Section 6A(4) of this regulation. The value of "$q_{x+k+t-1}$" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) Section 5A: The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(4) Section 5B: The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in Sections 5B(3)(a) to (i). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant Actuarial Standards of Practice.

(5) Section 6C: The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

(6) Section 6E(4): The calculations specified in Section 6E shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(7) Section 6F(4): The calculations specified in Section 6F shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(8) Section 6G(2): The calculations specified in Section 6G shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(9) Section 7A(1)(b): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

B. Nothing in this section shall be construed to expand the applicability of [insert applicable reference to the Valuation of Life Insurance Policies Model Regulation] to include life insurance policies exempted under Section 3A of [insert applicable reference to the *Valuation of Life Insurance Policies Model Regulation*] (#830).

Drafting Note: This section should be omitted by states that have not adopted the *Valuation of Life Insurance Policies Model Regulation* (#830).

Section 7. Gender-Blended Tables

A. For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 200[_] [insert same date as in Section 4A], that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection of the regulation.

B. The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002.

C. It shall not, in and of itself, be a violation of [insert applicable reference to unfair trade practices statute] for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Section 8. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 9. Effective Date

The effective date of this regulation is [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2002 Proc.3rd Quarter 12, 13, 118, 987, 989-992 (adopted).

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-130 (2004).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.620 to 28.690 (2005/2011).		
American Samoa	NO CURRENT ACTIVITY		
Arizona			BULLETIN 2006-10 (2006); BULLETIN 2008-5 (2008).
Arkansas	Code Ark. R. 054.00.83 (2005).		
California	BULLETIN 2003-5 (2003).		
Colorado	3 COLO. CODE REGS. § 702-4:4-1-10 (2004/2010).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-439-10 to 38a-439-15 (2005).		BULLETIN FS-22-2009 (2009).

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	18 DEL. CODE REGS. § 1213 (2004).		
District of Columbia	D.C. MUN. REGS. tit. 26, § 3005 (2004/2008).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-162.203 (2005/2008).		
Georgia	GA. COMP. R. & REGS. 120-2-90 (2005/2007).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-171-401 to 16-171-405 (2005/2010).		
Idaho	IDAHO ADMIN. CODE r. 59.18.01.59 (2004).		
Illinois	ILL. ADMIN. CODE. tit. 50, §§ 1412.20 to 1412.70 (2004/2008).		
Indiana	760 IND. ADMIN. CODE 1-69 (2004)		
Iowa	IOWA ADMIN. CODE r. 191-91.1 to 191-91.7 (2004/2010).		
Kansas	KAN. ADMIN. REGS. § 40-2-27 (2004) (adopted by reference with exceptions).		
Kentucky	806 KY. ADMIN. REGS. 6:110 (2005).		
Louisiana	LA. ADMIN. CODE tit. 37, XIII, §§10701 to 10717 (2005).		
Maine	02-031 ME. CODE R., ch. 340 (1984/2008).		
Maryland	MD. CODE REGS. 31.05.03.01 to 31.05.03. (2004/2010).		

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts	211 MASS. CODE REGS. 57:01 to 57:08 (2003).		
Michigan	MICH. COMP. LAWS § 500.838 (2004/2014).		
Minnesota	MINN. R. §§ 2748.0010 to 2748.0050 (2004).		
Mississippi	19 CODE MISS. R. Pt. 2, R. 16.01 to 16.08 (2004-1) (2004).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.170 (2004/2009).		
Montana	MONT. CODE ANN. § 33-2-409 (1959/2005).		
Nebraska	210 NEB. ADMIN. CODE § 79 (2004).		
Nevada	NEV. ADMIN. CODE §§ 688A.320 to 688A.363 (2005).		
New Hampshire	N.H. CODE ADMIN. R. INS. 3507.01 to 3507.06 (2004).		
New Jersey	N.J. ADMIN. CODE §§ 11:4-27.1 to 11:4-27.8 (2004/2007).		BULLETIN 2012-8 (2012).
New Mexico	N.M. CODE R. §§ 13.9.16.1 to 13.9.16.11 (2004).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 100.1 to 100.13 (Regulation 179) (2004/2014).		
North Carolina	11 N.C. ADMIN. CODE 11F.0601 to 11F.0606 (2004/2008).		
North Dakota	N.D. ADMIN. CODE 45-04-07.1 (2004).		

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-6-11 (2004/2006).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-21-1 to 365:10-21-9 (2003).		
Oregon	OR. ADMIN. R. 836-051-0106 (2004/2011).		
Pennsylvania	31 PA. CODE §§ 84d.1 to 84d.6 (2004/2006).		NOTICE 12-2-2006 (# 2) (2006).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-25-2.1 to 20-25-2.6 (2007).		
South Carolina	S.C. CODE ANN. REGS. 69-57.1 (2006).		
South Dakota	S.D. ADMIN. R. 20:06:08:44 to 20:06:08:46 (2004).		
Tennessee	TENN. COMP. R. & REGS. 0780-1-52-.04 (2004).		
Texas	28 TEX. ADMIN. CODE §§ 3.9101 to 3.9106 (2003).		
Utah	UTAH ADMIN. CODE R590-241 (2003/2013).		
Vermont	4-3 VT. CODE R. § 48 (2005).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-321-10 to 5-321-70 (2004/2009); §§ 5-322-10 to 5-322-50 (2007/2015) (portions of model).		

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Washington	WASH. ADMIN. CODE §§ 284-74-400 to 284-74-460 (2004).		
West Virginia	W. VA. CODE R. §§ 114-69-1 to 114-69-7 (2004/2005).		
Wisconsin	WIS. ADMIN. CODE INS. § 2.81 (2005/2010).		
Wyoming	WY. RULES AND REGS. 044.0002.59 (2010).		

PROJECT HISTORY – 2002

RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS MODEL REGULATION (#814)

1. What issues was the project intended to address?

Over the last four years, the Life and Health Actuarial Task Force has worked with the American Academy of Actuaries and the Society of Actuaries in the development of the 2001 Commissioners Standard Ordinary Mortality Table. The table will replace the 1980 CSO table as the minimum standard in the calculation of reserves and nonforfeiture values for life insurance policies. The purpose in developing the model is to provide states the regulatory language to implement the new table.

2. What states participated in drafting the model?

The following states are currently members of the Life and Health Actuarial Task Force: New Mexico (Chair), Arkansas (Vice-Chair), California, Connecticut, Florida, Illinois, Minnesota, Nebraska, New York, Oklahoma, Pennsylvania, Texas, Utah, and Washington.

3. When was the charge given to the task force, and what was the nature of the charge?

The following charge was formally given to the task force in 1999: "Work with the Society of Actuaries in the development of new mortality, annuity, and accidental death benefit mortality tables." Work on a new mortality table was given top priority. Also, the American Academy of Actuaries was a very significant participant in the project.

4. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?

The efforts of the task force were closely coordinated with all industry interested parties, with respect to the development of both the table and the model. In addition to open sessions at the quarterly meetings of the NAIC, numerous conference calls were held over the last several years to discuss the various drafts of the documents. Notice of those conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 200 interested parties, including representatives of the American Council of Life Insurers, the National Alliance of Life Companies, and the National Fraternal Congress of America.

This excerpt from the final report of the American Academy of Actuaries' Commissioner Standard Ordinary Task Force provides additional information on the process by which the table was developed. During this process there were extensive communications between the Society and Academy committees and the task force. All facets of the table were thoroughly reviewed with the task force prior to its completion.

> The current statutory valuation standard, the 1980 CSO Table, is more than 20 years old. As is shown in this report, current mortality levels, represented by the 2001 Valuation Basic Table, are lower than the mortality levels underlying the 1980 CSO Table. The current valuation mortality standard produces reserves, excluding deficiency reserves, that overall are higher for the illustrated model office than those produced by the proposed 2001 CSO Table.
>
> At the request of the LHATF, both the SOA and the Academy have worked to develop a proposed mortality table intended to replace the 1980 CSO Table in the current statutory valuation structure. While the Academy's Life Practice Council believes that a move to a valuation system that provides more actuarial flexibility and responsibility to set reserves that reflect individual company characteristics is desirable, we recognize that a new table is appropriate.
>
> The SOA and the Academy divided this work into two pieces: the construction of a valuation basic experience table, and the development of an appropriately loaded valuation table. The first part of this work was completed by the SOA's Individual Life Insurance Valuation Mortality Research Task Force (SOA Task Force). This group developed the 2001 VBT, a graduated experience table suitable for use as the basis for a valuation table. The second part was done by the Academy Task Force, which, with guidance and direction from the LHATF, developed the loads and reviewed the resulting reserves described in this report.

These two groups have developed the proposed 2001 CSO Table—a table that is appropriate as a replacement for the 1980 CSO Table. This proposed 2001 CSO Table is shown in Appendix A. Separate nonsmoker, smoker, and composite nonsmoker/smoker tables were developed for males and females for a total of six tables. Each table has values for a 25-year select period and for ultimate ages.

The proposed 2001 CSO Table is intended to provide a minimum standard for the valuation of standard ordinary life insurance. However, this standard may not produce adequate reserves in all cases. In addition, since the table is intended only for valuation, the use of this table may not be appropriate for pricing or for other pricing related purposes.

5. What significant issues were raised during the drafting process, and how were those issues resolved?

The process by which the table was developed is reviewed in Item #4. The following are three key issues that were addressed in developing the model:

A) Should a higher mortality standard than the table be used for certain types of business?

The following types of business were not included in the experience studies used to develop the table: guaranteed issue, simplified issue, substandard, ETI, and reduced paid up. Concerns were expressed that the table might not be adequate to cover the mortality levels typically exhibited by these types of business. Some consideration was given to requiring the use of either the 1980 CSO Table or some multiple of the 2001 CSO Table in the valuation of these products. Ultimately, these approaches were not incorporated into the model, primarily due to a) differences among companies as to what is regarded as "guaranteed issue," "simplified issue," and "substandard," and b) uncertainties regarding the tax consequences. Instead, the following provision was included in the model to provide additional assurance of adequate reserves:

> When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in Sections [insert applicable references to Section 5A of the Actuarial Opinion and Memorandum Regulation] of the [insert state] Insurance Regulations. A commissioner may exempt a company from this requirement if it only does business in this state and in no other state.

B) Should different mortality standards be permitted in the calculation of basic and deficiency reserves?

As codified in The Valuation of Life Insurance Policies Model Regulation ("XXX"), actuaries are currently permitted to use different mortality bases in the calculation of basic and deficiency reserves. Often, basic reserves are calculated using ultimate mortality, while deficiency reserves incorporate select mortality modified by "X-factors." Concerns were raised regarding the actuarial appropriateness of this practice, and some suggestions were made that the model prohibits this. In particular, this excerpt from the 1981 *Transactions of the Society of Actuaries* (Volume XXXIII) on the development of the 1980 CSO Table appears to support the use of a single mortality basis:

> It was originally indicated that the committee would develop only ultimate tables. However, because of the growing concern over deficiency reserve problems for certain plans of life insurance, Ten-Year Selection Factors have been developed and endorsed by the NAIC. These factors are for use in conjunction with 1980 CSO Tables as an alternative minimum standard for both valuation and deficiency reserves on a plan-by-plan basis. Companies would have the option of using 1980 CSO rates or applying selection factors to 1980 CSO rates. The basis chosen for a particular plan should be used to value both the basic life insurance reserve and the deficiency reserves.

In drafting the final version of the model, the task force decided to leave the approach codified in XXX unchanged. The view of the members is that it would be too disruptive of the long-standing actuarial practice to implement such a significant change. However, it should be noted that one component of achieving this consensus was the assurance that a provision requiring asset adequacy testing would be included in the model (that provision is shown in Item "A" above).

C) Should limitations be place on the use of gender-blended mortality tables for nonforfeiture purposes?

Use of gender-blended mortality tables in computing nonforfeiture values is currently authorized in the "NAIC Procedure for Permitting Same Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables." That model gives insurers a great deal of latitude in deciding when to use gender blended tables, as described in this excerpt from that model:

> (1) No attempt was made to define which policies and situations are covered by the *Norris* decision and which are not. The breadth of the *Norris* decision is unclear and may ultimately have to be resolved by further court decisions or federal legislation.
>
> (2) Insurers are given flexibility to use either:
> (a) The existing tables with mortality rates that vary by age and sex; or
> (b) Tables of mortality rates, which are a blend of the male and female mortality rates.

Some task force members raised concerns that this language is so broad that gender-blended tables can be used in situations that are clearly beyond the scope of the decision in *Arizona Governing Committee v. Norris.* In response to those concerns, the task force included language in the model that describes the general circumstances in which gender-blended tables may be used (underline added):

> For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 200[_] [insert same date as in Section 4A], <u>that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender</u>, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

6. What are the implications of this project for accreditation and codification?

The task force notes that the 2001 CSO Table represents a significant new mortality standard, which should be reviewed by the accreditation and codification committees.

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

Table of Contents

Section 1. Authority

This regulation is promulgated by the Commissioner of Insurance pursuant to Sections [insert applicable references to Section 4A(c) of the Standard Valuation Law and Sections [insert applicable references to Sections 5A and 5B of the Valuation of Life Insurance Model Regulation] of the [insert state] Insurance Regulations.

Drafting Note: The reference to the Valuation of Life Insurance Policies Model Regulation should be omitted by states that have not adopted that model.

Section 2. Purpose

The purpose of this regulation is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with [insert applicable references to Section 4A(c) of the Standard Valuation Law and Sections [insert applicable references to Sections 5A and 5B of the Valuation of Life Insurance Model Regulation] of the [insert state] Insurance Regulations.

Section 3. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)* and supplemented by the 2001 CSO Preferred Class Structure Mortality Table defined below in Subsection B. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2001 CSO Mortality Table include the following:

(1) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(2) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(3) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(4) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

B. "2001 CSO Preferred Class Structure Mortality Table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2001 CSO Nonsmoker and Smoker Tables, as adopted by the NAIC at the September, 2006 national meeting and published in the *NAIC Proceedings {3rd Quarter 2006}*. Unless the context indicates otherwise, the "2001 CSO Preferred Class Structure Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

C. "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information; demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers; and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

Section 4. 2001 CSO Preferred Class Structure Table

At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this regulation, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. For policies issued on or after [insert the effective date of adoption of the NAIC Model Regulation 814, Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits], and prior to January 1, 2007, these tables may be substituted with the consent of the commissioner and subject to the conditions of Section 5. In determining such consent, the commissioner may rely on the consent of the commissioner of the company's state of domicile. No such election shall be made until the company demonstrates at least 20% of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this rule, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of the NAIC model regulation, "Recognition of the 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits Model Regulation."

Section 5. Conditions

A. For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

B. For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

C. Unless exempted by the commissioner, every authorized insurer using the 2001 CSO Preferred Class Structure Table shall annually file with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports shall be established by the commissioner or the commissioner may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the commissioner.

D. The use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued prior to January 1, 2007 shall not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds, by more than the amount specified in this paragraph as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that (a) provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date, and (b) would be refunded to the ceding entity upon the termination of the policy.

(2) In cases where the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this paragraph as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

For purposes of this condition, the reserve (i) for the mean reserve method shall be defined as the mean reserve minus the deferred premium asset, and (ii) for the mid-terminal reserve method shall include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2001 CSO Preferred Class Structure Table.

Section 6. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 7. Effective Date

The effective date of this regulation is January 1, 2007.

Chronological Summary of Actions (All references are to NAIC Proceedings)

2006 Proc. 3rd Quarter 34, 2338-2342, 2662-2663, 2665, 2666, 2682 (adopted by Plenary).
2009 Proc. 3rd Quarter, Vol. I, 95-96, 114-117, 178-181, 315 (amended).

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-139-.01 to 482-1-139-.07 (2007/2010).		
Alaska			ALASKA ADMIN. CODE tit. 3 § 28.635 (2008/2010) (applicability of the 2001 CSO Mortality Tables).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas		054.00.92 ARK CODE R. §§ 1 to 7 (2008).	
California		CAL. CODE REGS. tit. 92, §§ 1 to 7 (2008).	BULLETIN 2009-2 (2009).
Colorado	3 COLO. CODE REGS. § 4-1-13 (2007/2010).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-33 to 38a-33-34 (2010).		
Delaware	18 DEL. CODE REGS. §§ 1200 to 1215 (2007/2009).		

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. Mun. Regs. tit. 26 § 3005 (2000/2008).
Florida	FLA. ADMIN. CODE ANN. r. 69O-162.203 (2011/2012).		
Georgia		GA. COMP. R. & REGS 120-2-90-.01 to 120-2-90-.08 (2007).	
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. 16-171-401 to 16-171-405 (2008/2012).		MEMORANDUM 2009-2 (2009).
Idaho		IDAHO ADMIN. CODE r. 18.01.79.000 to 18.01.79.012 (2007/2008).	BULLETIN 2008-4 (2008).
Illinois			ILL. ADMIN. CODE tit. 50, § 1412 (2018).
Indiana	760 IND. ADMIN. CODE 1-69-1 to 1-69-6 (2007/2010).		
Iowa	IOWA ADMIN. CODE r. 191-191-94.1 to 191-191-94.5 (2007/2010).		
Kansas	NO CURRENT ACTIVITY		
Kentucky		806 KY. ADMIN. REGS 6:120 (2007).	
Louisiana		LA. ADMIN. CODE tit. 37, §§ 11901 to 11913 (2007).	
Maine			02-031-340 ME. CODE R. § Art. VII (1984/2014).
Maryland	MD. CODE REGS. 31.05.03.15 (2007/2010).		
Massachusetts	211 MASS. CODE REGS. 58.01 to 58.06 (2006/2010).		

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	MICH. COMP. LAWS ANN. § 500.838a (2014).		
Minnesota	MINN. STAT. ANN. § 61A.257 (2007/2010).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.170 (2008/2011).		
Montana		MONT. ADMIN. R. 6.6.7101 to 6.6.7109 (2008).	
Nebraska	210 NEB. ADMIN. CODE §§ 84-001 to 84-007 (2008/2009).		NOTICE 7-9-2009 (2009).
Nevada	NO CURRENT ACTIVITY		NEV. ADMIN. CODE § 688A.327 92008/2016).
New Hampshire	N.H. CODE R. INS. 3508.01 to 3508.04 (2007/2015).		N.H. CODE R. INS. 307.01 to 307.06 (1985/2009).
New Jersey		N.J. ADMIN. CODE §§ 11:4-27A.1 to 4-27A.6 (2008).	§§ 13:36-11.1 to 13:36-11.3 (2012).
New Mexico	N.M. CODE R. §§ 13.9.18.1 to 13.9.18.9 (2007/2018).		
New York	NO CURRENT ACTIVITY		N.Y. COMP. CODES R. & REG. tit. 11 § 100.10 (2007/2017).
North Carolina		11 N.C. ADMIN. CODE §§ 11F.0801 (2007).	
North Dakota		N.D. ADMIN. CODE 45-04-07.2-01 to 45-04-07-03 (2008).	
Northern Marianas	NO CURRENT ACTIVITY		
Ohio		OHIO ADMIN. CODE 3901-6-12 (2009).	

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-25-1 to 365:10-25-7 (2007/2009).		
Oregon	OR. ADMIN. R. 836-031-0800 to 836-031-0815 (2007/2011).		
Pennsylvania	31 PA. CODE § 84d.3a (2007/2011).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina		S.C. CODE ANN. REGS. 69-57.2 (2007).	
South Dakota		S.D. ADMIN. R. 20:06:51:01 to 20:06:51:05 (2007/2008).	
Tennessee			TENN. COMP. R. 7 REG. 0780-01-52-.04 (1985/2003).
Texas	28 TEX. ADMIN. CODE §§ 3.9401 to 3.9404 (2007/2010).		
Utah		UTAH ADMIN. CODE r. 590-241-1 to 590-241-6 (2007).	
Vermont		I-2007 VT. CODE R. § 3 (2007).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 114-69A-1 to 114-69A-5 (2007/2011).		
Washington		WASH. ADMIN. CODE 284-74-470 to 284-74-500 (2007).	
West Virginia	W. VA. CODE R. §§ 114-69A-1 to 114-69A-4 (2008/2011).		

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2009

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES (#815)

1. Description of the Project, Issues Addressed, etc.

The project was to allow the 2001 CSO preferred mortality tables to be used with contracts based on the 2001 CSO and issued prior to January 1, 2007, with commissioner approval.

The proposed model regulation was expanded to include the use of 1980 CSO for determining minimum nonforfeiture benefits in addition to valuing reserves.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2009 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The initial charge was given to the Task Force in November 2008, by the Capital and Surplus Relief (EX) Working Group to consider the proposal from the American Council of Life Insurers. The proposal was rejected by the Executive Committee in January 2009. At the 2009 Commissioner Conference the Task Force was again charged with reviewing the proposal.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The initial drafts were provided by the American Council of Life Insurers. A subgroup of the Task Force made changes and made a recommendation to the Task Force. The Task Force made several modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at public conference calls on this topic on the following dates: March 27, 2009; March 31, 2009; April 7, 2009; April 14, 2009; April 21, 2009; and April 28, 2009. The Task Force held a public conference call on this topic on May 4, 2009. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment on December 23, 2008, and May 4, 2009. Several memos and letters were submitted to the Task Force relative to this project. Most urged not including the deferred premium asset in the model regulation. Due to the urgency of the situation addressed by the proposed model regulation and with encouragement from interested parties, the Task Force voted unanimously to adopt the model regulation with amendments on June 3, 2009, without an additional 30-day exposure period.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Issue #1 – Does the item provide relief without compromising regulatory objectives**;** the Task Force decided reserves for certain policies issued on a preferred basis may be overly conservative and that the reserves calculated under the 2001 CSO preferred mortality tables are adequate (assuming appropriate use of the tables) and therefore that this action may not compromise regulatory objectives.

Issue #2 – Accounting Treatment of the Reinsurance Deferred Premium Asset. Although the reserves for certain policies may be overly conservative, the Task Force decided some companies may already be addressing the overly conservative reserves through a questionable reinsurance accounting practice. For these companies, it would be ill-advised to allow them to further reduce reserves.

7. Any Other Important Information (e.g., amending an accreditation standard).

Although the Task Force adopted the model regulation without an additional 30-day exposure period for the revised transition rules, the model regulation is exposed for comment while awaiting action from the "A" Committee with comments forwarded to the "A" Committee staff support. The proposed model regulation is expected to have 30 days of exposure before being presented to the NAIC Executive and Plenary.

PROJECT HISTORY - 2006

MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR THE USE IN DETERMINING MINIMUM RESERVE LIABILITIES (#815)

Project Description

The proposed model regulation is connected with amendments to Actuarial Guideline XXXVIII (AG 38). The proposed changes in AG 38 benefited companies that wrote certain types of whole life policies. The proposed model regulation was intended to maintain the balance between whole life and term life insurance.

AG 38 was adopted by the NAIC in 2002 to address questions that arose regarding the appropriate application of the Valuation of Life Insurance Policies Model Regulation (often referred to as "XXX"). Section 8B was a temporary interpretation applicable to certain universal life policies issued between July 1, 2005, and March 31, 2007. These policies contained guarantees that the coverage would remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement. The drafting note of this section states:

> The "sunset" on April 1, 2007, creates a sense of urgency that will drive all concerned to work towards the quick development of a "principles-based" valuation methodology or, as an interim step while continuing to work on such methodology, to adopt a more readily achievable solution that provides relief from overly conservative reserve levels such as a change to valuation mortality requirements.

Although the Life and Health Actuarial Task Force (LHATF) has continued to work towards the quick development of a "principles-based" valuation methodology, such a methodology could not be developed and effective prior to the sunset. There was a need for an interim solution. On November 11, 2005, the American Council of Life Insurers (ACLI) submitted a letter to LHATF proposing an interim solution, which included amendments to AG 38 and a model regulation that would permit the use of preferred mortality tables based on a split of the 2001 Commissioners Standard Ordinary Mortality Table (2001 CSO). On December 1, 2005, the ACLI formally presented its proposal to LHATF at the National Meeting.

Group Responsible for Drafting Model and States Participating

The ACLI prepared and presented the draft of the revision to the Actuarial Guideline.

The 2006 members of the Task Force are: New Mexico (Chair), Kansas (Vice-Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Kentucky, Minnesota, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Texas, and Utah.

General Description of Drafting Process

The Task Force discussed the matter at public hearings during the National Meetings in December 2005, March 2006 and June 2006. In addition, the Task Force held public conference calls on this topic on the following dates: February 3, 2006; April 27, 2006; July 10, 2006; August 2, 2006; August 4, 2006; and August 29, 2006. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties, including representatives of the ACLI. Several dozen memos and letters were submitted to the Task Force relative to this project.

Significant Issues Raised

The following issues were raised relative to the proposed model regulation.

Question #1: Should the NAIC adoption a mortality table not produced by the Society of Actuaries?

Historically, the Society of Actuaries (SOA) has produced mortality tables and these tables were reviewed and modified by the American Academy of Actuaries (AAA), which provided public policy recommendations on the use of the tables. Industry had developed a split in the 1980 CSO Mortality table between smokers and non-smokers. This split was reviewed and adopted by the SOA and the AAA.

LHATF charged the SOA with reviewing the methodology used in developing the proposed split of the 2001 CSO. The SOA reviewed the method of construction of the split tables and reported that the method used was appropriate.

Question #2: Does the proposed model regulation provide sufficient guidance on the use of preferred and residual tables?

Some members and interested parties expressed concern that the proposed regulation allows the company's actuary to assign the table based on expected future experience without any guidance on how underwriting classes would be established. Some of the concerns included the use (possibly inadvertent) of proxies for race, economic status, or other inappropriate underwriting criteria. LHATF charged the AAA with reviewing the split for the appropriateness of its intended use as stated in the proposed model regulation. The AAA reviewed the split of the table for appropriateness for use as preferred and residual classes and determined that the tables could be appropriately used for these classes if proper guidance was provided on determining the appropriate table to use. The ACLI prepared a proposed actuarial guideline to provide guidance on the use of the preferred and residual tables. This actuarial guideline is being considered by LHATF, and a version of it is expected to be adopted by LHATF within a few months.

Question #3: Is it appropriate to adopt a new mortality table when the AAA is expected to present a new table within a year?

The AAA is expected to produce a new set of mortality tables in March 2007. The new tables are intended to be the starting tables for principles-based reserves. Industry expressed concerns that the effective date of principles-based reserves is unknown, and the use of a new table will present tax problems and require the filing of new policy forms.

Question #4: Should the adoption of the proposed amendments to AG 38 and the proposed model regulation be considered together or separately?

The ACLI had presented the two proposed documents together as a compromise between whole life and term life insurers, which would maintain balance. They stated that if only one of the documents were to be adopted, it would create an imbalance in the industry and requested that the two documents be considered as one packaged proposal. Some members wanted to vote on the two proposals separately. By a vote of 11 to 4, with 3 abstentions, LHATF decided to consider the two proposals as an integrated package.

Question #5: Should regulators monitor the experience from the use of the split of the 2001 CSO?

The proposed regulation is a movement towards principles-based reserves. It allows the company some discretion on which mortality table to use in establishing reserves. New York requested that a provision be added to the proposed model regulation, which would require companies to report their emerging experience to a statistical agent for regulatory review. The Task Force amended the model regulation to include this requirement.

Question #6: Are the minimum reserves established by the proposed model regulation sufficient?

The ACLI provided a number of examples compiled by a major consulting firm to help address the issue of sufficiency of reserves. The Task Force determined that with an actuarial guideline to provide direction on the appropriate use of the split of the 2001 CSO, the provisions of the model regulation addressing the use of overly optimistic assumptions, and an ability to monitor emerging experience, the reserves under the model regulation would be sufficient and could be monitored to verify future sufficiency.

Other Pertinent Information Relative to the Proposed Model Regulation Adopted on August 29, 2006

The Task Force's voted on August 29, 2006, to adopt the revisions to AG 38 by a vote of 12 "Yes," and 3 "No" with 4 members abstaining or not voting. The differing opinions among the Task Force members are described in the previous section.

Voting for the motion were Alabama, Arkansas, Connecticut, Kentucky, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Texas and Utah.

Opposing the motion were California, Florida and Minnesota

Abstaining were Alaska, Kansas and South Carolina. New Mexico, in its position as chair, did not vote.

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to section [insert applicable reference to the Standard Valuation Law] of the [insert State] Insurance Statute.

Section 2. Scope

This rule applies to preneed insurance contracts, as defined in section 4 of this regulation, and to similar policies and certificates.

Drafting Note: The definition of preneed insurance is not well defined. The definition in this model regulation is based on policies used in the study that determined the 2001 CSO was inappropriate for determining reserves for policies used to fund funeral services and expenses. The commissioner shall have the authority to determine what constitutes similar policies and certificates.

Section 3. Purpose

The purpose of this regulation is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products.

Drafting Note: Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death.

Section 4. Definitions

A. The term "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. The term "Ultimate 1980 CSO" means the Commissioners' 1980 Standard Ordinary Life Valuation Mortality Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

C. For the purposes of this regulation, preneed insurance is any life insurance policy or certificate that is issued in combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods and services to be provided at the time of and immediately following the death of the insured. Goods and services may include, but are not limited to embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone, and transportation of the deceased. The status of the policy or contract as preneed insurance is determined at the time of issue in accordance with the policy form filing.

Drafting Note: Many States already have a definition of preneed insurance, or preneed contract. Some might also be called prearrangement contract or prearrangement insurance; however, not all States have a definition for this type of insurance. We tried to specifically define what preneed insurance was for this legislation. It was not intended to redefine something already defined, only to clarify what insurance contracts and certificates would be subject to this regulation.

If a State already has a definition of preneed insurance and wants to incorporate that definition, then the State may insert the following as section 4C:

[C. The term "preneed insurance" shall include within its meaning life insurance as defined in [insert applicable reference to definition] of the [insert state] Insurance Statute.]

If existing definitions are not sufficiently precise to define preneed life insurance, below are some examples of definitions used by States that have already promulgated a definition for preneed insurance. States may incorporate some or all, in whole or in part, of the following definition(s) into this regulation:

[C. The term "preneed insurance" shall include within its meaning a life insurance policy, annuity contract, or other insurance contract issued by an insurance company which, whether by assignment or otherwise, has for a purpose, the funding of a preneed funeral contract or an insurance-funded funeral or burial agreement, the insured or annuitant being the person for whose service the funds were paid.] Used by North Carolina - Statute 90-210.60(4).

[C. The term "preneed insurance" shall include within its meaning any agreement or contract whether funded by trust deposits or life insurance policies or annuities, which has for a purpose the furnishing or performance of funeral services or the furnishing or delivery of any personal property, merchandise, or services of any nature in connection with the final disposition of a dead human body.] Used by Illinois - Statute 215 ILCS 45/1.

[C. The term "preneed insurance" shall include within its meaning any written contract, agreement, or mutual understanding, any series or combination of contracts, agreements, or mutual understandings, or any security or other instrument which is convertible into a contract, agreement, or mutual understanding whereby it is agreed that, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or services shall be provided or performed in connection with the final disposition of the preneed contract beneficiary's body. Consideration for a preneed contract is funds or the assignment of life insurance benefits.] Used by Colorado - Statute 10-15-102(13)(a).

Section 5. Minimum Valuation Mortality Standards

For preneed insurance contracts, as defined in section 4C, and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

Section 6. Minimum Valuation Interest Rate Standards

A. The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in [insert applicable reference of the Standard Valuation Law].

B. The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in [insert applicable reference to the Standard Nonforfeiture Law].

Drafting Note: Section 6 may not be appropriate or necessary for some States because specific language in their versions of the Standard Valuation Law or the Standard Nonforfeiture Law or their specific statutes.

Section 7. Minimum Valuation Method Standards

A. The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in [insert applicable reference of the Standard Valuation Law].

B. The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in [insert applicable reference to the Standard Nonforfeiture Law].

Drafting Note: Section 7 may not be appropriate or necessary for some States because specific language in their versions of the Standard Valuation Law or the Standard Nonforfeiture Law or their specific statutes.

Section 8. Transition Rules

A. For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

B. If an insurer elects to use the 2001 CSO as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

(1) A complete list of all preneed policy forms that use the 2001 CSO as a minimum standard;

(2) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed policies issued after the effective date and using the 2001 CSO as a minimum standard, develops adequate reserves (For the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies.); and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO as a minimum standard for reserves.

C. Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

Drafting Note: Section 8 provides a transition period for policy forms that use the 2001 CSO mortality as the minimum standard for nonforfeiture and reserves. It also contains provisions for demonstrating appropriate reserves are established for the policies issued using the 2001 CSO tables during the transition period. The intent of this section is to not create a burden for those companies whose current products use the 2001 CSO tables. It provides those companies time to file policy forms with the 1980 CSO tables as the minimum standard and have them reviewed and approved by the State regulatory departments.

Section 9. Effective Date

This rule is applicable to preneed insurance policies and certificates and similar contracts and certificates, as specified in section 2, issued on or after January 1, 2009.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2008 Proc. 1st Quarter 14-415, 14-418 to 14-419, 14-420 to 14-423, 14-501 to 14-503 (adopted)

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-143-.01 to 482-1-143-.10 (2008).		
Alaska	ALASKA ADMIN. CODE tit. 3, § 28.620 (2008) (incorporates model by reference).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE R. 054.00.95 (2009).		
California	BULLETIN 2008-2 (2008) (adopted by reference).		CAL. CODE REGS. tit. 16, §§ 1261 to 1277.5 (2011).
Colorado	3 COLO. CODE REGS. 702-4:4-1-15 (2009/2014).		BULLETIN B-2.9 (2010).
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-36 to 38a-78-44 (2009).		
Delaware	NO CURRENT ACTIVITY		

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-164.040 (2009).		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1414.10 to 1414.50 (2008).		
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-95.1 to 191-95.9 (2008).		IOWA CODE § 523A.204 (2001/2009).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	MD. CODE REGS. 31.05.03.05 (2008/2009).		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	BULLETIN 2008-17-INS (2008) (incorporates model by reference).		
Minnesota	MINN. STAT. ANN. § 61A.258 (2009/2013).		
Mississippi	NO CURRENT ACTIVITY		

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.175 (2008).		
Montana	NO CURRENT ACTIVITY		
Nebraska	NEB. ADMIN. R. & REGS. Tit. 210, Ch. 83 (2008).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 3509 (2008).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	N.M. ADMIN. CODE §§ 13.9.19.1 to 13.9.19.11 (2009).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 102.1 to 102.5 (2008/2009).		
North Carolina	11 N.C. ADMIN. CODE 11F.0606 (2008) (portions of model)		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-6-15 (2009).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-27-1 to 365:10-27-7 (2008/2009).		
Oregon	OR. ADMIN. R. 836-051-0750 to 836-051-0775 (2008).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. REGS. 69-57.3 (2008/2009).		BULLETIN 7-2009 (2009).

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. COMP. R. & REGS. 0780-1-52-.05 to 0780-1-52-.07 (2009).		
Texas	NO CURRENT ACTIVITY		
Utah	UTAH ADMIN. CODE R590-251-1 to R590-251-9 (2008/2013).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE 5-323-10 to 5-323-70 (2008).		
Washington	NO CURRENT ACTIVITY		
West Virginia	W. VA. CODE R. §§ 114-86-1 to 114-86-6 (2009).		
Wisconsin	BULLETIN 1-6-2009 (2009) (incorporates model by reference).		
Wyoming	WYO. ADMIN. CODE 044.0002.61 (2008).		

PROJECT HISTORY - 2008

PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES MODEL REGULATION (#817)

1. Description of the Project, Issues Addressed, etc.

Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death. The 1980 CSO Mortality Table was determined to produce adequate reserves for these policies and contracts.

Conversion to the 2001 CSO is mandatory on January 1, 2009, unless the regulation is adopted.

A few companies had already converted to the 2001 CSO and requested a transition period.

The proposed model regulation was expanded to include the use of 1980 CSO for determining minimum nonforfeiture benefits in addition to valuing reserves.

2. Name of Group Responsible for Drafting the Model and States Participating

The Michael Villa (Homesteaders Life) worked on the Society of Actuaries group studying the preneed issue and prepared the initial draft of the model regulation.

The 2008 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Kentucky, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas, Utah and Vermont.

3. Project Authorized by What Charge and Date First Given to the Group

The Task Force had the following applicable charges during the time the model regulation was being considered:

2007 – Work on implementation of tables necessary for use in current valuation requirements
2007 – Study the feasibility of developing new valuation and nonforfeiture mortality tables for preneed life insurance.
2008 – Work on implementation of tables necessary for use in current valuation requirements.
2008 – Review and make recommendations on rules for appropriate reserve mortality tables for simplified issue and guaranteed issue forms of life insurance. Review and recommend, if appropriate, a revised structure for regulating these forms of life insurance to establish it as a class distinct from industrial and ordinary lines.

The implementation charge is a standing charge to the Task Force and the date of origination is unknown.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Michael Villa (Homesteader's Life) presented the initial draft of the proposed model regulation following the Society of Actuaries report of the status of the preneed mortality study. The study revealed that mortality on the 2001 CSO is significantly understated in the first few years of preneed insurance. The Task Force obtained permission to work on mortality table issues from the Executive Committee, including the drafting of proposed model regulations at the Summer 2007 National Meeting. Several proposed amendments to the proposed model regulation were submitted and considered by the Task Force.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Task Force discussed the matter at public hearings during the National Meetings in June and September 2007. In addition, the Task Force held public conference calls on this topic on the following dates: August 15, 2007; November 6, 2007; and February 7, 2008. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment on June 1, 2007; August 15, 2007; and January 8, 2008. Several memos and letters were submitted to the Task Force relative to this project. Most urged rapid adoption and a transition period. Due to the urgency of the situation addressed by the proposed model regulation and with encouragement from interested parties, the Task Force voted unanimously to adopt the model regulation with amendments on February 7, 2008, without an additional 30-day exposure period. The substantive amendments to the draft released for comment on January 8, 2008, were related to the issue of a transition period. They were the result of a compromise agreed to by regulators and interested parties. Interested parties expressed support of the amendments only if an additional 30-day exposure period was not required. The subject of the transition period was identified on the January 8, 2008, document as the topic of upcoming discussion, so any party interested in commenting on the transition rules could have participated in the amendment consideration discussion.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Issue #1 – Definition of "preneed" insurance. Preneed insurance is not well-defined. The study included policies and contracts used to fund funeral services and expenses. The issue of including limited underwriting and guaranteed issue policies was discussed. The ACLI requested that the regulation be limited to policies and contract used to fund funeral services and expenses. The Task Force decided the definition of preneed insurance could be determined by the State and offered several options for this definition. Additionally, the regulation included "similar policies and contracts", which allows the commissioner to determine if limited underwriting and guaranteed issue policies are to use the 1980 CSO.

Issue #2 – Transition Period. Several companies had already converted to the 2001 CSO, as required by Model Regulation No. 814, which in Section 4B requires the 2001 CSO be used for all ordinary life insurance issued on or after January 1, 2009. Transition rules were established to allow companies to use the 2001 CSO until January 1, 2012, provided adequate reserves are established and a stand-alone asset adequacy study is provided to the commissioner to demonstrate the adequacy of reserves.

Issue #3 – Urgency. Due to the urgency of making this change, interested parties proposed changes that were substantive but indicated the need to adopt the model regulation quickly was more important than the changes proposed. Although the transition period was amended at the time the Task Force adopted the proposed model regulation, the Task Force voted unanimously to forward the model regulation without an additional 30-day exposure period. Interested parties voiced support of this and no objections to the action were expressed.

7. Any Other Important Information (e.g., amending an accreditation standard).

Although the Task Force adopted the model regulation without an additional 30-day exposure period for the revised transition rules, the model regulation is exposed for comment while awaiting action from the "A" Committee with comments forwarded to the "A" Committee staff support. The proposed model regulation is expected to have 30 days of exposure before being presented to the NAIC Executive and Plenary.

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

Table of Contents

Section 1. Authority

This rule is promulgated by the Commissioner of Insurance pursuant to Section [insert applicable reference to the Standard Valuation Law] of the [insert state] Insurance Statute.

Section 2. Scope

This rule applies to credit life insurance policies and certificates, and those similar policies and certificates where there is no identifiable charge made to the debtor.

Section 3. Purpose

The purpose of this rule is to:

A. Recognize the 2001 CSO Male Composite Ultimate Mortality Table for use in determining the minimum standard of valuation.

B. Specify the interest rate and method to be used in determining the minimum standard of valuation.

Section 4. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

B. "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

C. "Credit life insurance" means life insurance as defined in [insert applicable reference to definition] of the [insert state] Insurance Statute.

Drafting Note: If existing definitions are not sufficiently precise to define Credit Life Insurance, some or all of the following definition may be added to the regulation:

"Credit life insurance" means insurance on a debtor or debtors, pursuant to or in connection with a specific loan or other credit transaction, to provide for satisfaction of a debt, in whole or in part, upon the death of an insured debtor.

Credit life insurance does NOT include:

(a) Insurance written in connection with a credit transaction that is:

(i) Secured by a first mortgage or deed of trust; and

(ii) Made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose;

(b) Insurance sold as an isolated transaction on the part of the insurer and not related to an agreement or a plan for insuring debtors of the creditor.

(c) Insurance for which no identifiable charge is made to the debtor.

(d) Insurance on accounts receivable.

Section 5. 2001 CSO Male Composite Ultimate Mortality Table

A. The minimum standard for both male and female insureds shall be 2001 CSO Male Composite Ultimate Mortality Table.

B. Where the credit life insurance policy or certificate insures two lives, the minimum standard shall be twice the mortality in the 2001 CSO Male Composite Ultimate Mortality Table based on the age of the older insured.

Section 6. Minimum Standards

A. [Insert applicable reference to the Valuation of Life Insurance Policies Model Regulation] shall not apply to credit life insurance.

B. The interest rates used in determining the minimum standard for valuation shall be the calendar year statutory valuation interest rates as defined in [insert applicable reference to Section 4b of the Standard Valuation Law].

C. The method used in determining the minimum standard for valuation shall be the commissioners reserve valuation method as defined in [insert applicable reference to Section 5 of the Standard Valuation Law].

Drafting Note:

1) Section 6 may not be appropriate or necessary for some states because of specific language in their versions of the Standard Valuation Law, the Valuation of Life Insurance Policies Model Regulation, or their specific statutes on credit insurance.

2) States should be aware that there may be requirements elsewhere in statutory accounting to test reserves against the premium refund net liability.

3) In applying the commissioners reserve valuation method, consideration should be given to the period of time for which renewability of benefits are guaranteed under the contract. If benefits are guaranteed for less than one year, the method produces a reserve equal to the mortality cost from the valuation date to the premium "paid-to" date.

4) The Standard Valuation Law contains language permitting the use of "group methods and approximate averages for fractions of a year or otherwise." Such methods may be appropriate in those situations where individual certificate data is not readily available to the insurer. This is especially common in monthly payment programs, with frequent remittance of small premiums.

Section 7. Effective Date

This rule is applicable to credit life policies and certificates issued on or after January 1, 200[_] [insert January 1 of the year next following or coincident with the effective date of the state's version of the Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits Model Regulation].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2004 Proc.1st Quarter 331, 1668, 1988-1991 (adopted by parent committee).
2004 Proc. 2nd Quarter 50 (adopted by Plenary).

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

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DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-162.202 (2005).		FLA. STAT. § 625.121 (13) (2004) (authority to adopt regulation).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky			806 KY. ADMIN. REGS. 6:010 (1975/2005).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. CODE ADMIN. R. INS. 1201.01 (1982/2010).
New Jersey			BULLETIN No. 06-21 (2006).
New Mexico	NO CURRENT ACTIVITY		
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 98.1 to 98.11 (1994/2007).

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	11 N.C. ADMIN. CODE 11F.0701 (2005).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	31 PA. CODE § 73.138 (2007).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			TENN. CODE ANN. 56-7-911 (1985/2005).
Texas	28 TEX. ADMIN. CODE § 3.6101 (2010).		
Utah			UTAH ADMIN. CODE r. 590-228-1 to 590-228-13 (2004/2014).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-3723 (1986/2014) (portions of model).		
Washington	NO CURRENT ACTIVITY		

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2004

DETERMINING RESERVE LIABILITIES FOR CREDIT LIFE INSURANCE MODEL REGULATION (#818)

1. Description of the project, Issues Addressed, etc.

The "Purpose" section of the model describes its objective:

Section 3. Purpose

The purpose of this rule is to:

A. Recognize the 2001 CSO Male Composite Ultimate Mortality Table for use in determining the minimum standard of valuation.

B. Specify the interest rate and method to be used in determining the minimum standard of valuation.

This model evolved from the work of the Credit Insurance Experience Committee of the Society of Actuaries. This excerpt from that committee's June 2002 report gives its recommendation:

> In May of 2001 the Credit Insurance Experience Committee was asked to respond to the National Association of Insurance Commissioner's request to the Society of Actuaries to develop a recommendation for a uniform national valuation standard for credit life insurance policy reserves.
>
> The enclosed report contains the recommendation along with supporting material.
>
> The Committee recommends that the 200X (i.e., 2001) CSO Male Composite Ultimate Table be used for the valuation of credit life policy reserves using the dynamic interest rate appropriate for the original term of insurance. For joint life coverage the Committee recommends that the reserve be set assuming 200X (i.e., 2001) CSO Male Composite Ultimate Table using twice the mortality for the age of the primary insured. Credit insurers do not normally maintain gender specific records, so certificates of both genders should be reserved on the male table.
>
> The recommended standard is set at a level such that 23 of the 27 companies contributing data to the study, or 85%, showed aggregate mortality less than or equal to the standard. Overall, this standard provides a 27% margin over the experience from 1998 and 1999.

2. Name of Group Responsible for Drafting the Model and States Participating

The Life and Health Actuarial Task Force developed this model. The 2004 members are: South Carolina (Chair), Alaska (Vice-Chair), Arkansas, California, Connecticut, Florida, Kansas, Minnesota, Nebraska, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The 2004 charge given to the Task Force was: "Discuss the feasibility of developing a valuation mortality table for credit life insurance. Consult with the Society of Actuaries, the American Academy of Actuaries, and other interested parties on this matter. Complete work on this matter by the Winter National Meeting." This charge represents a continuation of previous charges given to the Task Force.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

This model evolved from the work of the Credit Insurance Experience Committee of the Society of Actuaries. That committee presented its recommendations to the Task Force in a June 2002 report. Subsequently, the full Task Force worked with a representative of that committee and other interested parties in the development of the model.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The efforts of the Task Force were closely coordinated with all industry interested parties. In addition to open sessions at the quarterly meetings of the NAIC, numerous conference calls were held to discuss this matter. Notice of those conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 200 interested parties, including representatives of the American Council of Life Insurers and the Consumer Credit Insurance Association.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Given the complexity of this project, it is impossible for a brief summary to address all the issues that were raised. However, two main issues that were addressed are:

- The extent to which use of unearned premium reserves is consistent with the Commissioners Reserve Valuation Method (CRVM) as prescribed by the Standard Valuation Law.

- The appropriate application of CRVM to such plans as "level monthly" plans.

Relative to the first point, the task force agreed to include this Drafting Note in the model:

> The Standard Valuation Law contains language permitting the use of "group methods and approximate averages for fractions of a year or otherwise." Such methods may be appropriate in those situations where individual certificate data is not readily available to the insurer. This is especially common in monthly payment programs, with frequent remittance of small premiums.

The intent of the Drafting Note is to point out that, under the circumstances described, there may be multiple acceptable techniques for achieving compliance with CRVM. On the July 24, 2003, conference call of the Task Force, Michael Batte (NM) (chair of the Task Force at that time) made the following statement, which explicitly referenced unearned premiums:

> Mr. Batte stated, "my own personal opinion is the reason we use unearned premiums for these kinds of group life insurance contracts is because that exceeds what would be required on a mortality basis for the risk guaranteed." Mr. Batte summarized his comments by saying, for many of the types of group contracts under discussion, the unearned premium reserve "is a CRVM compliant reserve."

The decision was made to address this point through a Drafting Note rather than the formal text of the model. This excerpt from the Nov. 18, 2003, conference call of the Task Force documents the decision not to reference any reserve methodology other than CRVM (i.e., Section 5 of the SVL) within the formal text:

> Ms. Philips asked Mr. Carmello if Mr. Hause's suggestions addressed his concerns. Mr. Carmello stated that he was unclear as to the exact nature of Mr. Hause's proposal. Ms. Philips responded that Mr. Hause's proposal is to "strike the portion that talks about a different reserve method for outstanding balance or MOB (monthly outstanding balance) or anything, and just say that the minimum reserve standard shall be the Commissioners Reserve Valuation Method." Mr. Carmello said, "so that would require a mortality reserve, even for MOB?" Mr. Hause responded "yes." Mr. Carmello stated this would also "address the level premium issue, because under CRVM they would have to go through the motions there, even if it doesn't produce anything."

Relative to the second point pertaining to "monthly level" plans, the concerns of the industry were expressed in these excerpts from an August 20, 2003, letter from William F. Burfeind, Executive Vice President, Consumer Credit Insurance Association:

> Group term life insurance is renewable by group and rates are subject to change, generally once a year. For many group life insurance cases the amount of insurance is a fixed level amount and not tied to the employees' current salary. The rate charged is usually one rate for all ages and while the rate may be changed annually it is the practice of insurers to avoid rate changes. These same group term life risk characteristics are also applicable to most level monthly credit life products.

> Many of the monthly level credit life products have one rate for all ages. This is consistent with the prima facie rates in the states. While states allow actuarial equivalent rates our experience has been that some states will not approve age rated credit life products.
>
> The model valuation law requires in any contract year where the gross premium charged is less than the valuation net premium, the valuation premium is replaced by the gross premium in determining the present value of future premiums. This "premium deficiency reserve" will be onerous at high issue ages in the level monthly credit life products that have one all age rate. If CRVM reserves are required will this premium deficiency reserve requirement follow, even when rates are not guaranteed?

In response, the Task Force agreed to the inclusion of the following Drafting Note:

> In applying the commissioners reserve valuation method, consideration should be given to the period of time for which renewability of benefits are guaranteed under the contract. If benefits are guaranteed for less than one year, the method produces a reserve equal to the mortality cost from the valuation date to the premium "paid-to" date.

7. Any Other Important Information (e.g., amending an accreditation standard)

This is a new model regulation. The NAIC has never before promulgated reserve standards that explicitly address credit life insurance.

The scope of Statement of Statutory Accounting Principles No. 59 is:

> This statement establishes statutory accounting principles for income recognition and policy reserves for all contracts classified as credit life and credit accident and health contracts defined in *SSAP No. 50 – Classifications and Definitions of Insurance or Managed Care Contracts In Force.*

Given that the model directly relates to the issues addressed by SSAP No. 59, the Statutory Accounting Principles (E) Working Group may wish to consider the extent to which the model should be incorporated into the *Accounting Practices and Procedures Manual.*

STANDARD VALUATION LAW

Table of Contents

Section 1. Title and Definitions

A. This Act shall be known as the Standard Valuation Law.

B. For the purposes of this Act the following definitions shall apply on or after the operative date of the valuation manual:

(1) The term "accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in Section 3B of this Act.

(3) The term "company" means an entity, which (a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and has at least one such policy in force or on claim or (b) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this State.

(4) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) The term "life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) The term "NAIC" means the National Association of Insurance Commissioners.

(7) The term "policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Act including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and are required to comply with Section 12 of this Act as specified in the valuation manual.

(9) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Act or as subsequently amended.

Drafting Note: The term commissioner means the insurance supervisory official of a State or jurisdiction of the United States and therefore, the term commissioner should be replaced with the appropriate title in the adopting State or jurisdiction. In addition, the term State should be replaced with the appropriate term for the adopting jurisdiction.

Drafting Note: It is critical that each state retain the terms "accident and health", "deposit-type contract", and "life insurance" in this section because the terms are specifically defined for purposes of the standard valuation law and applicability of the valuation manual standards for such contracts issued on or after the operative date of the valuation manual.

Section 2. Reserve Valuation

A. Policies and Contracts Issued Prior to the Operative Date of the Valuation Manual

(1) The commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this State issued on or after [insert the original effective date of the Standard Valuation Law in this State] and prior to the operative date of the valuation manual. In calculating reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any State or other jurisdiction when the valuation complies with the minimum standard provided in this Act.

(2) The provisions set forth in Sections 4, 4a, 4b, 5, 5a, 6, 7, 8, 9, and 10 of this Act shall apply to all policies and contracts, as appropriate, subject to this Act issued on or after [insert the original effective date of the Standard Valuation Law in this State] and prior to the operative date of the valuation manual and the provisions set forth in Sections 11 and 12 of this Act shall not apply to any such policies and contracts.

(3) The minimum standard for the valuation of policies and contracts issued prior to [insert the original effective date of the Standard Valuation Law in this State] shall be that provided by the laws in effect immediately prior to that date.

Drafting Note: The Standard Valuation Law prior to the operative date of the valuation manual applies to deposit-type contracts. There is no intent to change the valuation standards for deposit-type contracts.

Drafting Note: The dates inserted should remain unchanged from those appearing in the State's existing Standard Valuation Law.

B. Policies and Contracts Issued On or After the Operative Date of the Valuation Manual

(1) The commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any State or other jurisdiction when the valuation complies with the minimum standard provided in this Act.

(2) The provisions set forth in Sections 11 and 12 of this Act shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

Section 3. Actuarial Opinion of Reserves

A. Actuarial Opinion Prior to the Operative Date of the Valuation Manual

(1) General

Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) Actuarial Analysis of Reserves and Assets Supporting Reserves

(a) Every life insurance company , except as exempted by regulation , shall also annually include in the opinion required by Subsection (1) of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(b) The commissioner may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(3) Requirement for Opinion Under Section 3A(2)

Each opinion required by Subsection (2) shall be governed by the following provisions:

(a) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(4) Requirement for All Opinions Subject to Section 3A

Every opinion required by Section 3A shall be governed by the following provisions:

(a) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, [ ].

Drafting Note: The date inserted should remain unchanged from the one appearing in the State's existing Standard Valuation Law.

(b) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(c) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation.

(f) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(g) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in regulations by the commissioner.

(h) Except as provided in Paragraphs (l), (m) and (n), documents, materials or other information in the possession or control of the Department of Insurance that are a memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(i) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Paragraph (h).

(j) In order to assist in the performance of the commissioner's duties, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Paragraph (h) with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) [Optional provision] May enter into agreements governing sharing and use of information consistent with Paragraphs (h) to (j).

Drafting Note: The language in paragraph (j)(i) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

(k) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the comissioner under this section or as a result of sharing as authorized in Paragraph (j).

(l) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by regulations promulgated hereunder.

(m) The memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(n) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

B. Actuarial Opinion of Reserves after the Operative Date of the Valuation Manual

(1) General

Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) Actuarial Analysis of Reserves and Assets Supporting Reserves

Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by Subsection (1) of this section, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but

not limited to the benefits under and expenses associated with the policies and contracts.

(3) Requirements for Opinions Subject to Section 3B(2)

Each opinion required by Subsection 3B shall be governed by the following provisions:

(a) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(4) Requirement for All Opinions Subject to Section 3B

Every opinion shall be governed by the following provisions:

(a) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(b) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(c) The opinion shall apply to all policies and contracts subject to Section 3B(2), plus other actuarial liabilities as may be specified in the valuation manual.

(d) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(e) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another State if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(f) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

(g) Disciplinary action by the commissioner against the company or the appointed actuary shall be defined in regulations by the commissioner.

Drafting Note: States may need to adopt regulations to address disciplinary action.

Section 4. Computation of Minimum Standard

Except as provided in Sections 4a, 4b and 10, the minimum standard for the valuation of policies and contracts issued prior to the effective date of this Act shall be that provided by the laws in effect immediately prior to that date. Except as otherwise provided in Sections 4a, 4b and 10, the minimum standard for the valuation of all policies and contracts issued on or after [insert original effective date of the Standard Valuation Law in this State] shall be the commissioners reserve valuation methods defined in Sections 5, 5a, 8 and 10, three and one-half percent (3 1/2%) interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after [insert effective date of 1972 NAIC amendments to the Standard Valuation Law], four percent (4%) interest for policies issued prior to [insert effective date of 1976

NAIC amendments to the Standard Valuation Law], five and one-half percent (5 1/2%) interest for single premium life insurance policies and four and one-half percent (4 1/2%) interest for all other policies issued on and after [insert effective date of 1976 NAIC amendments to the Standard Valuation Law], and the following tables:

A. For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies: the Commissioners 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of Section 5a of the Standard Nonforfeiture Law for Life Insurance as amended, the Commissioners 1958 Standard Ordinary Mortality Table for policies issued on or after the operative date of Section 5a of the Standard Nonforfeiture Law for Life Insurance as amended and prior to the operative date of Section 5c of the Standard Nonforfeiture Law for Life Insurance as amended, provided that for any category of policies issued on female risks, all modified net premiums and present values referred to in this Act may be calculated according to an age not more than six (6) years younger than the actual age of the insured; and for policies issued on or after the operative date of Section 5c of the Standard Nonforfeiture Law for Life Insurance as amended:

(1) The Commissioners 1980 Standard Ordinary Mortality Table;

(2) At the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(3) Any ordinary mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies;

B. For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies: the 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of Section 5b of the Standard Nonforfeiture Law for Life Insurance as amended, and for policies issued on or after the operative date of Section 5b, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the policies;

C. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies: the 1937 Standard Annuity Mortality Table, or at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner;

D. For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies: the Group Annuity Mortality Table for 1951, a modification of the table approved by the commissioner, or at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

E. For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the NAIC, that are approved by regulation promulgated by the commissioner for use in determining the

minimum standard of valuation for those policies; for policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966, either those tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

F. For accidental death benefits in or supplementary to policies issued on or after January 1, 1966: the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the NAIC that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for those policies, for policies issued on or after January 1, 1961 and prior to January 1, 1966, either that table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies; and

G. For group life insurance, life insurance issued on the substandard basis and other special benefits: tables approved by the commissioner.

Drafting Note: The dates inserted should remain unchanged from those appearing in the State's existing Standard Valuation Law.

Section 4a. Computation of Minimum Standard for Annuities

A. Except as provided in Section 4b, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this Section 4a and for annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in Sections 5 and 5a and the following tables and interest rates:

(1) For individual annuity and pure endowment contracts issued prior to [insert effective date of 1976 NAIC amendments to the Standard Valuation Law], excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent (6%) interest for single premium immediate annuity contracts and four percent (4%) interest for all other individual annuity and pure endowment contracts;

(2) For individual single premium immediate annuity contracts issued on or after [insert effective date of 1976 NAIC amendments to the Standard Valuation Law], excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for these contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent (7 1/2%) interest;

(3) For individual annuity and pure endowment contracts issued on or after [insert effective date of 1976 NAIC amendments to the Standard Valuation Law], other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in those contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for those contracts, or any modification of these tables approved by the commissioner, and five and one-half percent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4 1/2%) interest for all other individual annuity and pure endowment contracts;

(4) For annuities and pure endowments purchased prior to [insert effective date of 1976 NAIC amendments to the Standard Valuation Law] under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table or any modification of this table approved by the commissioner, and six percent (6%) interest; and

(5) For annuities and pure endowments purchased on or after [insert effective date of 1976 NAIC amendments to the Standard Valuation Law] under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: the 1971 Group Annuity Mortality Table, or any group annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent (7 1/2%) interest;

B. After [insert effective date of 1972 NAIC amendments to the Standard Valuation Law], any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for that company. If a company makes no election, the operative date of this section for that company shall be January 1, 1979.

Drafting Note: The dates inserted should remain unchanged from those appearing in the State's existing Standard Valuation Law.

Section 4b. Computation of Minimum Standard by Calendar Year of Issue

A. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this section:

(1) Life insurance policies issued in a particular calendar year, on or after the operative date of Section 5c of the Standard Nonforfeiture Law for Life Insurance as amended;

(2) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 19[ ] [insert the calendar year next following the effective date of the 1980 NAIC amendments to the Standard Valuation Law];

(3) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 19[ ] [insert the calendar year next following the effective date of the 1980 NAIC amendments to the Standard Valuation Law] under group annuity and pure endowment contracts; and

(4) The net increase, if any, in a particular calendar year after January 1, 19[ ] [insert the calendar year next following the effective date of the 1980 NAIC amendments to the Standard Valuation Law], in amounts held under guaranteed interest contracts.

Drafting Note: The dates inserted should remain unchanged from those appearing in the State's existing Standard Valuation Law.

B. Calendar Year Statutory Valuation Interest Rates

(1) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent (1/4 of 1%):

(a) For life insurance:

$$I = .03 + W \cdot (R_1 - .03) + \frac{W}{2} \cdot (R_2 - .09)$$

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W \cdot (R - .03)$$

Where R_1 is the lesser of R and .09,
R_2 is the greater of R and .09,
R is the reference interest rate defined in this section,
W is the weighting factor defined in this section;

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subparagraph (b) above, the formula for life insurance stated in Subparagraph (a) above shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in Subparagraph (b) above shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less;

(d) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subparagraph (b) above shall apply.

(e) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subparagraph (b) above shall apply.

(2) However, if the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent (1/2 of 1%), the calendar year statutory valuation interest rate for the life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined in 1979) and shall be determined for each subsequent calendar year regardless of when Section 5c of the Standard Nonforfeiture Law for Life Insurance as amended becomes operative.

C. Weighting Factors

(1) The weighting factors referred to in the formulas stated above are given in the following tables:

(a) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(b) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(c) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Subparagraph (b) above, shall be as specified in items (i), (ii) and (iii) below, according to the rules and definitions in items (iv), (v) and (vi) below:

(i) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in item (i) above increased by:

Plan Type A	B	C
.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in item (i) or derived in item (ii) increased by:

Plan Type A	B	C
.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (l) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without an adjustment but installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without an adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

D. Reference Interest Rate

(1) The reference interest rate referred to in subsection B of this section shall be defined as follows:

(a) For life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subparagraph (b) above, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subparagraph (b) above, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Subparagraph (b) above, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

E. Alternative Method for Determining Reference Interest Rates. In the event that the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc. or in the event that the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the NAIC and approved by regulation promulgated by the commissioner may be substituted.

Section 5. Reserve Valuation Method—Life Insurance and Endowment Benefits

A. Except as otherwise provided in Sections 5a, 8 and 10, reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided for by those policies, over the then present value of any future modified net premiums therefor. The modified net premiums for a policy shall be the uniform percentage of the respective contract premiums for the benefits such that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of (1) over (2), as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy.

(2) A net one-year term premium for the benefits provided for in the first policy year.

B. For a life insurance policy issued on or after January 1, 19[ ] [insert the fourth calendar year commencing after the effective date of the 1980 NAIC amendments to the Standard Valuation Law] for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium shall, except as otherwise provided in Section 8, be the greater of the reserve as of the policy anniversary calculated as described in the preceding paragraph and the reserve as of the policy anniversary calculated as described in that paragraph, but with (i) the value defined in subsection A of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on that date as an endowment, and (iv) the cash surrender value provided on that date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Sections 4 and 4b shall be used.

Drafting Note: The date inserted should remain unchanged from the one appearing in the State's existing Standard Valuation Law.

C. Reserves according to the commissioners reserve valuation method shall be calculated by a method consistent with the principles of the preceding paragraphs of this section for:

(1) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended;

(3) Disability and accidental death benefits in all policies and contracts; and

(4) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

Section 5a. Reserve Valuation Method—Annuity and Pure Endowment Benefits

A. This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

B. Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

Section 6. Minimum Reserves

A. In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after [insert original effective date of the Standard Valuation Law in this State], be less than the aggregate reserves calculated in accordance with the methods set forth in Sections 5, 5a, 8 and 9 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

B. In no event shall the aggregate reserves for all policies, contracts and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by Section 3.

Drafting Note: The date inserted should remain unchanged from the one appearing in the State's existing Standard Valuation Law.

Section 7. Optional Reserve Calculation

A. Reserves for policies and contracts issued prior to [insert original effective date of the Standard Valuation Law in this State] may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date.

B. Reserves for any category of policies, contracts or benefits established by the commissioner, issued on or after [insert original effective date of the Standard Valuation Law in this State], may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided herein, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies or contracts.

C. A company, which adopts at any time a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this Act, may adopt a lower standard of valuation with the approval of the commissioner, but not lower than the minimum provided herein; provided that, for the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by Section 3 shall not be deemed to be the adoption of a higher standard of valuation.

Drafting Note: The dates inserted should remain unchanged from those appearing in the State's existing Standard Valuation Law.

Section 8. Reserve Calculation—Valuation Net Premium Exceeding the Gross Premium Charged

If in any contract year the gross premium charged by a company on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in Sections 4 and 4b.

For a life insurance policy issued on or after January 1, 19[ ] [insert the fourth calendar year commencing after the effective date of the 1980 NAIC amendments to the Standard Valuation Law] for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the provisions of this section shall be applied as if the method actually used in calculating the reserve for the policy were the method described in Section 5, ignoring the second paragraph of Section 5. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with Section 5, including the second paragraph of that section, and the minimum reserve calculated in accordance with this section.

Drafting Note: The date inserted should remain unchanged from the one appearing in the State's existing Standard Valuation Law.

Section 9. Reserve Calculation—Indeterminate Premium Plans

In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in Sections 5, 5a and 8, the reserves that are held under the plan shall:

A. Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

B. Be computed by a method that is consistent with the principles of this Standard Valuation Law, as determined by regulations promulgated by the commissioner.

Drafting Note: If desired the following paragraph may be added.

"Notwithstanding any other provision in the laws of this State, a policy, contract or certificate providing life insurance under such a plan shall be affirmatively approved by the commissioner before it can be marketed, issued, delivered or used in this State."

If the previous paragraph is enacted in a State where prior filing and approval of life insurance policy forms has not been previously required by statute, this paragraph would mandate such action for plans requiring approval under Section 9. If the previous paragraph is enacted in a State where approval is deemed under certain circumstances, the deemed provision would be overridden by the terms of this section. In some States specific reference must be made to any statutory provision that is overridden.

Section 10. Minimum Standard for Accident and Health Insurance Contracts

For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under Section 2B. For [disability, accident and sickness, accident and health] insurance contracts issued on or after [insert the original effective date of the Standard Valuation Law in the State] and prior to the operative date of the valuation manual the minimum standard of valuation is the standard adopted by the commissioner by regulation.

Drafting Note: States should substitute their state specific terminology for accident and health contracts in place of the bracketed terms. However, it is critical that each state retain the terms "accident and health" in the title and first sentence of this section because the term is specifically defined for purposes of the standard valuation law and applicability of the valuation manual standards for such contracts issued on or after the operative date of the valuation manual.

Section 11. Valuation Manual for Policies Issued On or After the Operative Date of the Valuation Manual

A. For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under Section 2B, except as provided under Paragraphs E or G of this section.

B. The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths of the members voting, whichever is greater.

(2) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by States representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(3) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions: The fifty States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

C. Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when [all of the following have occurred]:

(1) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(a) At least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership, and

(b) Members of the NAIC representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in Subsection C(1)(a): life, accident and health annual statements, health annual statements, or fraternal annual statements.

Drafting Note: The following section is optional:

[(2) The valuation manual becomes effective pursuant to [an order of] [regulation adopted by] the commissioner.]

D. The valuation manual must specify all of the following:

(1) Minimum valuation standards for and definitions of the policies or contracts subject to Section 2B. Such minimum valuation standards shall be:

(a) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to Section 2B;

(b) The commissioners annuity reserve valuation method for annuity contracts subject to Section 2B; and

(c) Minimum reserves for all other policies or contracts subject to Section 2B.

(2) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in Section 12A and the minimum valuation standards consistent with those requirements;

(3) For policies and contracts subject to a principle-based valuation under Section 12:

(a) Requirements for the format of reports to the commissioner under Section 12B(3) and which shall include information necessary to determine if the valuation is appropriate and in compliance with this Act;

(b) Assumptions shall be prescribed for risks over which the company does not have significant control or influence**.**

(c) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(4) For policies not subject to a principle-based valuation under Section 12 the minimum valuation standard shall either

(a) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(b) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

Drafting Note: The wording of 11D(4)(b) does not preclude, for policies with significant tail risk, reflecting in the reserve conditions appropriately adverse to quantify the tail risk.

(5) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(6) The data and form of the data required under Section 13, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

E. In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this Act, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

F. The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this Act. The commissioner may rely upon the opinion, regarding provisions contained within this Act, of a qualified actuary engaged by the commissioner of another State, district or territory of the United States. As used in this paragraph, term "engage" includes employment and contracting.

G. The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this Act; and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to [insert applicable law].

Drafting Note: This section is intended to conform to the State's administrative procedures, including notice and due process.

Drafting Note: Section 11 presumes that each State is permitted under their State laws to "adopt" the valuation manual in a manner similar to how the *Accounting Practices and Procedures Manual* becomes effective in many States, without a separate regulatory process such as adoption by regulation. It is desirable that all States adopt the valuation manual requirements and that such adoption be achieved without a separate State regulatory process in order to achieve uniformity of reserve standards in all States. However, to the extent that a State may need to adopt the valuation manual through a formal State regulatory process, Sections 11B and/or 11C may be amended to reflect any State's need to adopt the valuation manual through regulation.

Section 12. Requirements of a Principle-Based Valuation

A. A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(1) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(2) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(3) Incorporate assumptions that are derived in one of the following manners:

(a) The assumption is prescribed in the valuation manual.

(b) For assumptions that are not prescribed, the assumptions shall:

(i) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(ii) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(4) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

B. A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(2) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(3) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

C. A principle-based valuation may include a prescribed formulaic reserve component.

Section 13. Experience Reporting for Policies In Force On or After the Operative Date of the Valuation Manual

A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

Section 14. Confidentiality

A. For purposes of this Section 14, "Confidential Information" shall mean:

(1) A memorandum in support of an opinion submitted under Section 3 of this Act and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

(2) All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under Section 11F of this Act; *provided, however*, that if an examination report or other material prepared in connection with an examination made under the **[**insert reference to examination law**]** is not held as private and confidential information under the **[**insert reference to examination law**]**, an examination report or other material prepared in connection with an examination made under Section 11F of this Act shall not be "Confidential Information" to the same extent as if such examination report or other material had been prepared under the **[**insert reference to examination law**]**;

(3) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under Section 12B(2) of this Act evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials and other information;

(4) Any principle-based valuation report developed under Section 12B(3) of this Act and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such report; and

(5) Any documents, materials, data and other information submitted by a company under Section 13 of this Act (collectively, "experience data") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any "experience data", the "experience materials") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

B. Privilege for, and Confidentiality of, Confidential Information

(1) Except as provided in this Section 14, a company's Confidential Information is confidential by law and privileged, and shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the Confidential Information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(2) Neither the commissioner nor any person who received Confidential Information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any Confidential Information.

(3) In order to assist in the performance of the commissioner's duties, the commissioner may share Confidential Information (a) with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (b) in the case of Confidential Information specified in Sections 14A(1) and 14A(4) only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the Confidential Information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials; in the case of (a) and (b), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the commissioner.

Drafting Note: Subsection B(3) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

(4) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(5) The commissioner may enter into agreements governing sharing and use of information consistent with this Section 14B.

(6) No waiver of any applicable privilege or claim of confidentiality in the Confidential Information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Section 14B(3).

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this Section 14B shall be available and enforced in any proceeding in, and in any court of, this State.

(8) In this Section 14 "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

C. Notwithstanding Section 14B, any Confidential Information specified in Sections 14A(1) and 14A(4):

(1) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under Section 3 of this Act or principle-based valuation report developed under Section 12B(3) of this Act by reason of an action required by this Act or by regulations promulgated hereunder;

(2) May otherwise be released by the commissioner with the written consent of the company; and

(3) Once any portion of a memorandum in support of an opinion submitted under Section 3 of this Act or a principle-based valuation report developed under Section 12B(3) of this Act is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

Drafting Note: The following section is optional:

Section 15. Single State Exemption

A. The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in [Name of State] from the requirements of Section 11 provided:

(1) The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(2) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by regulation.

B. For any company granted an exemption under this section, Sections 3, 4, 4a, 4b, 5, 5a, 6, 7, 8, 9 and 10 shall be applicable. With respect to any company applying this exemption, any reference to Section 11 found in Sections 3, 4, 4a, 4b, 5, 5a, 6, 7, 8, 9 and 10 shall not be applicable.]

Section [15 or16]. Effective Date

All acts and parts of acts inconsistent with the provision of this Act are hereby repealed as of [insert original effective date of the Standard Valuation Law in this State]. This Act shall take effect [insert original effective date of the Standard Valuation Law in this State].

Drafting Note: A state that has adopted specific valuation standards, other than the SVL, will need to review those standards and make changes if needed in order for the valuation manual standards to apply (such as sunsetting the specific State standard on the operative date of the valuation manual or subsequent changes to the valuation manual).

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1942 Proc. Supp. 271-274 (printed).
1943 Proc. 13 (adopted).
1959 Proc. I 183, 193, 203-206, 294 (amended).
1960 Proc. II 518, 536, 537-538 (amended).
1962 Proc. I 140, 144, 146, 166 (amended).
1973 Proc. I 9, 11, 251, 277, 283 (amended).
1973 Proc. II 533, 543-546 (reprinted).
1974 Proc. II 464-466 (reprinted).
1977 Proc. I 20, 22, 23, 26, 28, 317, 478-479, 481-483, 487-491 (amended).
1977 Proc. II 19, 21, 432, 494, 557-559 (corrected).
1981 Proc. I 47, 51, 421, 517, 761, 765-773 (amended and reprinted).
1981 Proc. II 27, 35, 559, 793, 802-811 (amended and reprinted).
1991 Proc. I 9, 17, 539, 1029-1045 (amended and reprinted).
1992 Proc. I 86, 94, 97, 861, 1389-1391 (amended).
1999 Proc. 4th Quarter 15, 843, 845-847 (amended).
2009 Proc. 3rd Quarter, Vol. I, 95-96, 114-117, 151-194 (amended).

STANDARD VALUATION LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

STANDARD VALUATION LAW

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-36A-1 to 27-36A-20 (1971/2016).		
Alaska	ALASKA STAT. §§ 21.18.110; 21.18.112 (1966/2018).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-510 (1982/2014).		
Arkansas	ARK. CODE ANN. §§ 23-84-101 to 23-84-119 (1959/2019).		BULLETIN 8-2016 (2016).
California	CAL. INS. CODE §§ 10489.1 to 10489.992 (1981/2016).		
Colorado	COLO. REV. STAT. § 10-7-101 (2015); §§ 10-7-309 to 10-7-316 (1961/2015); § 10-7-114 (1992/2015).		
Connecticut	CONN. GEN. STAT. §§ 38a-77; 38a-78 (2018); 38a-78a; 38a-79a (1978/2018).		BULLETIN FS-32-2017 (2017); BULLETIN FS-31-2016 (2016).
Delaware	DEL. CODE ANN. tit. 18, §§ 1111 to 1126 (1983/2015).		

STANDARD VALUATION LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. CODE § 31-4701 (1978/1996); § 31-4901 (1993/2019).		
Florida	FLA. STAT. § 625.121 (1959/2014); FLA. STAT. § 625.1212 (2014).		
Georgia	GA. CODE ANN. § 33-10-13 (1960/2019).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:5-307 (1988/2019).		MEMORANDUM 2009-2 (A) (2009).
Idaho	IDAHO CODE ANN. § 41-612 (1961/2016).		
Illinois	215 ILL. COMP. STAT. 5/223 (1983/2016).		
Indiana	IND. CODE §§ 27-1-12.8-1 to 27-1-12.8-40 (2013/2018).		BULLETIN 230 (2016).
Iowa	IOWA CODE § 508.36 (1963/2014).		
Kansas	KAN. STAT. ANN. § 40-409 (1927/2015).		
Kentucky	KY. REV. STAT. ANN. §§ 304.6-120 to 304.6-180 (1970/2015).		BULLETIN 2016-3 (2016).
Louisiana	LA. REV. STAT. ANN. §§ 22:751 to 22:755 (2008/2016).		BULLETIN 7-5-2016 (2016).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 951 to 962 (1969/2013).		
Maryland	MD. CODE ANN. INS. § 5-201; §§ 5-301 to 5-317 (1939/2018).		
Massachusetts	MASS. GEN. LAWS ch. 175, § 9 (1982/2011); § 9 ½ (2018); § 9B (1993); § 9B ½ (2018).		

STANDARD VALUATION LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	MICH. COMP. LAWS §§ 500.834 to 500.836 (1974/2016).		BULLETIN 2016-17-INS (2016).
Minnesota	MINN. STAT. § 61A.25 (1967/2016).		
Mississippi	MISS. CODE ANN. § 83-7-23 (1975/2014).		
Missouri	MO. REV. STAT. § 376.380 (1959/2015).		
Montana	MONT. CODE ANN. §§ 33-2-401 to 33-2-418 (1959/2015).		
Nebraska	NEB. REV. STAT. § 44-8901 to 44-8912 (2014); §§ 44-420 to 44-427 (1994).		BULLETIN CB-136 (2016).
Nevada	NEV. REV. STAT. §§ 681B.110 to 681B.150 (1971/2015); § 681B.220 (1995/2015); §§ 681b.350 to 681b.380 (2015).		BULLETIN 2016-008 (2016).
New Hampshire	N.H. REV. STAT. ANN. §§ 410:1 to 410:18 (1943/2014).		
New Jersey	N.J. STAT. ANN. § 17B:19-1.1 (2014); § 17B:19-2.1 (2014); §§ 17B:19-8 to 17B:19-14 (1971/2014).		BULLETIN 2018-15 (2018).
New Mexico	N.M. STAT. ANN. §§ 59A-8A-1 to 59A-8A-12 (2014).		
New York	N.Y. INS. LAW § 4217 (1984/2018).		
North Carolina	N.C. GEN. STAT. § 58-58-50 (1945/2019).		
North Dakota	N.D. CENT. CODE §§ 26.1-35-01 to 26.1-35-14 (1985/2015).		
Northern Marianas	NO CURRENT ACTIVITY		

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio	OHIO REV. CODE ANN. §§ 3903.72 to 3903.7211 (1983/2014).		BULLETIN 2016-3 (2016).
Oklahoma	OKLA. STAT. tit. 36, § 1510 (1957/2014); § 4061 (1997/2014).		BULLETIN FIN 2016-01 (2016).
Oregon	OR. REV. STAT. §§ 733.300 to 733.340 (1991/2015).		OR. ADMIN. R. 836-031-0605 (2017).
Pennsylvania	40 PA. CONS. STAT. §§ 7-101 to 7142 (2016/2018).		
Puerto Rico		P.R. LAWS. ANN. tit. 26, §§ 523 to 524 (2003/2008); P.R RULE XLVIII Part A (1984).	
Rhode Island	R.I. GEN. LAWS §§ 27-4.5-1 to 27-4.5-17 (1994/2014).		
South Carolina	S.C. CODE ANN. § 38-9-180 (1988/2016).		
South Dakota	S.D. CODIFIED LAWS §§ 58-26-45 to 58-26-105 (1995/2015).		S.D. CODIFIED LAWS § 58-26-13.1 (1992/1997) (actuarial opinion).
Tennessee	TENN. CODE ANN. §§ 56-1-901 to 56-1-919 (2013/2016).		
Texas	TEX. INS. CODE ANN. §§ 425.051 to 425.077 (2005/2015); 28 TEX. ADMIN. CODE §§ 3.9901 to 3.9902 (2017).		
Utah	UTAH CODE ANN. §§ 31A-17-501 to 31A-17-519 (1993/2019).		
Vermont	VT. STAT. ANN. tit. 8, §§ 3791 to 3791r (2015).		
Virgin Islands	V.I. CODE ANN. tit. 22, §§ 531 to 549 (2018).		

STANDARD VALUATION LAW

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1365 to 38.2-1385 (2014).		ADMINISTRATIVE LETTER 2016-7 (2016).
Washington	WASH. REV. CODE ANN. §§ 48.74.010 to 48.74.130 (1982/2016).		
West Virginia	W. VA. CODE § 33-7-9 (1957/2019).		
Wisconsin	WIS. STAT. § 623.06 (1943/2017).		
Wyoming	WYO. STAT. ANN. §§ 26-6-201 to 26-6-213 (1967/2017).		

PROJECT HISTORY - 2009

STANDARD VALUATION LAW (#820)

1. Description of the Project, Issues Addressed, etc.

The project modifies the Standard Valuation Law to enable a principle-based valuation methodology. The major issues were to authorize the use of a valuation manual which will contain the minimum reserve and related requirements and to determine which items would be in the revised Standard Valuation Law and which items would be in the valuation manual. The modifications to the model consist of adding new sections to the existing model: a section regarding the valuation manual; a section to list the requirements of a principle-based valuation; a section to require companies to submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual; and a section regarding confidentiality. There is also an optional section to exempt specific product forms or product lines of a domestic company that is licensed and doing business only in one jurisdiction from the principle-based valuation requirements.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2009 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

From 2002 to 2005 the Task Force was given the charge to review the Standard Valuation Law to determine if changes are necessary. In 2006 the charge was to review the Standard Valuation Law, related model regulations, and actuarial guidelines to determine if changes are necessary, particularly any that are needed to facilitate the implementation of a principles-based approach. In 2007 the request for model law development was approved.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Several regulators developed drafts of the required modifications. A subgroup of the Task Force was formed to made changes and made a recommendation to the Task Force. The Task Force made several modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at public conference calls on this topic on the following dates: February 7, 2006; March 9, 2006; May 4, 2006; July 31, 2006; August 15, 2006; March 9, 2007; April 30, 2007; July 19, 2007; and August 23, 2007. The Task Force held public conference calls on this topic on October 22, 2007; November 1, 2007; February 5, 2008; February 20, 2008; February 27, 2008; April 23, 2008; April 29, 2008; May 5, 2008; May 8, 2008; July 18, 2008; August 5, 2008; August 19, 2008; August 21, 2008; November 7, 2008; November 13, 2008; February 9, 2008; April 8, 2009; April 27, 2009; and May 11, 2009. The Task Force also discussed the modifications at National Meeting in June, 2007; September, 2007; December, 2007; March, 2008; June, 2008; September, 2008; December, 2008; March, 2009; and June, 2009. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment on October 20, 2006; January 25, 2007; February 13, 2007; July 19, 2007; September 29, 2007; November 30, 2007; January 7, 2008; March 29, 2008; May 31, 2008; September 22, 2008; November 13, 2008; December 5, 2008; April 27, 2009; and May 21, 2009. Several memos and letters were submitted to the Task Force relative to this project.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Issue #1 – Scope of the law**;** The Task Force decided that principle-based reserves would be authorized on a prospective basis and the existing provisions of the Standard Valuation Law should not change for policies and contracts currently in-force. Because some of the definitions in Section 1 could change the valuation requirements for policies or contracts currently in-force, the definitions are applicable only after the operative date of the valuation manual. Section 2 and Section 3 were split so that the reserve requirements and the actuarial opinion requirements are defined in model regulations and actuarial guidelines prior to the operative date of the valuation manual, and in the valuation manual thereafter.

Issue #2 – Actuarial Opinion and Memorandum; The current requirements for the actuarial opinion and memorandum are in the Actuarial Opinion and Memorandum Regulation. Several members of the Task Force wanted to continue the use of a regulation. The Task Force decided to include the actuarial opinion and memorandum requirements in the valuation manual to be effective after the operative date of the valuation manual.

Issue #3 – Peer Review; The American Academy of Actuaries recommended the use of a peer review actuary to review the principle-based reserve process. Several drafts of the law included a requirement that a peer review actuary be appointed. Because the peer review actuary would be appointed by the company and several states indicated they could rely only on an actuary engaged by the state, the Task Force decided to delete the provision.

Issue #4 – Adoption of the Valuation Manual; The Task Force discussed the requirements to adopt the valuation manual and ensuing revisions. Some members of the Task Force wanted a unanimous vote of the NAIC for adoption and revisions. The Task Force decided to require least three-fourths of the members of the NAIC and 75% of the total direct premium written to approve adoption and revisions.

At the Summer National Meeting in June 2009, a motion was made to adopt the revisions to the Standard Valuation Law. The motion passed with Alabama, Alaska, California, Connecticut, Florida, Minnesota, Nebraska, Ohio, South Carolina, and Texas voting yes. New York abstained and Arkansas was absent.

On July 28, 2009, the Principles-Based Reserve (EX) Working Group, the Solvency Modernization (EX) Task Force and the Life Insurance and Annuities (A) Committee held a joint conference call to consider the revisions adopted by Task Force. During the call, the Principles-Based Reserve (EX) Working Group and the Solvency Modernization (EX) Task Force voted to adopt the revisions, but the Life Insurance and Annuities (A) Committee deferred voting on the revisions until additional information could be obtained concerning how the revisions to the Standard Valuation Law would work with the yet to be completed Valuation Manual.

The Life Insurance and Annuities (A) Committee held a conference call on Sept. 9, 2009, to consider the revisions. A motion was made to adopt the revisions subject to two conditions: (1) the Valuation Manual be completed by the end of 2009; and (2) the Valuation Manual include safeguards for minimum prescribed formulaic reserves. The motion passed with Alabama, California, District of Columbia, Florida, Iowa, Louisiana, Minnesota, Nebraska, Nevada, North Dakota and Wisconsin voting yes. New York abstained.

7. Any Other Important Information (e.g., amending an accreditation standard).

The Standard Valuation Law is an accreditation standard. The modifications need to be adopted in a substantially similar manner.

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

Table of Contents

Section 1. Authority

This rule is promulgated by the Commissioner of Insurance pursuant to Section [insert applicable reference to the Standard Valuation Law] of the [insert state] Insurance Statute.

Section 2. Purpose

The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a," the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, the 2012 Individual Annuity Reserving (2012 IAR) Mortality Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.

Section 3. Definitions

A. As used in this rule "1983 Table 'a'" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners. [See *1982 Proceedings of the NAIC II*, page 454.]

B. As used in this rule "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners. [See *1984 Proceedings of the NAIC I*, pages 414 to 415.]

C. As used in this rule "1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

D. As used in this rule "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

E. As used in this rule, "Period table" means a table of mortality rates applicable to a given calendar year (the Period).

F. As used in this rule, "Generational mortality table" means a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a Period table and a projection scale containing rates of mortality improvement.

G. As used in this rule "2012 IAR Mortality Table" means that Generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n}, derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in Section 5.

H. As used in this rule, "2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table" means the Period table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices 1-2.

I. As used in this rule, "Projection Scale G2 (Scale G2)" is a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices 3-4.

Section 4. Individual Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this section, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after [insert effective date of 1976 amendments to the Standard Valuation Law].

B. Except as provided in Subsection C of this section, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after [insert date on or after the effective date of original adoption of this regulation].

C. Except as provided in Subsection D of this section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after [insert date on or after effective date of this amended regulation].

D. Except as provided in Subsection E of this section, the 2012 IAR Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after [insert date on or after effective date of this amended regulation].

E. The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after [insert appropriate date on or after the effective date of this amended regulation], solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(1) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(2) Settlements involving similar actions such as worker's compensation claims; or

(3) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Section 5. Application of the 2012 IAR Mortality Table

In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows:

$$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$$

The resulting q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate.

For example, for a male age 30, $q_x^{2012} = 0.741$.
$q_x^{2013} = 0.741 * (1 – 0.010) ^ 1 = 0.73359$, which is rounded to 0.734.
$q_x^{2014} = 0.741 * (1 – 0.010) ^ 2 = 0.7262541$, which is rounded to 0.726.
A method leading to incorrect rounding would be to calculate q_x^{2014} as $q_x^{2013} * (1 – 0.010)$, or 0.734 * 0.99 = 0.727. It is incorrect to use the already rounded q_x^{2013} to calculate q_x^{2014}.

Section 6. Group Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this section, the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after [insert effective date of 1976 amendments to the Standard Valuation Law] under a group annuity or pure endowment contract.

B. Except as provided in Subsection C of this section, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after [insert date on or after effective date of original adoption of this regulation] under a group annuity or pure endowment contract.

C. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after [insert appropriate date on or after effective date of this amended regulation] under a group annuity or pure endowment contract.

Section 7. Application of the 1994 GAR Table

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994}(1 - AA_x)^n$$

where the q_x^{1994} and AA_x are as specified in the 1994 GAR Table.

Section 8. Separability

If any provision of this rule or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

Section 9. Effective Date

The effective date of this rule is [it is recommended that the amended regulation be effective 1/1/2014].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1983 Proc. I 12, 35, 448-449, 459, 520
1984 Proc. I 6, 31, 376, 392, 471-472 (adopted).
1996 Proc. 3rd Quarter 9, 40, 908, 1202, 1236-1237 (amended and reprinted).
2012 Proc. 3rd Quarter, Vol. I 99, 113-115, 146-153, 687, 1097 (amended).
2014 4th Quarter (technical correction).

APPENDIX I

2012 IAM Period Table
Female, Age Nearest Birthday

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.621**	30	**0.300**	60	**3.460**	90	**88.377**
1	**0.405**	31	**0.321**	61	**3.916**	91	**97.491**
2	**0.259**	32	**0.338**	62	**4.409**	92	**107.269**
3	**0.179**	33	**0.351**	63	**4.933**	93	**118.201**
4	**0.137**	34	**0.365**	64	**5.507**	94	**130.969**
5	**0.125**	35	**0.381**	65	**6.146**	95	**146.449**
6	**0.117**	36	**0.402**	66	**6.551**	96	**163.908**
7	**0.110**	37	**0.429**	67	**7.039**	97	**179.695**
8	**0.095**	38	**0.463**	68	**7.628**	98	**196.151**
9	**0.088**	39	**0.504**	69	**8.311**	99	**213.150**
10	**0.085**	40	**0.552**	70	**9.074**	100	**230.722**
11	**0.086**	41	**0.600**	71	**9.910**	101	**251.505**
12	**0.094**	42	**0.650**	72	**10.827**	102	**273.007**
13	**0.108**	43	**0.697**	73	**11.839**	103	**295.086**
14	**0.131**	44	**0.740**	74	**12.974**	104	**317.591**
15	**0.156**	45	**0.780**	75	**14.282**	105	**340.362**
16	**0.179**	46	**0.825**	76	**15.799**	106	**362.371**
17	**0.198**	47	**0.885**	77	**17.550**	107	**384.113**
18	**0.211**	48	**0.964**	78	**19.582**	108	**400.000**
19	**0.221**	49	**1.051**	79	**21.970**	109	**400.000**
20	**0.228**	50	**1.161**	80	**24.821**	110	**400.000**
21	**0.234**	51	**1.308**	81	**28.351**	111	**400.000**
22	**0.240**	52	**1.460**	82	**32.509**	112	**400.000**
23	**0.245**	53	**1.613**	83	**37.329**	113	**400.000**
24	**0.247**	54	**1.774**	84	**42.830**	114	**400.000**
25	**0.250**	55	**1.950**	85	**48.997**	115	**400.000**
26	**0.256**	56	**2.154**	86	**55.774**	116	**400.000**
27	**0.261**	57	**2.399**	87	**63.140**	117	**400.000**
28	**0.270**	58	**2.700**	88	**71.066**	118	**400.000**
29	**0.281**	59	**3.054**	89	**79.502**	119	**400.000**
						120	**1000.000**

APPENDIX II

2012 IAM Period Table
Male, Age Nearest Birthday

AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$	AGE	$1000 \cdot q_x^{2012}$
0	**1.605**	30	**0.741**	60	**5.096**	90	**109.993**
1	**0.401**	31	**0.751**	61	**5.614**	91	**123.119**
2	**0.275**	32	**0.754**	62	**6.169**	92	**137.168**
3	**0.229**	33	**0.756**	63	**6.759**	93	**152.171**
4	**0.174**	34	**0.756**	64	**7.398**	94	**168.194**
5	**0.168**	35	**0.756**	65	**8.106**	95	**185.260**
6	**0.165**	36	**0.756**	66	**8.548**	96	**197.322**
7	**0.159**	37	**0.756**	67	**9.076**	97	**214.751**
8	**0.143**	38	**0.756**	68	**9.708**	98	**232.507**
9	**0.129**	39	**0.800**	69	**10.463**	99	**250.397**
10	**0.113**	40	**0.859**	70	**11.357**	100	**268.607**
11	**0.111**	41	**0.926**	71	**12.418**	101	**290.016**
12	**0.132**	42	**0.999**	72	**13.675**	102	**311.849**
13	**0.169**	43	**1.069**	73	**15.150**	103	**333.962**
14	**0.213**	44	**1.142**	74	**16.860**	104	**356.207**
15	**0.254**	45	**1.219**	75	**18.815**	105	**380.000**
16	**0.293**	46	**1.318**	76	**21.031**	106	**400.000**
17	**0.328**	47	**1.454**	77	**23.540**	107	**400.000**
18	**0.359**	48	**1.627**	78	**26.375**	108	**400.000**
19	**0.387**	49	**1.829**	79	**29.572**	109	**400.000**
20	**0.414**	50	**2.057**	80	**33.234**	110	**400.000**
21	**0.443**	51	**2.302**	81	**37.533**	111	**400.000**
22	**0.473**	52	**2.545**	82	**42.261**	112	**400.000**
23	**0.513**	53	**2.779**	83	**47.441**	113	**400.000**
24	**0.554**	54	**3.011**	84	**53.233**	114	**400.000**
25	**0.602**	55	**3.254**	85	**59.855**	115	**400.000**
26	**0.655**	56	**3.529**	86	**67.514**	116	**400.000**
27	**0.688**	57	**3.845**	87	**76.340**	117	**400.000**
28	**0.710**	58	**4.213**	88	**86.388**	118	**400.000**
29	**0.727**	59	**4.631**	89	**97.634**	119	**400.000**
						120	**1000.000**

APPENDIX III

Projection Scale G2
Female, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.013**	90	**0.006**
1	**0.010**	31	**0.010**	61	**0.013**	91	**0.006**
2	**0.010**	32	**0.010**	62	**0.013**	92	**0.005**
3	**0.010**	33	**0.010**	63	**0.013**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.013**	94	**0.004**
5	**0.010**	35	**0.010**	65	**0.013**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.013**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.013**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.013**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.013**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.013**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.013**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.013**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.013**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.013**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.013**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.013**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.013**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.013**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.013**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.013**	110	**0.000**
21	**0.010**	51	**0.010**	81	**0.012**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.012**	112	**0.000**
23	**0.010**	53	**0.011**	83	**0.011**	113	**0.000**
24	**0.010**	54	**0.011**	84	**0.010**	114	**0.000**
25	**0.010**	55	**0.012**	85	**0.010**	115	**0.000**
26	**0.010**	56	**0.012**	86	**0.009**	116	**0.000**
27	**0.010**	57	**0.012**	87	**0.008**	117	**0.000**
28	**0.010**	58	**0.012**	88	**0.007**	118	**0.000**
29	**0.010**	59	**0.013**	89	**0.007**	119	**0.000**
						120	**0.000**

APPENDIX IV

Projection Scale G2
Male, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	**0.010**	30	**0.010**	60	**0.015**	90	**0.007**
1	**0.010**	31	**0.010**	61	**0.015**	91	**0.007**
2	**0.010**	32	**0.010**	62	**0.015**	92	**0.006**
3	**0.010**	33	**0.010**	63	**0.015**	93	**0.005**
4	**0.010**	34	**0.010**	64	**0.015**	94	**0.005**
5	**0.010**	35	**0.010**	65	**0.015**	95	**0.004**
6	**0.010**	36	**0.010**	66	**0.015**	96	**0.004**
7	**0.010**	37	**0.010**	67	**0.015**	97	**0.003**
8	**0.010**	38	**0.010**	68	**0.015**	98	**0.003**
9	**0.010**	39	**0.010**	69	**0.015**	99	**0.002**
10	**0.010**	40	**0.010**	70	**0.015**	100	**0.002**
11	**0.010**	41	**0.010**	71	**0.015**	101	**0.002**
12	**0.010**	42	**0.010**	72	**0.015**	102	**0.001**
13	**0.010**	43	**0.010**	73	**0.015**	103	**0.001**
14	**0.010**	44	**0.010**	74	**0.015**	104	**0.000**
15	**0.010**	45	**0.010**	75	**0.015**	105	**0.000**
16	**0.010**	46	**0.010**	76	**0.015**	106	**0.000**
17	**0.010**	47	**0.010**	77	**0.015**	107	**0.000**
18	**0.010**	48	**0.010**	78	**0.015**	108	**0.000**
19	**0.010**	49	**0.010**	79	**0.015**	109	**0.000**
20	**0.010**	50	**0.010**	80	**0.015**	110	**0.000**
21	**0.010**	51	**0.011**	81	**0.014**	111	**0.000**
22	**0.010**	52	**0.011**	82	**0.013**	112	**0.000**
23	**0.010**	53	**0.012**	83	**0.013**	113	**0.000**
24	**0.010**	54	**0.012**	84	**0.012**	114	**0.000**
25	**0.010**	55	**0.013**	85	**0.011**	115	**0.000**
26	**0.010**	56	**0.013**	86	**0.010**	116	**0.000**
27	**0.010**	57	**0.014**	87	**0.009**	117	**0.000**
28	**0.010**	58	**0.014**	88	**0.009**	118	**0.000**
29	**0.010**	59	**0.015**	89	**0.008**	119	**0.000**
						120	**0.000**

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-076-.01 to 482-1-076-.09; Apps. I to IV (1985/2014).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.600 to 28.690 (1985/2014).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	BULLETIN 2014-6 (2014) (portions of model).		
Arkansas	054 ARK. CODE. R. § 38 (2014).		
California	BULLETIN 2014-5 (2014) (portions of model).		BULLETIN 85-14 (1985); BULLETIN 98-1 (1998).
Colorado	3 COLO. CODE REGS. § 702-4:4-1-7 (2016).		
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-21 to 38a-78-30 (1992/2014).		
Delaware	18 DEL. CODE REGS. § 1208 (1985/2015).		

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	D.C. MUN. REGS. tit. 26-A, §§ 1100 to 1199 (2000/2015).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-162.101 to 69O-162.108 (1998/2015).		FLA. STAT. § 625.121 (1959/2000).
Georgia	GA. COMP. R. & REGS. 120-2-39-.01 to 120-2-39-.09 (1987/2015).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO ADMIN. CODE r. 18.07.02.000 to 18.07.02.014 (2021).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 935.10 to 935.55 (1985/2014).		BULLETIN 2014-11 (2014); BULLETIN 2014-12 (2014).
Indiana	760 IND. ADMIN. CODE 1-35 (1985/2015).		
Iowa	IOWA ADMIN. CODE r. 191-43.1 to 191-43.7; Apps. I to IV (1985/2015).		
Kansas			KAN. ADMIN. REGS. § 40-2-18 (1986).
Kentucky	806 KY. ADMIN. REGS. 6:070 (1985/2015).		
Louisiana	LA. ADMIN. CODE tit. 37, §§ XI.2101 to XI.2113 (Rule 8) (1985/2014).		
Maine	CODE ME. R. § 02-031 Ch. 340, Art. V (1984/2014).		
Maryland	MD. CODE REGS. 31.05.04.01 to 31.05.04.08 (1985/2014) (individual); 31.05.05.01 to 31.05.05.06 (2004) (group).		

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			211 MASS. CODE REGS. 39.01 to 39.08 (2000/2009).
Michigan	MICH. COMP. LAWS ANN. § 500.835 (2017).		
Minnesota	MINN. R. 2752.0010 to 2752.0040 (1999/2014).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-1.130 (1986/2015).		
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE § 42 (1985/2014).		
Nevada			NEV. ADMIN. CODE §§ 681B.162 to 681B.164 (1998).
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. 307.01 to 307.07 (1985/2001).
New Jersey	N.J. ADMIN. CODE §§ 11:4-26.1 to 11:4-26.7 (1985/2015).		
New Mexico			N.M. CODE R. §§ 13.9.11.1 to 13.9.11.10 (1985/1997).
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 99.1 to 99.11 (Regulation 151) (2001/2014).		
North Carolina	11 N.C. ADMIN. CODE 11F.0505 (2014).		
North Dakota	N.D. ADMIN. CODE §§ 45-04-08-01 to 45-04-08-04 (1986/2015).		

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-3-17 (2015).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-9-1 to 365:10-9-6 (1998/2015).		
Oregon	OR. ADMIN. R. 836-051-0200 to 836-051-0250 (1997/2015).		
Pennsylvania	31 PA. CODE §§ 84.1 to 84.6; Apps. I to IV (1986/2016).		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-25-9.1 to 20-25-9.7 (2018).		
South Carolina	S.C. CODE ANN. REGS. 69-37 (1984/2014).		
South Dakota	S.D. ADMIN. R. 20:06:43:01 to 20:06:43:04; Apps. A to D (1999/2014).		
Tennessee			TENN. COMP. R. & REGS. 0780-1-52-.01 (1985/2004); TENN. CODE ANN. § 56-7-108 (2007).
Texas	TEX. ADMIN. CODE §§ 3.1501 to 3.1506 (1985/2014).		
Utah	UTAH ADMIN. CODE R590-96 (1985/2014).		
Vermont	VT. ADMIN. CODE 4-3-14:A (Regulation 88-4, Part A) (1989/2015).		
Virgin Islands	NO CURRENT ACTIVITY		

NAIC MODEL RULE (REGULATION) FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	14 VA. ADMIN. CODE §§ 5-50-10 to 5-50-50 (1985/2014).		
Washington	WASH. ADMIN. CODE 284-74-010 to 284-74-020 (1987/2014).		
West Virginia	W. VA. CODE R. §§ 114-45-1 to 114-45-7 (1996/2012).		
Wisconsin	WIS. ADMIN. CODE INS. § 2.30 (1985/2015).		
Wyoming	WY Rules and Regs. 044.0002.17. (1985/2015).		

PROJECT HISTORY - 2012

MODEL REGULATION FOR RECOGNIZING A NEW ANNUITY MORTALITY TABLE FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES (#821)

1. Description of the Project, Issues Addressed, etc.

In August 2011, the Life Actuarial (A) Task Force voted to send a model law development request to the Life Insurance and Annuities (A) Committee to amend the *Model Regulation for Recognizing a New Annuity Mortality Table for use in Determining Reserve Liabilities for Annuities* (#821). The Executive (EX) Committee approved the request to work on this model regulation at the 2011 Fall National Meeting. This model specifies the annuity mortality table to be used for determining the minimum reserves for individual and group annuities. This regulation was last amended in 1996 to incorporate the Annuity 2000 Mortality Table for individual annuities. The Life Actuarial (A) Task Force has released for comment the 2012 Individual Annuity Mortality Table, which was developed by the Society of Actuaries and the American Academy of Actuaries. Proposed amendments to the model regulation were released for comment at the 2012 Spring National Meeting. The model regulation was adopted by the Life Actuarial (A) Task Force Oct. 23, 2012, and adopted by the Life Insurance and Annuity (A) Committee Nov. 13, 2012. The model regulation is on the agenda for consideration of adoption during the Executive (EX) Committee and Plenary joint meeting at the 2012 Fall National Meeting.

2. Name of Group Responsible for Drafting the Model and States Participating

The Life Actuarial (A) Task Force was charged by the Life Insurance and Annuities (A) Committee with development of the Valuation Manual. The 2012 members of the Task Force are: Alabama, Connecticut, Florida, Kansas, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Texas, and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The Life and Health Actuarial Task Force (now the Life Actuarial (A) Task Force) was given the following 2011 Charge: Work with the American Academy of Actuaries and the Society of Actuaries to develop new mortality tables for the valuation of payout annuities, for preneed, simplified issue and guaranteed issue forms of life insurance and minimum nonforfeiture requirements for life insurance. Provide periodic status reports on this project. 2010 Summer National Meeting

4. A General Description of the Drafting Process and Due Process

- The 2011 Life Actuarial (A) Task Force (formerly the Life and Health Actuarial Task Force) Charge included the development of new mortality tables, including a payout annuity table.
- The Life Actuarial (A) Task Force adopted a model law development request to send to the Life Insurance and Annuities (A) Committee to amend the *Model Regulation for Recognizing a New Annuity Mortality Table for use in Determining Reserve Liabilities for Annuities* (#821).
- The Executive (EX) Committee approved the request to work on this model law at the 2011 Fall National Meeting.
- The Life Actuarial (A) Task Force released for comment the 2012 Individual Annuity Mortality Table, which was developed by the Society of Actuaries and the American Academy of Actuaries. Proposed amendments to the model regulation were released for comment at the 2012 Spring National Meeting.
- The model regulation was adopted by the Life Actuarial (A) Task Force Oct. 23, 2012.
- The Life Insurance and Annuity (A) Committee adopted the model regulation Nov. 13, 2012.
- The model regulation is on the agenda for consideration of adoption during the Executive (EX) Committee and Plenary joint meeting at the 2012 Fall National Meeting.

5. A Discussion of the Significant Issues

This regulation was last amended in 1996 to incorporate the Annuity 2000 Mortality Table for individual annuities.

6. Any Other Important Information

None

ACTUARIAL OPINION AND MEMORANDUM REGULATION

Table of Contents

Section 1. Purpose

The purpose of this regulation is to prescribe:

A. Requirements for statements of actuarial opinion that are to be submitted in accordance with [insert state equivalent to Section 3 of the Standard Valuation Law], and for memoranda in support thereof;

B. Rules applicable to the appointment of an appointed actuary; and

C. Guidance as to the meaning of "adequacy of reserves."

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner of Insurance of the State of [insert state] under [insert citation, generally the state's standard valuation law]. This regulation will take effect for annual statements for the year 20[ ].

Section 3. Scope

This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

This regulation shall be applicable to all annual statements filed with the office of the commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6 of this regulation, and a memorandum in support thereof in accordance with Section 7 of this regulation, shall be required each year.

Section 4. Definitions

A. "Actuarial Opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6 of this regulation and with applicable Actuarial Standards of Practice.

B. "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

C. "Annual statement" means that statement required by Section [insert applicable section] of the Insurance Law to be filed by the company with the office of the commissioner annually.

D. "Appointed actuary" means an individual who is appointed or retained in accordance with the requirements set forth in Section 5C of this regulation to provide the actuarial opinion and supporting memorandum as required by [insert reference to state equivalent of Section 3 of the Standard Valuation Law].

E. "Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in Section 5D of this regulation.

F. "Commissioner" means the Insurance Commissioner of this State.

G. "Company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

H. "Qualified actuary" means an individual who meets the requirements set forth in Section 5B of this regulation.

Section 5. General Requirements

A. Submission of Statement of Actuarial Opinion

(1) There is to be included on or attached to Page 1 of the annual statement for each year beginning with the year in which this regulation becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 6 of this regulation.

(2) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

B. Qualified Actuary. A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American Academy of Actuaries;

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

(a) Violated any provision of, or any obligation imposed by, the Insurance Law or other law in the course of his or her dealings as a qualified actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(d) Submitted to the commissioner during the past five (5) years, pursuant to this regulation, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

(e) Resigned or been removed as an actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under Paragraph (4) above.

C. Appointed Actuary. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in Subsection B. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in Subsection B. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

D. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this regulation:

(1) Shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and on any additional standards under this regulation, which standards are to form the basis of the statement of actuarial opinion in accordance with this regulation; and

(2) Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

E. Liabilities to be covered.

(1) Under authority of [insert state equivalent of Section 3 of the Standard Valuation Law], the statement of actuarial opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 8, 9 and 10, and claim liabilities in Exhibit 11, Part 1 and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in the Standard Valuation Law, the company shall establish the additional reserve.

(3) Additional reserves established under Paragraph (2) above and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

Section 6. Statement of Actuarial Opinion Based On an Asset Adequacy Analysis

A. General Description. The statement of actuarial opinion submitted in accordance with this section shall consist of:

(1) A paragraph identifying the appointed actuary and his or her qualifications (see Subsection B(1));

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Subsection B(2)) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Subsection B(3)), supported by a statement of each such expert in the form prescribed by Subsection E; and

(4) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Subsection B(6)).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

(a) If the appointed actuary considers it necessary to state a qualification of his or her opinion;

(b) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(c) If the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release;

(d) If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

B. Recommended Language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

For a consulting actuary, the opening paragraph should include a statement such as:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

Asset Adequacy Tested Amounts—Reserves and Liabilities					
Statement Item	**Formula Reserves (1)**	**Additional Actuarial Reserves (a) (2)**	**Analysis Method (b)**	**Other Amount (3)**	**Total Amount (1)+(2)+(3) (4)**
Exhibit 8 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability—Active					
F Disability—Disabled					
G Miscellaneous					
Total (Exhibit 8 Item 1, Page 3)					
Exhibit 9 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 9 Item 2, Page 3)					
Exhibit 10 Premium and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities Certain (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 10 (Column 1, Line 14)					

Asset Adequacy Tested Amounts—Reserves and Liabilities					
Statement Item	**Formula Reserves (1)**	**Additional Actuarial Reserves (a) (2)**	**Analysis Method (b)**	**Other Amount (3)**	**Total Amount (1)+(2)+(3) (4)**
Exhibit 11 Part 1 1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 11, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					

IMR (General Account, Page ___ Line ___)	
(Separate Accounts, Page ___ Line ___)	
AVR (Page ___ Line ___)	(c)
Net Deferred and Uncollected Premium	

Drafting Notes: (a) The additional actuarial reserves are the reserves established under Paragraph (2) of Section 5E; (b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Section 5D of this regulation, by means of symbols that should be defined in footnotes to the table; (c) Allocated amount of Asset Valuation Reserve (AVR).

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

"I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of the experts in the form prescribed by Section 6E.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

"In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The section shall be accompanied by a statement by each person relied upon in the form prescribed by Subsection E.

(6) The opinion paragraph should include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

(a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(b) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(c) Meet the requirements of the Insurance Law and regulation of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

(e) Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the commissioner, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion; or

The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

Drafting Note: Choose one of the above two paragraphs, whichever is applicable.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____
Signature of Appointed Actuary

_____
Address of Appointed Actuary

_____
Telephone Number of Appointed Actuary

_____
Date"

C. Assumptions for New Issues

The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this Section 6.

D. Adverse Opinions

If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

E. Reliance on Information Furnished by Other Persons

If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

F. Alternate Option

(1) The Standard Valuation Law gives the commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of Subsection B(6)(c), the commissioner may make one or more of the following additional approaches available to the opining actuary:

(a) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the commissioner chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(b) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met." If the commissioner chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. It shall remain valid until rescinded or modified by the commissioner. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

(c) A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state."

(i) If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in Item (ii) below) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

(ii) If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under NAIC codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(iii) The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

(iv) If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(v) The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding the above, the commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract an independent actuary at the company's expense to prepare and file the opinion.

Section 7. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary

A. General

(1) In accordance with [insert state equivalent of Section 3 of the Standard Valuation Law], the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Section 5B of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

(5) In accordance with [insert reference to state equivalent to Section 3 of the Standard Valuation Law], the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection C. The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. Details of the Memorandum Section Documenting Asset Adequacy Analysis

When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Section 5D of this regulation and any additional standards under this regulation. It shall specify:

(1) For reserves:

(a) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(b) Source of liability in force;

(c) Reserve method and basis;

(d) Investment reserves;

(e) Reinsurance arrangements;

(f) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(g) Documentation of assumptions to test reserves for the following:

(i) Lapse rates (both base and excess);

(ii) Interest crediting rate strategy;

(iii) Mortality;

(iv) Policyholder dividend strategy;

(v) Competitor or market interest rate;

(vi) Annuitization rates;

(vii) Commissions and expenses; and

(viii) Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) For assets:

(a) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(b) Investment and disinvestment assumptions;

(c) Source of asset data;

(d) Asset valuation bases; and

(e) Documentation of assumptions made for:

(i) Default costs;

(ii) Bond call function;

(iii) Mortgage prepayment function;

(iv) Determining market value for assets sold due to disinvestment strategy; and

(v) Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) For the analysis basis:

(a) Methodology;

(b) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(c) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(d) Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

(e) Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) Summary of results; and

(6) Conclusions

C. Details of the Regulatory Asset Adequacy Issues Summary

(1) The regulatory asset adequacy issues summary shall include:

(a) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(b) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

(c) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

(d) Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;

(e) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

(f) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

D. Conformity to Standards of Practice. The memorandum shall include a statement:

"Actuarial methods, considerations and analysis used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

E. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve

An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

Drafting Note: It has been suggested by some that, if the required interest rate scenarious are removed, they should be restored in five years if the commissioner is not satisfied with the scenarios upon which the asset adequacy opinion is based.

F. Documentation. The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1991 Proc. II 25, 57, 685, 1202-1215 (adopted).
1992 Proc. I 86, 94, 97, 861, 1391-1392 (adopted technical amendments).
1993 Proc. I 8, 136, 801, 1400-1414, 1457 (amended and reprinted).
2001 Proc. 1st Quarter 918, 999-1015 (amendments adopted later are printed here).
2001 Proc. 2nd Quarter 11, 14, 80, 112 (amended).
2009 Proc. 3rd Quarter, Vol. I, 95, 114-118, 177-202 (amended).

ACTUARIAL OPINION AND MEMORANDUM REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ACTUARIAL OPINION AND MEMORANDUM REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-112 (1996/2016).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.800 to 21.845 (1996/2011) (portions of model; does not include 2009 amendment).		BULLETIN 94-11 (1994); BULLETIN 96-12 (1996).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-696 to 20-696.04 (1996/2013) (does not include 2009 amendment).		
Arkansas	ARK. ADMIN. CODE §§ 054.00.64-I1 to 054.00.64-13 (1995/2008) (does not include 2009 amendment); ARK. ADMIN. CODE §§ 054.00.64A-1 to 054.0064A-10 (2008) (portions of model; does not include 2009 amendment).		

ACTUARIAL OPINION AND MEMORANDUM REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
California	CAL. CODE REGS. tit. 10, §§ 2580.1 to 2580.9 (1995/2005) (does not include 2009 amendment).		
Colorado	3 COLO. CODE REGS § 702-3:3-1-8 (1992/2017).		3 COLO. CODE REGS. 702-1:1-1-1 (2012).
Connecticut	CONN. AGENCIES REGS. §§ 38a-78-1 to 38a-78-9 (1993/2008) (does not include 2009 amendment).		CONN. AGENCIES REGS. §§ 38a-53-1 to 38a-53-2 (1993/2010); §§ 38A-459-17 to 38A-459-20 (2002/2017).
Delaware	18 DEL. ADMIN. CODE §§ 305-1.0 to 305-8.0 (1994/2009) (does not include 2009 amendment).		
District of Columbia	D.C. MUN. REGS. tit. 26, §§ 2900 to 2999 (1997/2005) (does not include 2009 amendment).		
Florida	FLA. ADMIN. CODE ANN. r. 69O-138.040 to 69O-138.047 (1993/2017).		FLA. ADMIN. CODE ANN. r. 69O-149.006 (1985/2019).
Georgia	GA. COMP. R. & REGS. 120-2-74-.01 to 120-2-74-.09 (1997/2011).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. CODE R. §§ 16-169-1 to 16-169-13 (1997/2012) (does not include 2009 amendment).		
Idaho	IDAHO ADMIN. CODE 18.01.77.000 to 18.01.77.024 (1997/2009).		
Illinois			215 ILL. COMP. STAT. ANN. § 5/223 (1937/2016) (establishes valuation manual as source for standards); BULLETIN 2013-20 (2013); BULLETIN 2014-12 (2014).

ACTUARIAL OPINION AND MEMORANDUM REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Indiana	760 IND. ADMIN. CODE 1-57 (1997/2015) (does not include 2009 amendment).		
Iowa	IOWA ADMIN. CODE r. 191-5.34 (1996/2010).		
Kansas	KAN. ADMIN. REGS. § 40-1-44 (1997/2005) (adopts model by reference to dept. policy).		
Kentucky	806 KY. ADMIN. REGS. § 6:100 (1998/2009) (does not include 2009 amendment).		
Louisiana	LA. ADMIN. CODE tit.37, §§ XIII.2101 to XIII.2117 (Regulation No. 47) (2005/2011) (does not include 2009 amendment).		
Maine	02-031 ME. CODE R. § 780 (1995/2006) (does not include 2009 amendment).		ME. REV. STAT. ANN. tit. 24A, § 952A (2003/2013).
Maryland	MD. CODE REGS. 31.05.01.01 to 31.05.01.10 (1994/2012).		MD. CODE REGS. 31.04.21.01 to 31.04.21.03 (2011).
Massachusetts	211 MASS. CODE REGS. 132.01 to 132.08 (1997/2010).		
Michigan	MICH. ADMIN. CODE r. 500.991 to 500.997 (2006) (does not include 2009 amendment).		
Minnesota	MINN. R. 2711.0200 to 2711.0240 (2013).		
Mississippi	19 MISS. ADMIN. CODE PT. 2, §§ 17.01 to 17.10 (2008-3) (2012) (does not include 2009 amendment).		
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 200-1.115 to 200-1.116 (1992/2009) (does not include 2009 amendment).		MO. CODE REGS. ANN. tit. 20, §§ 200-1.110 to 200-1.115 (1974/2019).

ACTUARIAL OPINION AND MEMORANDUM REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. ADMIN. R. 6.6.6501 to 6.6.6509 (1996/2017).		
Nebraska	210 NEB. ADMIN. CODE § 69 (1995/2010).		
Nevada	NEV. ADMIN. CODE §§ 681B.100 to 681B.245 (1996/2013) (portions of model).		
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. §§ 2401.01 to 2401.07 (2005/2019).		
New Jersey	N.J. ADMIN. CODE §§ 11:1-21A.1 to 11:1-21A.6 (1995/2012) (portions of model).		BULLETIN 2009-27 (2009); BULLETIN 2010-20 (2010).
New Mexico	N.M. CODE R. §§ 13.2.6.1 to 13.2.6.11 (1997/2003) (does not include 2009 amendment).		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 95.1 to 95.12 (Regulation 126) (1994/2014) (does not include 2009 amendment).		Circular Letter 2005-22 (2009); MEMORANDUM 11-18-2010 (2010).
North Carolina	11 N.C. ADMIN. CODE §§ 11F.0301 to 11F.0307 (1994/2015).		
North Dakota	N.D. ADMIN. CODE §§ 45-03-19-01 to 45-03-19-07 (1995/2004) (does not include 2009 amendment).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3903.726 (2014) (adopts valuation manual).

ACTUARIAL OPINION AND MEMORANDUM REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-170 to 365:10-5-177 (1998/2012).		
Oregon	OR. ADMIN. R. 836-031-600 to 836-31-690 (1992/2019).		
Pennsylvania	31 PA. CONS. STAT. § 84b (1994/2011) (portions of model).		Notice 10-25-2008 (2008).
Puerto Rico	P.R. REGS. 7995 (Rule No. 95) (2011).		
Rhode Island	230 R.I. CODE R. §§ 20-45-9.1 to 20-45-9.8 (1996/2010).		
South Carolina	S.C. CODE ANN. REGS. R. 69-52 (1993/2008) (does not include 2009 amendment).		S.C. CODE ANN. REGS. 38-9-225 to 38-9-230 (2009).
South Dakota	S.D. ADMIN. R. 20:06:37:01 to 20:06:37:47 (1997/2008) (does not include 2009 amendment).		S.D. ADMIN. R. 20:06:25:02 (1995/2014).
Tennessee	TENN. COMP. R. & REGS. 0780-1-64-.01 to 0780-1-62-.07 (1995/2009) (does not include 2009 amendment).		
Texas	28 TEX. ADMIN. CODE §§ 3.1601 to 3.1608 (1992/2010).		TEX. INS. CODE § 802.002 (2001).
Utah	UTAH ADMIN. CODE r. R590-162-1 to R590-162-9 (1994/2015); BULLETIN 2013-9 (2013).		BULLETIN 2013-1 (2013).
Vermont	VT. ADMIN. CODE 4-3-33:1 to 4-3-33:7 (1997/2010) (does not include 2009 amendment).		
Virgin Islands	V.I. CODE ANN. tit. 22 §§ 1031 to 1037 (2018).		

ACTUARIAL OPINION AND MEMORANDUM REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virginia	14 VA. ADMIN. CODE §§ 5-310-10 to 5-310-120 (1992/2015).		
Washington	WASH. ADMIN. CODE 284-07-310 to 284-07-400 (1995/2007) (does not include 2009 amendment).		
West Virginia	W. VA. CODE R. §§ 114-41-1 to 114-41-6; Table I. (1996/2011).		
Wisconsin	WIS. ADMIN. CODE INS. §§ 50.60 to 50.80 (1996/2014).		
Wyoming	044-53 WYO. CODE R. §§ 1 to 9 (1997/2010).		

PROJECT HISTORY - 2009

ACTUARIAL OPINION AND MEMORANDUM REGULATION (#822)

1. Description of the Project, Issues Addressed, etc.

The project was to remove the restrictions on the mortality adjustment factors (X factors) in the deficiency reserve calculation required by the Valuation of Life Insurance Policies Model Regulation. Therefore, the Task Force, as part of the Regulatory Asset Adequacy Issues Summaries required of life insured companies each year, required the appointed actuary to make a statement as to the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods. The definition of the Regulatory Asset Adequacy Issues Summary as defined in the Actuarial Opinion and Memorandum Regulation was modified to reflect this requirement.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2009 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The initial charge was given to the Task Force in November 2008, by the Capital and Surplus Relief (EX) Working Group to consider the November 11, 2008, proposal from the American Council of Life Insurers. The proposal was rejected by the Executive Committee in January 2009. At the 2009 Commissioners Conference the Task Force was again charged with reviewing the proposal.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The initial drafts were provided by the American Council of Life Insurers. A subgroup of the Task Force made changes and made a recommendation to the Task Force. The Task Force made several modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at public conference calls on this topic on the following dates: March 27, 2009; March 31, 2009; April 7, 2009; April 14, 2009; April 21, 2009; and April 28, 2009. The Task Force held a public conference call on this topic on May 4, 2009. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment on December 23, 2008 and May 4, 2009. The Task Force voted to adopt the model regulation on June 3, 2009, without an additional 30-day exposure period. The vote was eleven in favor (Alabama, Alaska, Arkansas, California, Connecticut, Minnesota, Missouri, Nebraska, Oklahoma, South Carolina, and Texas), two abstaining (Florida and New York) and one not voting (Ohio).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

7. Any Other Important Information (e.g., amending an accreditation standard).

This model regulation is an accreditation standard.

PROJECT HISTORY - 2001

ACTUARIAL OPINION AND MEMORANDUM REGULATION (#822)

1. What issues was the project intended to address?

This project addressed four primary questions: 1) Should small companies be exempt from performing an asset adequacy analysis; 2) What flexibility should be provided commissioners in accepting actuarial opinions based on foreign states' laws; and 3) Should additional information be required to be included in the actuarial memorandum; and 4) Should a confidential summary of the assumptions and results of the asset adequacy analysis be prepared and submitted to the commissioners?

2. What states participated in drafting the model?

The following states are currently members of the Task Force: New Mexico (Chair), California (Vice-Chair), Arkansas, Connecticut, Florida, Illinois, Kansas, Michigan, Minnesota, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Texas, and Utah

3. When was the charge given to the task force, and what was the nature of the charge?

The AOMR was adopted by the NAIC in 1991. A limited number of revisions to the model were made in the eighteen months subsequent to its adoption. Since that time, discussions have been ongoing relative to numerous aspects of the model. The primary aspects which have been addressed are identified in Item #1.

4. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?

The efforts of the Task Force were closely coordinated with all industry interested parties. In addition to open sessions at the quarterly meetings of the NAIC, numerous conference calls were held over the last several years to discuss the various drafts of the revised model. Notice of those conference calls were posted on the NAIC's home page on the Internet and e-mailed to approximately 150 interested parties, including representatives of the American Council of Life Insurers, the National Alliance of Life Companies, and the National Fraternal Congress of America. Additionally, representatives of the American Academy of Actuaries and the Actuarial Standards Board provided significant input on this matter.

5. What significant issues were raised during the drafting process, and how were those issues resolved?

a) Should small companies be exempt from performing an asset adequacy analysis?

All life insurers are required to file an actuarial opinion with their annual financial statement. In 1991, the NAIC adopted the AOMR which, in essence, established a two-tier system for these opinions. Companies whose admitted assets exceed $500 million are required to conduct sufficient tests such that they can certify that their assets "make adequate provision" for their liabilities, i.e., their actuaries must perform an asset adequacy analysis. Under certain conditions, companies whose admitted assets fall below $500 million are exempt from this requirement and need only certify that their reserves have been computed in accordance with the formulas specified in the law. (The larger companies must also meet this additional requirement.)

The two-tier system was adopted due to concerns over the expense that asset adequacy analyses would impose on smaller companies. The following excerpt is from the June 3, 1989, Report of the Special Advisory Committee on the Standard Valuation Law: "At the committee's Dec. 1, 1988, meeting, Kenneth Andre, president of Guarantee Reserve Life and then chairman-elect of the National Association of Life Companies, discussed the thrust of the committee's work from a small and medium company perspective. Mr. Andre urged the committee to keep in mind that analyses of the kind being discussed by the committee can represent a major challenge and expense impact for small and medium companies. He said that this should not, however, be interpreted to suggest that such companies would not generally support the goals of this approach to valuation."

The concern stated above continues to be expressed by industry representatives. This excerpt from a April 5, 2000, memo written by Scott Cipinko, Executive Director of the National Alliance of Life Companies ("NALC"), is representative of the fears which have been communicated to the Task Force:

The NALC remains opposed to additional testing for two reasons:

1) The cost of the testing is not justified by the "Benefit," which is as yet unknown--what benefit will be received for the additional cost? and
2) What is the harm to be avoided by the additional testing?

Industry representatives also point out that the current version of the AOMR contains the following language: "the Commissioner may require any company otherwise exempt pursuant to this regulation to submit a statement of actuarial opinion and to prepare a memorandum in support thereof in accordance with Sections 8 and 9 of this regulation if, in the opinion of the Commissioner, an asset adequacy analysis is necessary with respect to the company." They argue that this gives the commissioners all the authority they need to require asset adequacy testing for smaller companies without totally eliminating the exemptions.

Those comments notwithstanding, the Task Force is recommending removal of the exemptions, thereby requiring all companies to demonstrate the adequacy of their reserves. The Task Force is in agreement with the position expressed by the State Variations in Valuation Laws Task Force of the American Academy of Actuaries in its May 10, 1996, report. On page 4, the following recommendation is made:

AOM Model Regulation: Delete Sections 6 and 7 completely. The rationale is:

- Uniform Actuarial Opinions are important, both in terms of policyholder protection and the integrity of the statutory accounting system;
- There is no precedence in GAAP, Risk Based Capital requirements, etc. for different standards based on size;
- Formula reserves alone may not be sufficient;
- Foreign states are more likely to accept a domiciliary state's AOM if the reserves are tested for adequacy.

The Task Force does recognize that the issue of expenses is a legitimate concern. During this project, the Task Force has received the assistance of the Actuarial Standards Board, which has developed revised standards of actuarial practice relative to this matter. The revised standards are currently being exposed and will be finalized later this year. They provide for the actuary to perform necessary testing based on the degree of risk inherent in the contracts sold. This ranges from very little (in some cases only intermittent testing is necessary) to cash flow modeling. This availability of a range of methods will allow each company to choose the one (or combination) which best fits its circumstances, thereby minimizing the expense each will incur in fulfilling this requirement.

b) What flexibility should be provided commissioners in accepting actuarial opinions based on foreign states' laws?

Section 3A of the Standard Valuation Law requires the filing of an actuarial opinion stating that "reserves and related actuarial items…comply with applicable laws of this state. The commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope." In implementing that provision, the current AOMR requires all companies to file an actuarial opinion that the reserves 1) meet the requirements of the law of the state of domicile and 2) are at least as great, in the aggregate, as required by the state in which the filing is made. Many industry representatives strongly object to the second provision. They argue that it is an unreasonable burden for them to monitor compliance of their reserves relative to the laws of every state in which they do business. They want this second provision eliminated, so that they only have to certify that they meet the requirements of their state of domicile.

On the other side, many regulators are strongly opposed to eliminating the "state of filing" provision. They argue that that this would amount to a usurpation of their right to impose the solvency standards they believe are best for companies (both domestic and foreign) that do business in their state. They also argue that, if this rule were to be implemented, companies domiciled in states with relatively weaker reserving laws would have an unfair advantage over other companies. (In response to that argument, critics of the current requirement maintain that the accreditation process assures that each state has appropriate reserving requirements.)

In an effort to reach a compromise, the Task Force is proposing amendments to the AOMR. The general standard will be maintained that reserves are subject to the laws of the state where the statement is filed, i.e., a State A domestic operating in State B will remain subject to State B's laws relative to reserves. However, State B would then have three options that may be used in lieu of simply requiring the "state of filing" opinion. In essence, the

options permit a "state of domicile" opinion, but they require that certain financial standards be met or that financial information be provided so that State B can make an informed decision as to whether the domestic state's reserve laws, as applied to this specific State A domestic, reasonably meet State B's standards. If the State B is satisfied, then the "state of domicile" opinion would be deemed to meet its reserve requirements. If State B is not satisfied, or if the State A domestic simply decides to go ahead an submit a "state of filing" opinion, then it would submit an actuarial opinion that certifies, in the aggregate, its reserves comply with State B's standards.

The American Council of Life Insurers is strongly opposed to these amendments as written. Following is an excerpt from a November 9, 2000 memo on behalf of the ACLI's Actuarial Committee: "The ACLI's Actuarial Committee has carefully reviewed the proposed AOMR revision, with particular attention to the proposals for an alternate option with respect to state of domicile opinions in Section 6F(1), and, while the Committee recognizes and appreciates the effort that went into attempting to solve the vexing problem of different requirements among the states, it concluded that the proposal should be withdrawn." Essentially, their position is the proposed changes are cumbersome and would accomplish little towards simplifying the process.

Most of the Task Force takes a contrary view. They believe that if a significant number of states adopt these amendments, it will accomplish two things: 1) Provide relief for the companies from keeping abreast of reserve requirements in the adopting states, and 2) Preserve the principle of a state's right to adopt the laws it feels are best suited to its circumstances.

c) Should additional information be required to be included in the Actuarial Memorandum?

The AOMR requires that "in accordance with Section 3 of the Standard Valuation Law, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves under a Section 8 opinion." Since the implementation of the AOMR, new products have emerged and new insights have been gained regarding the key aspects which ought to be documented in the memorandum. The proposed revisions to the AOMR include updated requirements for documentation of the various assumptions, economic scenarios, and product features incorporated into the asset adequacy analysis.

d) Should a confidential summary of the assumptions and results of the asset adequacy analysis be prepared and submitted to the commissioners?

Depending upon a particular company's circumstances, the actuarial memorandum may be a voluminous and complex document. The proposed revisions to the AOMR include a requirement that a "Regulatory Asset Adequacy Issues Summary" be prepared which summarizes the major assumptions and economic scenarios embedded in the actuarial memorandum. It is hoped that inclusion of this confidential summary will increase the efficiency with which the actuarial opinion and memorandum are reviewed.

6. What are the implications of this project for accreditation and codification?

The accreditation standards require that "the NAIC's Standard Valuation Law and Actuarial Opinion and Memorandum Regulation or substantially similar provisions shall be in place." Appendix A-822 of the Accounting Practices and Procedures Manual includes substantial portions of the AOMR.

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

(Including the Introduction and Use of New Select Mortality Factors)

Table of Contents

Section 1. Purpose

A. The purpose of this regulation is to provide:

(1) Tables of select mortality factors and rules for their use;

(2) Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

(3) Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

B. The method for calculating basic reserves defined in this regulation will constitute the Commissioners' Reserve Valuation Method for policies to which this regulation is applicable.

Section 2. Authority

This regulation is issued under the authority of Section [insert applicable section] of the Insurance Laws of [insert state].

Section 3. Applicability

This regulation shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this regulation, subject to the following exceptions and conditions.

A. Exceptions

(1) This regulation shall not apply to any individual life insurance policy issued on or after the effective date of this regulation if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this regulation, that guarantees the premium rates of the new policy. This regulation also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(2) This regulation shall not apply to any universal life policy that meets all the following requirements:

(a) Secondary guarantee period, if any, is five (5) years or less;

(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in Section 4F and the applicable valuation interest rate; and

(c) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

Drafting Note: Policies with a secondary guarantee are described in Section 7.

(3) This regulation shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(4) This regulation shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(5) This regulation shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Conditions

(1) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of Section 6.

(2) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of Section 7.

Section 4. Definitions

For purposes of this regulation:

A. "Basic reserves" means reserves calculated in accordance with Section [cite section of state law comparable to Section 5 of the NAIC Standard Valuation Law].

B. "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in Subsection F of this section, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Section 5B of this regulation.

The length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t (if G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; *t* is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$, However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and

$q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the

mortality of Section 5B(2) if Section 5B(3) is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

Drafting Note: The purpose of the one percent tolerance in the R factor is to prevent irrational segment lengths due to such things as premium rounding. For example, consider a plan in which gross premiums are designed at some point to be a ratio times the underlying ultimate mortality rates, where the ratio varies by issue age. The resulting segments may be greater than one year, because the guaranteed gross premiums are not expressed in fractional cents. The tolerance factor allows the creation of one year segments for a plan in which premiums parallel the underlying valuation mortality table.

C. "Deficiency reserves" means the excess, if greater than zero, of

(1) Minimum reserves calculated in accordance with Section [cite section of the state law comparable to Section 8 of the NAIC Standard Valuation Law] over

(2) Basic reserves.

D. "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

E. "Maximum valuation interest rates" means the interest rates defined in Section [cite section of state law comparable to Section 4b of the NAIC Standard Valuation Law] (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

F. "1980 CSO valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

Drafting Note: This regulation defines the 1980 CSO Tables without the existing ten -year select mortality factors to assure that, if select mortality factors are elected, only one set of factors may be applied to the base valuation mortality table.

G. "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in Section 7A(3), if any, or else the minimum premium described in Section 7A(4).

H. (1) "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(a) The present value of the death benefits within the segment, plus

(b) The present value of any unusual guaranteed cash value (see Section 6D) occurring at the end of the segment, less

(c) Any unusual guaranteed cash value occurring at the start of the segment, plus

(d) For the first segment only, the excess of the Item (i) over Item (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(2) The length of each segment is determined by the "contract segmentation method," as defined in this section.

(3) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(4) For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

Drafting Note: The segmentation requirement should not be limited to plans with no cash surrender values; otherwise companies could avoid segmentation entirely by designing policies with minimal (positive) cash values. Segmentation for plans with cash surrender values should be based solely upon gross premium levels. Basing segmentation upon the level of cash surrender values introduces complications because of the inter-relationship between minimum cash surrender values and gross premium patterns. The requirements of this regulation relating to reserves for plans with unusual cash values and to reserves if cash values exceed calculated reserves serve to link required reserves and cash surrender values. The calculation of segmented reserves shall not be linked to the occurrence of a positive unitary terminal reserve at the end of a segment. The requirement of this regulation to hold the greater of the segmented reserve or the unitary reserve eliminates the need for any linkage.

I. "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

J. "Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

K. (1) "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(a) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(b) Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Item (i) over Item (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(ii) A net one year term premium for the benefits provided for in the first policy year.

(2) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

Drafting Note: The purpose of this subsection is to define as specifically as possible what has become commonly called the unitary method. The NAIC Standard Valuation Law does not define the term "unitary" for policies with nonlevel premiums or benefits; its requirement for reserves "computed by a method that is consistent with the principles of the NAIC Standard Valuation Law" has not been uniformly interpreted.

L. "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

Section 5. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves

A. At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix; or

Drafting Note: The select mortality factors for duration 1 through 15 in the Appendix of this regulation reflect the Society of Actuaries' data for the years 1983 through 1986, split by sex and smoking status, with fifteen years of mortality improvement, based on Society of Actuaries' Projection Scale A applied. A 50% margin was added. The factors were then graded to the 1980 CSO Tables over the next five durations. A 50% margin was deemed appropriate to provide a reasonable margin, with little likelihood that actual experience for significant blocks of business would exceed it.

(3) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating basic reserves.

B. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix of this regulation;

Drafting Note: The select mortality factors in the Appendix of this regulation do not reflect the underwriting risk classes that have evolved since the period of the underlying experience. In light of this consideration and the recent recognition of the regulatory value of actuarial opinions, this regulation allows actuarial judgment to be used for deficiency reserves.

(3) For durations in the first segment, X percent of the select mortality factors in the Appendix , subject to the following:

(a) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(b) X is such that, when using the valuation interest rate used for basic reserves, Item (i) is greater than or equal to Item (ii);

(i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(c) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

(d) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Subsection B(3);

(e) The appointed actuary may decrease X at any valuation date as long as X continues to meet all the requirements of Subsection B(3); and

(f) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(g) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Section [insert applicable section for asset adequacy opinion requirement of the Actuarial Opinion and Memorandum Regulation];

(ii) The appointed actuary shall disclose, in the Regulatory Asset Adequacy Issues Summary, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; and

(iii) The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Subsection B(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(4) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating deficiency reserves.

C. This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

Drafting Note: This regulation does not allow the use of select mortality factors beyond the first segment. The rationale is that the result of a premium increase that is sufficient to require a new segment will be increased lapsation, leading to mortality deterioration after the increase. Also, for policies that have reentry provisions, select mortality factors shall not be used in segments beginning after reentry unless a new policy is actually issued. However, this regulation allows the use of the ten-year select mortality factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law beyond the first segment (but in no case beyond the tenth policy year) in recognition that the mortality deterioration is unlikely to occur to a significant degree within the first ten (10) years.

D. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

E. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

F. The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Section [insert applicable section of asset adequacy opinion requirement of the Actuarial Opinion and Memorandum Regulation].

Section 6. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)

A. Basic Reserves

Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in Paragraph (1) or (2) below may be made:

(1) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

B. Deficiency Reserves

(1) The deficiency reserve at any duration shall be calculated:

(a) On a unitary basis if the corresponding basic reserve determined by Subsection A is unitary;

(b) On a segmented basis if the corresponding basic reserve determined by Subsection A is segmented; or

(c) On the segmented basis if the corresponding basic reserve determined by Subsection A is equal to both the segmented reserve and the unitary reserve.

(2) This subsection shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in Section 5B) and rate of interest.

(3) Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Section 5B.

(4) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

C. Minimum Value

Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

D. Unusual Pattern of Guaranteed Cash Surrender Values

Drafting Note: This requirement is independent of both the segmentation process and the unitary process. After the greater of the segmented or the unitary reserve has been determined, then this subsection imposes an additional floor on the ultimate reserve. The purpose of this subsection is to assure adequate funding of significant increases in guaranteed cash surrender values.

(1) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(2) The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where

(a) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(i) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) The mandatory expiration date of the policy; and

(b) The net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(c) The net to gross ratio is equal to Item (i) divided by Item (ii) as follows:

(i) The present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the n year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period.

(ii) The present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

(3) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(a) One hundred ten percent (110%) of the scheduled gross premium for that year;

(b) One hundred ten percent (110%) of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(c) Five percent (5%) of the first policy year surrender charge, if any.

E. Optional Exemption for Yearly Renewable Term Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

Drafting Note: Traditional reserves for yearly renewable term (YRT) reinsurance, the calculations of which this section describes, are already adequate and sufficient. However, without this option in the regulation, YRT reinsurance would be subject to the more complex segmentation calculations.

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection C.

(3) Deficiency reserves.

(a) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(b) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A reinsurance agreement shall be considered YRT reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(6) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

F. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

Drafting Note: Traditional reserves for attained-age-based YRT policies, the calculations of which this subsection describes, are already adequate and sufficient. However, without this option in the regulation, these policies would be subject to the more complex segmentation calculations.

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 6C.

(3) Deficiency reserves.

(a) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(b) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this subsection if:

(a) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(b) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

(6) For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(a) The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(b) The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(c) After the initial period of coverage, the policy meets the conditions of Paragraph (5) above.

(7) If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this regulation.

G. Exemption from Unitary Reserves for Certain *n*-Year Renewable Term Life Insurance Polices. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

Drafting Note: Without this exemption, companies issuing certain *n*-year renewable term policies could be forced to hold reserves higher than *n*-year term reserves, even though in many cases gross premiums are well above valuation mortality rates.

(1) The policy consists of a series of *n*-year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(2) The guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

(3) There are no cash surrender values in any policy year.

H. Exemption from Unitary Reserves for Certain Juvenile Policies

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(1) At issue, the insured is age twenty-four (24) or younger;

(2) Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and

(3) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

Drafting Note: The jumping juvenile policy described has traditionally been valued in two segments. This exemption will allow that practice to continue without requiring the calculation of reserves on a unitary basis. However, within each segment, both basic and deficiency reserves shall comply with the segmented reserve requirements.

Section 7. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period

A. General

(1) Policies with a secondary guarantee include:

(a) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(b) A policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose; or

(c) A policy with any combination of Subparagraph (a) and (b).

Drafting Note: Universal life and variable universal life policies with secondary guarantees that meet the requirements of Section 3A(2) are not subject to this regulation.

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subsections B and C below shall be recalculated from issue to reflect these changes.

(3) Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(4) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(5) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Section 5B(2), (3), and (4) may not be used to calculate the one-year valuation premiums.

(6) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

B. Basic Reserves for the Secondary Guarantees

Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in Section 4B.

C. Deficiency Reserves for the Secondary Guarantees

Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in Section 6B with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

D. Minimum Reserves

The minimum reserves during the secondary guarantee period are the greater of:

(1) The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) The minimum reserves required by other rules or regulations governing universal life plans.

Section 8. Effective Date

This regulation shall become effective January 1, 2000.

Appendix

SELECT MORTALITY FACTORS

This appendix contains tables of select mortality factors that are the bases to which the respective percentage of Section 5A(2), 5B(2) and 5B(3) are applied.

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male nonsmoker, (3) male smoker, (4) female aggregate, (5) female nonsmoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.

For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table in this Appendix, plus twenty percent (20%) of the appropriate female table in this Appendix.

Appendix

SELECT MORTALITY FACTORS

Male, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100

Male, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100

Male, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100

Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100

Female, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Aggregate

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100

Female, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Smoker

Issue	Duration																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1994 Proc. 4th Quarter 17, 26, 653, 1098, 1126-1159 (adopted).
1998 Proc. 4th Quarter 15-16, 17, 608, 978, 1126-1148 (amended and reprinted).
2009 Proc. 3rd Quarter, Vol. I, 95, 114-118, 178-186, 199-202 (amended).

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

What are the state pages?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

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RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-120 (1999/2010).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 21.900 to 21.949 (2011/2012).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas		CODE ARK. R. 054.00.47 (1999/2001).	
California	CAL. CODE REGS. tit. 10, §§ 2542 to 2542.8 (2003/2010).		
Colorado	3 COLO CODE REGS. § 702-4:4-1-9 (2000/2010).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	18 DEL. CODE REGS. § 1212 (2002/2009).		
District of Columbia		D.C. MUN. REGS. tit. 26, §§ 3000 to 3005 (2000/2008).	
Florida	FLA. ADMIN. CODE ANN. r. 69O-164.020 (2003/2013).		

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO ADMIN. CODE r. 18.07.03 (2000/2012).		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 1409.10 to 1409.60 (1996/2010).		.
Indiana		760 IND. ADMIN. CODE 1-64 (1999/2005).	
Iowa	IOWA ADMIN. CODE r. 191-47 (2000/2010).		
Kansas		KAN. ADMIN. REGS. § 40-2-26 (1997/2004) (adopted by reference).	
Kentucky		806 KY. ADMIN. REGS. 6:075 (2000/2005).	
Louisiana		LA. ADMIN. CODE tit. 37, §§10901 to 10917 (2005).	
Maine	CODE ME. R. tit. 02-031 Ch. 830 (2016).		
Maryland	MD. CODE REGS. 31.05.03.01 to 31.05.03.14 (1997/2009).		
Massachusetts	211 MASS. CODE REGS. 29.01 to 29.100 (2001/2010).		
Michigan		MICH. COMP. LAWS ANN. § 500.834 (2016) (portions of model).	
Minnesota	MINN. R. §§ 2747.0010 to 2747.0065 (2000/2013).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 200-1.160 (2001/2011).		

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	MONT. ADMIN. R. 6.6.6701 to 6.6.6713 (2000/2012).		
Nebraska	NEB. ADMIN. R. & REGS. Tit. 210, Ch. 71, §§ 002 to 007(2000/2010).		Notice 6-23-2009 (#2) (2009); Notice 11-2-2010 (2010).
Nevada		NEV. ADMIN. CODE 681B.161 (2000) (adopted by reference).	
New Hampshire			N.H. CODE ADMIN. R. ANN. 3501.01 to 3506.04 (2001/2009).
New Jersey	N.J. ADMIN. CODE §§ 11:4-32.1 to 11:4-32.6 (2000/2010).		BULLETIN 99-12 (1999); BULLETIN 2006-21 (2006).
New Mexico		N.M. ADMIN. CODE §§ 13.9.13.1 to 13.9.13.30 (1997/200).	
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 98.1 to 98.11 (Regulation 147) (1994/2014).		
North Carolina	11 N.C. ADMIN. CODE §§ 11F.0401 to 11F.0406 (1998/2011).		
North Dakota			N.D. ADMIN. CODE §§ 45-04-12-01 to 45-04-12-05 (2000/2010).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-6-10 (2000/2014).		
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-17-1 to 365:10-17-7 (2000/2009).		
Oregon	OR. ADMIN. R. 836-031-0750 to 836-031-0775 (2000/2013).		
Pennsylvania	31 PA. CODE §§ 84c.1 to 84c.7 (2000/2011).		

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. Code R. 20-25-8.1 to 20-25-8.8 (2000/2010).		
South Carolina		S.C. CODE ANN. REGS. 69-57 (2002).	
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	28 TEX. ADMIN. CODE §§ 3.4501 to 3.4509 (2000/2010).		
Utah		UTAH ADMIN. CODE r. 590-198 (1997/2014).	
Vermont		4-3 VT. CODE R. § 39 (REG. 99-3) (2000).	
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-319-10 to 5-319-80 (2000/2009).		
Washington	WASH. ADMIN. CODE 284-74-300 to 284-74-380 (2000/2012).		.
West Virginia	W. VA. CODE REGS. §§ 114-68-1 to 114-68-6 (2004/2011).		.
Wisconsin	WIS. ADMIN. CODE INS. § 2.80 (1997/2014).		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2009

VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION (#830)

1. Description of the Project, Issues Addressed, etc.

The project was to remove the restrictions on the mortality adjustment factors (X factors) in the deficiency reserve calculation required by the Valuation of Life Insurance Policies Model Regulation. The deficiency reserve calculation allows companies to adjust the valuation mortality to mortality that approximates the expected mortality by use of the X factors. The arbitrary restrictions in the model regulation prevent the use of mortality with the amount and slope similar to the expected mortality. The model regulation requires the appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of the X factors meet the requirements for deficiency reserves. This opinion has to be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

The reduction in deficiency reserve requirements that would result from the changes to the limitations on the use of X factors could result in reserves not being sufficient to provide for the payment of benefits and expenses and the establishment of statutory reserves during interim periods prior to the end of the projection period used in the asset adequacy analysis. Therefore, the Task Force, as part of the Regulatory Asset Adequacy Issues Summaries required of life insured companies each year, required the appointed actuary to make a statement as to the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2009 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, Arkansas, California, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The initial charge was given to the Task Force in November 2008, by the Capital and Surplus Relief (EX) Working Group to consider the November 11, 2008, proposal from the American Council of Life Insurers. The proposal was rejected by the Executive Committee in January 2009. At the 2009 Commissioners Conference the Task Force was again charged with reviewing the proposal.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The initial drafts were provided by the American Council of Life Insurers. A subgroup of the Task Force made changes and made a recommendation to the Task Force. The Task Force made several modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at public conference calls on this topic on the following dates: March 27, 2009; March 31, 2009; April 7, 2009; April 14, 2009; April 21, 2009; and April 28, 2009. The Task Force held a public conference call on this topic on May 4, 2009, and June 3, 2009. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 300 interested parties. Drafts of the document were released for comment on December 23, 2008, and May 4, 2009. The Task Force voted to adopt the modifications to the model regulation on June 3, 2009. The vote was eleven in favor (Alabama, Alaska, Arkansas, California, Connecticut, Minnesota, Missouri, Nebraska, Oklahoma, South Carolina, and Texas), two abstaining (Florida and New York) and one not voting (Ohio).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

7. Any Other Important Information (e.g., amending an accreditation standard).

This model regulation is not an accreditation standard.

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

Table of Contents

Section 1. Purpose of Act

A. The purpose of this act is to subject to the jurisdiction of the Insurance Commissioner of this state and to the jurisdiction of the courts of this state, insurers not authorized to transact business in this state that place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers that solicit insurance business in this state in the manner set forth in the preceding sentence that these insurers be subject to the provisions of this Act. In furtherance of this state interest, the legislature herein provides a method of substituted service of process upon these insurers and declares that in so doing, it exercises its power to protect its residents and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states. The authority provided herein to be in addition to any existing powers of this state.

B. The provisions of this Act shall be liberally construed.

Section 2. Definitions

When used in this Act:

A. "Commissioner" shall mean the Commissioner of Insurance of this state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term commissioner appears.

B. "Unfair Trade Practices Act" shall mean [insert applicable cite] Laws of 19 [insert year], approved [insert month], 19[insert year].

C. "Resident" shall include a person, partnership or corporation, domestic, alien or foreign.

Section 3. Notice to Domiciliary Supervisory Official

No unauthorized foreign or alien insurer of the kind described in Section 1 shall make, issue, circulate or cause to be made, issued or circulated, to residents of this state any estimate, illustration, circular, pamphlet or letter, or cause to be made in any newspaper, magazine or other publication or over any radio or television station, any announcement or statement to this state's residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of the Unfair Trade Practices Act, and whenever the commissioner shall have reason to believe that an insurer is engaging in such unlawful advertising, it shall be the duty of the commissioner to give notice of that fact by registered mail to the insurer and to the insurance supervisory official of the domiciliary state of the insurer. For the purpose of this section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

Section 4. Action by Commissioner

If, after thirty (30) days following the giving of the notice mentioned in Section 3, the insurer has failed to cease making, issuing or circulating the false misrepresentations or causing the same to be made, issued or circulated in this state, and if the commissioner has reason to believe that a proceeding in respect to these matters would be to the interest of the public, and that the insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on contracts or doing any of the acts enumerated in Section 5, the commissioner shall take action against the insurer under the Unfair Trade Practices Act.

Section 5. Service Upon Unauthorized Insurer

A. Any of the following acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer is equivalent to and shall constitute an appointment by the insurer of the commissioner of insurance and his or her successor or successors in office, to be its true and lawful attorney, upon whom may be served all statements of charges, notices and lawful process in any proceeding instituted in respect to the misrepresentations set forth in Section 3 under the provisions of the Unfair Trade Practices Act, or in any action, suit or proceeding for the recovery of any penalty provided in the Unfair Trade Practices Act, and any such act shall be signification of its agreement that the service of statement of charges, notices or process is of the same legal force and validity as personal service of the statement of charges, notices or process in this state, upon the insurer:

(1) The issuance or delivery of contracts of insurance to residents of this state;

(2) The solicitation of applications for contracts;

(3) The collection of premiums, membership fees, assessments or other considerations for contracts; or

(4) Any other transaction of insurance business,

B. Service of a statement of charges and notices under the Unfair Trade Practices Act shall be made by a deputy or employee of the Department of Insurance delivering to and leaving with the commissioner or some person in apparent charge of the commissioner's office, two (2) copies thereof. Service of process issued by any court in any action, suit or proceeding to collect any penalty under the Unfair Trade Practices Act provided, shall be made by delivering and leaving with the commissioner, or some person in apparent charge of the commissioner's office, two copies thereof. The commissioner shall forthwith cause to be mailed by registered mail one of the copies of the statement of charges, notices or process to the defendant at its last known principal place of business, and shall keep a record of all statements of charges, notices and process so served. The service of statement of charges, notices or process shall be sufficient, provided they have been so mailed and the defendant's receipt or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the letter showing a compliance are filed with the commissioner in the case of a statement of charges or notices, or with the clerk of the court in which an action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as may be allowed.

C. Service of statement of charges, notices and process in a proceeding, action or suit shall in addition to the manner provided in Subsection B of this section be valid if served upon any person within this state who on behalf of such insurer is soliciting insurance, making, issuing or delivering any contract or insurance, or collecting or receiving in this state any premium for insurance and a copy of the statement of charges, notices or process is sent within ten (10) days thereafter by registered mail by or on behalf of the commissioner to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the letter showing compliance, are filed with the commissioner in the case of a statement of charges or notices, or with the clerk of the court in which the action is pending in the case of a statement of charges or notices, or with the clerk of the court in which the action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as the court may allow.

D. No cease or desist order or judgment by [default or a judgment pro confesso] [select appropriate language] under this section shall be entered until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

E. Service of process and notice under the provisions of this Act shall be in addition to all other methods of service provided by law, and nothing in this Act shall limit or prohibit the right to serve a statement of charges, notices or process upon an insurer in any other manner now or hereafter permitted by law.

Section 6. Constitutionality

If any provision of this Act or its application to any person or circumstances is held invalid, the invalidity shall not affect other provisions or application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 7. Short Title

This Act may be cited as the Unauthorized Insurers False Advertising Process Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1960 Proc. II 507-509 (printed).
1961 Proc. I 307, 309, 316 (adopted).

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

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UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	CAL. INS. CODE §§ 1620.1 to 1620.7 (1961/1963).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware			DEL. CODE ANN. tit. 18, § 2102 (1968); §§ 2109 to 2111 (1953/1995).
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia			GA. CODE ANN. § 33-5-2 (1960/1983).
Guam	NO CURRENT ACTIVITY		

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii			HAW. REV. STAT. §§ 431:8-201 to 431:8-211 (1988).
Idaho			IDAHO CODE ANN. §§ 41-1235 to 41-1237 (1969).
Illinois	215 ILL. COMP. STAT. 5/123.1 (1961/1984).		
Indiana	IND. CODE §§ 27-4-6-1 to 27-4-6-6 (1963/1993).		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. §§ 40-2415 to 40-2421 (1963).		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	LA. REV. STAT. ANN. §§ 22:1941 to 22:1946 (1966).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2101 to 2114 (1970/1991).		
Maryland	MD. CODE ANN., INS. §§ 27-701 to 27-706 (1957/1997).		
Massachusetts			MASS. GEN. LAWS ch. 175, § 110E (1973/1984).
Michigan	MICH. COMP. LAWS §§ 500.2091 to 500.2093 (1961/1970).		
Minnesota	MINN. STAT. §§ 72A.33 to 72A.39 (1967/1992).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NEB. REV. STAT. §§ 44-1801 to 44-1806 (1965/1993).		
Nevada			NEV. REV. STAT. §§ 685B.090 to 685B.110 (1971).
New Hampshire	N.H. REV. STAT. ANN. §§ 406-A:1 to 406-A:7 (1961).		
New Jersey	N.J. STAT. ANN. §§ 17B:33-9 (1971).		
New Mexico	N.M. STAT. ANN. §§ 59A-15-11 to 59A-15-13 (1985).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. §§ 58-29-1 to 58-29-25 (1965/1991).		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. §§ 3901.24 to 3901.26 (1965/1967-1968).		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1004 to 1005 (1977).
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. CODIFIED LAWS §§ 58-33-47 to 58-33-57 (1966/1982).		

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 547.001 to 547.053 (2005).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming			WYO. STAT. ANN. §§ 26-12-301 to 26-12-303 (1967/1983).

UNAUTHORIZED INSURERS PROCESS ACT

Table of Contents

Introduction

An Act relating to insurers not authorized to transact business in this state; providing for actions in this state against and for the service of process upon these insurers; prescribing how a defense may be made by these insurers; and providing for the allowance of attorneys' fees in actions against these insurers.

Section 1. Purpose of Act

The purpose of this Act is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts.

The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to these residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under these policies. In furtherance of the state interest, the legislature herein provides a method of substituted service of process upon the insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this statute, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of United States Code tit. 15 § 1011, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

Section 2. Service of Process Upon Unauthorized Insurer

A. Any of the following acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer is equivalent to and shall constitute an appointment by the insurer of the Commissioner of Insurance and the commissioner's successor or successors in office, to be its true and lawful attorney, upon whom may be served all lawful process in any action, suit or proceeding instituted by or on behalf of an insured or beneficiary arising out of a contract of insurance, and any act shall be signification of its agreement that the service of process is of the same legal force and validity as personal service of process in this state upon the insurer.

(1) The issuance or delivery of insurance contracts to residents of this state or to corporations authorized to do business in the state;

(2) The solicitation of applications for insurance contracts;

(3) The collection of premiums, membership fees, assessments or other considerations for insurance contracts; or

(4) Any other transaction of insurance business.

Drafting Note: Insert the title of the chief regulatory official wherever the term "commissioner" appears.

B. Service of process shall be made by delivering to and leaving with the commissioner or some person in apparent charge of the office two (2) copies thereof and the payment of the fees prescribed by law. The commissioner shall forthwith mail by registered mail one of the copies of the process to the defendant at its last known principal place of business, and shall keep a record of all process so served upon the commissioner. The service of process is sufficient, provided notice of such service and a copy of the process are sent within ten (10) days thereafter by registered mail by the plaintiff or plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing compliance are filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear, or within a further time the court may allow.

C. Service of process in an action, suit or proceeding shall, in addition to the manner provided in Subsection B of this section, be valid if served upon a person within this state who, in this state on behalf of the insurer, is:

(1) Soliciting insurance; or

(2) Making, issuing or delivering any contract of insurance; or

(3) Collecting or receiving any premium, membership fee, assessment or other consideration for insurance;

and a copy of the process is sent within ten (10) days thereafter by registered mail by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear, or within a further time the court may allow.

D. A plaintiff or complainant shall not be entitled to a [insert appropriate state procedure, either judgment by default, or a judgment with leave to prove damages, or a judgment *pro confesso*] under this section until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

E. Nothing in this section contained shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner now or hereafter permitted by law.

Section 3. Defense of Action By Unauthorized Insurer

A. Before any unauthorized foreign or alien insurer shall file or cause to be filed any pleading in any action, suit or proceeding instituted against it, the unauthorized insurer shall deposit with the clerk of the court in which the action, suit or proceeding is pending, cash or securities or file with the clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in the action; or procure a certificate of authority to transact the business of insurance in this state.

B. The court in any action, suit or proceeding in which service is made in the manner provided in Section 2B or 2C may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.

C. Nothing in Subsection A of this section is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in Section 2B or 2C on the ground either that:

(1) The unauthorized insurer has not done any of the acts enumerated in Section 2A; or

(2) The person on whom service was made pursuant to Section 2C was not doing any of the acts therein enumerated.

Section 4. Attorney Fees

In an action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that the refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include the fee in any judgment that may be rendered in the action. The fee shall not exceed twelve and one-half percent (12-1/2%) of the amount that the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall the fee be less than $25. Failure of an insurer to defend an action shall be deemed *prima facie* evidence that its failure to make payment was vexatious and without reasonable cause.

Section 5. Constitutionality

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 6. Short Title

This Act may be cited as the Unauthorized Insurers Process Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1949 Proc. 126-130, 132, 315-316 (adopted).
1951 Proc. 166-168, 182 (printed and reaffirmed).

UNAUTHORIZED INSURERS PROCESS ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNAUTHORIZED INSURERS PROCESS ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-10-50 to 27-10-56 (1951/1971).		
Alaska			ALASKA STAT. §§ 21.33.011 to 21.33.035 (1968/1992).
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. §§ 20-403 to 20-406 (1972/1989).		
Arkansas	ARK. CODE ANN. §§ 23-65-201 to 23-65-205 (1959).		
California	CAL. INS. CODE §§ 1610 to 1620 (1949/1982).		CAL. INS. CODE § 12931 (1970/1985).
Colorado	COLO. REV. STAT. §§ 10-3-1001 to 10-3-1005 (1955/1997).		
Connecticut	CONN. GEN. STAT. § 38a-27 (1970/1996).		
Delaware	DEL. CODE ANN. tit. 18, §§ 2101 to 2108 (1956/1995).		

UNAUTHORIZED INSURERS PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. STAT. §§ 626.904 to 626.912 (1982/1997).		
Georgia	GA. CODE ANN. §§ 33-5-50 to 33-5-59 (1960/2000).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. §§ 431:8-206 to 431:8-211 (1988/2006).		
Idaho	IDAHO CODE ANN. §§ 41-1204 to 41-1210 (1961).		
Illinois	215 ILL. COMP. STAT. 5/123 (1949/1997).		
Indiana	IND. CODE §§ 27-4-4-1 to 27-4-4-8 (1955/1994).		
Iowa			IOWA CODE §§ 507A.5 to 507A.6 (1967/1974).
Kansas	KAN. STAT. ANN. §§ 40-2001 to 40-2006 (1949).		
Kentucky	KY. REV. STAT. ANN. § 304.11-040 (1982).		
Louisiana	LA. REV. STAT. ANN. §§ 22:1906 to 22:1908 (1958/1999).		
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2101 to 2108 (1970/1991).		
Maryland			MD. CODE ANN., INS. § 4-206 (1957/1997).
Massachusetts	MASS. GEN. LAWS ch. 175B, §§ 1 to 6 (1950/1973).		

UNAUTHORIZED INSURERS PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan			MICH. COMP. LAWS § 500.456 (1956/2003).
Minnesota	MINN. STAT. § 60A.21 (1978/1994).		
Mississippi	MISS. CODE ANN. §§ 83-21-33 to 83-21-51 (1958/1991).		
Missouri	MO. REV. STAT. §§ 375.256 to 375.301 (1967/1998).		
Montana	MONT. CODE ANN. §§ 33-1-611 to 33-1-616 (1959/1987).		
Nebraska	NEB. REV. STAT. §§ 44-2009 to 44-2013 (1949/1992).		
Nevada	NEV. REV. STAT. §§ 685B.050 to 685B.080 (1971/1993).		
New Hampshire	N.H. REV. STAT. ANN. §§ 406-B:4 to 406-B:7 (1967/1983).		
New Jersey	N.J. STAT. ANN. §§ 17B:33-1 to 17B:33-9 (1971); §§ 17:51-1 to 17:51-5 (1952/1996).		
New Mexico	N.M. STAT. ANN. §§ 59A-15-6 to 59A-15-8 (1985).		
New York	N.Y. INS. LAW § 1213 (1984).		
North Carolina	N.C. GEN. STAT. § 58-16-35 (1955/1999).		
North Dakota	N.D. CENT. CODE §§ 26.1-02-10 to 26.1-02-12 (1983).		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3901.26 (1965).		

UNAUTHORIZED INSURERS PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma			OKLA STAT. tit. 36, §§ 1103 to 1105 (1957/1997).
Oregon	OR. REV. STAT. §§ 746.320 (1967/1991).		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1005 to 1006 (1977).
Rhode Island	R.I. GEN. LAWS §§ 27-16-3 to 27-16-14 (1956).		
South Carolina	S.C. CODE ANN. §§ 38-25-510 to 38-25-560 (1988/1993).		
South Dakota	S.D. CODIFIED LAWS §§ 58-8-6 to 58-8-19 (1966/1982).		
Tennessee	TENN. CODE ANN. §§ 56-2-601 to 56-2-609 (1955).		
Texas			TEX. INS. CODE ANN. §§ 804.106 to 804.201 (2003).
Utah			UTAH CODE ANN. §§ 31A-2-309 to 31A-2-311 (1985/2004).
Vermont	VT. STAT. ANN. tit. 8, §§ 3381 to 3390 (1968).		
Virgin Islands			V.I. CODE ANN. tit. 22, § 665 (1968).
Virginia			VA. CODE ANN. §§ 38.2-800 to 38.2-807 (1986).
Washington			WASH. REV. CODE. §§ 48.05.200 to 48.05.220 (1947/1985).

UNAUTHORIZED INSURERS PROCESS ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE § 33-4-13 (1957/1997).		
Wisconsin			WIS. STAT. §§ 601.72 to 601.73 (1969/1996); BULLETIN 5-29-2012 (2012).
Wyoming			WYO. STAT. ANN. §§ 26-12-201 to 26-12-206 (1967/1983).

NONADMITTED INSURANCE MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as "The Nonadmitted Insurance Act."

Section 2. Purpose—Necessity for Regulation

This Act shall be liberally construed and applied to promote its underlying purposes which include:

A. Protecting persons seeking insurance in this state;

B. Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;

C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;

D. Providing a system through which persons may purchase insurance other than surplus lines insurance, from nonadmitted insurers pursuant to this Act;

E. Protecting revenues of this state; and

F. Providing a system pursuant to this Act which subjects nonadmitted insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

Section 3. Definitions

As used in this Act:

A. "Admitted insurer" means an insurer licensed to engage in the business of insurance in this state.

B. ''Affiliate'' means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

C. ''Affiliated group'' means any group of entities that are all affiliated.

D. "Commissioner" means the insurance commissioner of [insert name of state], or the commissioner's deputies or staff, or the commissioner, director or superintendent of insurance in any other state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

E. "Control" means with respect to an insured:

(1) A person, either directly or indirectly, or acting through one or more other persons, owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or

(2) The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

F. [OPTIONAL: "Domestic surplus lines insurer" means a surplus lines insurer domiciled in this state, that may write insurance in this state on a surplus lines basis.]

G. "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance pursuant to Section 5 of this Act.

H. "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) Has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months; and

(2) (a) Meets at least one of the following criteria:

(i) Possesses a net worth in excess of $20,000,000;

(ii) Generates annual revenues in excess of $50,000,000;

(iii) Employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;

(iv) Is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000; or

(v) Is a municipality with a population in excess of 50,000 persons.

(b) Effective on July 21, 2010, every five years on January 1, the amounts in Subsections (i), (ii), and (iv) of Section 3H(2)(a) shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

Drafting Note: The definition of "exempt commercial purchaser" follows the language of the federal Nonadmitted and Reinsurance Reform Act (NRRA). Some states have chosen not to adopt the inflation adjustment. The NRRA uses the term "municipality," which some states may find limiting. States may choose to use terminology consistent with state law to expand this provision to include counties and other public entities.

I. "Export" means to place surplus lines insurance with a nonadmitted insurer.

J. "Home state" with respect to an insured, means:

(1) The state in which an insured maintains its principal place of business or, in the case of a natural person, the person's principal place of residence;

(2) If 100 percent of the insured risk is located out of the state referred to in Section 3J(1), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or

(3) If the insured is an affiliated group with more than one member listed as a named insured on a single nonadmitted insurance contract, the home state is the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract.

Drafting Note: The NRRA definition of "home state" includes Subsections (1), (2), and (3) of Section 3J. The NRRA definition does not expressly cover unaffiliated groups. States have taken different approaches to the taxation of unaffiliated group policies. Some states tax based on the "home state" of the group policyholder. Other states tax based on the "home state" of the group member or certificate holder under the unaffiliated group policy. Some states assess tax on the "home state" of the person that pays the premium. Not all states have an express provision to address unaffiliated group policies.

K. "Nonadmitted insurance" means any insurance written on properties, risks or exposures, located or to be performed in this state, by an insurer not licensed to engage in the business of insurance in this state [or a domestic surplus lines insurer].

L. "Nonadmitted insurer" means an insurer not licensed to engage in the business of insurance in this does not include a risk retention group pursuant to the federal Liability Risk Retention Act of 1986.

M. "Person" means any natural person or business entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

N. "Premium" means any payment made as consideration for an insurance contract.

O. "Principal place of business" means:

(1) The state where a person maintains its headquarters and where the person's high-level officers direct, control, and coordinate business activities; or

(2) If the person's high-level officers direct, control, and coordinate the business activities in more than one state, or if the person's principal place of business is located outside any state, then it is the state to which the greatest percentage of the person's taxable premium for that insurance contract is allocated.

P. "Principal residence" means:

(1) The state where the person resides for the greatest number of days during a calendar year; or

(2) If the person's principal residence is located outside any state, the state to which the greatest percentage of the person's taxable premium for that insurance contract is allocated.

Q. "Surplus lines insurance" means any insurance permitted to be placed through a surplus lines licensee with an eligible surplus lines insurer, pursuant to Section 5 of this Act.

R. "Surplus lines insurer" means a nonadmitted [or domestic surplus lines] insurer that is eligible to accept the placement of surplus lines insurance pursuant to Section 5 of this Act.

S. "Surplus lines licensee" means any person licensed under Section 5 of this Act to place surplus lines insurance in this state with an eligible surplus lines insurer.

T. "Taxable premium" means any premium less return premium that is not otherwise exempt from tax pursuant to this Act. [OPTIONAL: Premium on property risk or exposure that is properly allocated to federal or international waters or is under the jurisdiction of a foreign government is not taxable in this state.]

U. "Transaction of insurance"

(1) For purposes of this Act, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

(a) The making of or proposing to make, as an insurer, an insurance contract;

(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of an application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for insurance or any part thereof;

(e) The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(f) The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;

(g) The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;

(h) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;

(i) The offering of insurance or the transacting of insurance business; or

(j) Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract.

(2) The provisions of this subsection shall not operate to prohibit employees, officers, directors or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person's compensation is not based on buying insurance.

(3) The venue of an act committed by mail is the location where the matter transmitted by mail is delivered or issued for delivery or takes effect.

Drafting Note: States may need to alter this subsection to reflect their decision as to whether they intend to permit citizens to directly purchase coverage within the state from a nonadmitted insurer, or if self-procurement of coverage will be permitted only when it occurs outside the state. States electing to allow direct procurement will need to insert an appropriate exemption in Section 4A of this Act. Additionally, states should consider whether the preceding definition of "transaction of insurance" is consistent with other statutory definitions of this phrase in the state. Finally, states may want to consider whether group insurance purchases or the maintenance of insurance books and records in this state should fall within the scope of the definition of "transaction of insurance."

V. "Wet marine and transportation insurance" means:

(1) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;

(2) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

(3) Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

(4) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment, or reshipment; provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:

(a) Been transported solely by land; or

(b) Reached its final destination as specified in the bill of lading or other shipping document; or

(c) The insured no longer has an insurable interest in the property.

Drafting Note: In addition to the definitions provided in this section, individual states may wish to consider adopting definitions for "agent," "broker" or "producer" in a manner consistent with its other laws. Additionally, states may want to cross-reference the definition of "insurance" as it appears elsewhere in the state insurance code. The definition of insurance should reach illegal unauthorized activities.

Section 4. Placement of Insurance Business

A. An insurer shall not engage in the transaction of insurance unless authorized by a license in force pursuant to the laws of this state or exempted by this Act or the insurance laws of this state.

B. A person shall not directly or indirectly engage in a transaction of insurance with or on behalf of a nonadmitted insurer in this state.

C. A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in Section 7 of this Act. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.

D. If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this state, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.

E. Section 4B or 4D shall not apply to a person in regard to an insured who independently procures insurance as provided under Section 6. This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured.

Drafting Note: If a state collects tax on unlicensed transactions which violate this Act, it may consider imposing liability for payment of those taxes on persons who violate this Act by assisting in the procurement of nonadmitted insurance.

Drafting Note: Some states permit other licensed professionals to engage in these activities as provided in their insurance statutes or other state statutes. Those states may want to amend Section 4E to include those professionals, to the extent they act within the scope of their licenses.

F. This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in Paragraphs (1), (2), (3) and (4) below:

(1) Surplus lines insurance as provided in Section 5. For the purposes of this subsection, a licensee shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of Section 5 that proximately caused loss to the insured;

(2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

(3) Reinsurance provided that, unless the commissioner waives the requirements of this subsection:

(a) The assuming insurer is authorized to engage in the business of insurance or reinsurance in its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and

(b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;

(4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine and transportation insurance;

(5) Transactions subsequent to issuance of a policy not covering properties, risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

Drafting Note: States may also wish to consider exempting from Section 4A of this Act self-procured insurance or industrial insurance purchased by a sophisticated buyer who does not necessarily require the same regulatory protections as an average insurance buyer. Additionally, some states allow other insurance transactions with nonadmitted insurers. Examples include certain aviation and railroad risks. Other states may want to narrow the scope of the exemptions above or reserve the right to approve exemptions on a case-by-case basis.

Section 5. Surplus Lines Insurance

A. Surplus lines insurance may be placed by a surplus lines licensee if:

(1) Each insurer is eligible to write surplus lines insurance; and

(2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and

(3) Other than for exempt commercial purchasers, the full amount or type of insurance cannot be obtained from insurers who are admitted to engage in the business of insurance in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state if any are writing it; and

(4) All other requirements of this Act are met.

Drafting Note: The diligent search requirement of Section 5A(3) must be satisfied in accordance with the statutes and regulations of the governing state. Diligent search statutes and regulations vary from state to state in terms of the number of declinations required and the person designated to conduct the search. Several states permit surplus lines placement without a diligent search for or without regard to the availability of admitted coverage. States may want to consider changing diligent search requirements in light of electronic transactions. Section 5A(3) does not prohibit a regulatory system in which a surplus lines licensee may place with an eligible nonadmitted insurer any coverage listed on a current "Export List" maintained by the commissioner. The export list would identify types of insurance for which no admitted market exists. The commissioner may waive the diligent search requirement for any such type of insurance.

Drafting Note: Utilizing the "full amount" standard in Section 5A(3) of this Act may have certain market implications. An alternative to this approach would be to require that whatever part of the coverage is attainable through the admitted market be placed in the admitted market and only the excess part of the coverage may be exported.

B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place any coverage with an eligible surplus lines insurer, unless specifically prohibited by the laws of this state.

[Alternative Subsection B]

[B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place only the following types of coverage with an eligible surplus lines insurer: (list acceptable coverage).]

Drafting Note: The two statutory alternatives described in Section 5B represent different regulatory approaches to defining those coverages which may be placed in the nonadmitted market and they would impact the admitted market in different manners.

C. A surplus lines licensee shall not place surplus lines insurance, unless, at the time of placement, the surplus lines licensee has determined that the insurer:

Drafting Note: Current numbering is retained in this Model to remain consistent with the reference within the NRRA.

2. Is eligible to write surplus lines insurance under one of the following subsections:

a. For a nonadmitted insurer domiciled in another United States jurisdiction, the insurer shall have both of the following:

(i) The authority to write the type of insurance in its domiciliary jurisdiction; and

(ii) Capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals the greater of:

(I) (A) The minimum capital and surplus requirements under the law of this state; or

(B) $15,000,000;

(II) The requirements of Subparagraph (a)(ii)(I) may be satisfied by an insurer possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than $4,500,000; or

b. For a nonadmitted insurer domiciled outside the United States, the insurer shall be listed on the *Quarterly Listing of Alien Insurers* maintained by the International Insurers Department of the National Association of Insurance Commissioners (NAIC); [or]

c. [For an insurer domiciled in this state, the insurer is a domestic surplus lines insurer.]

D. The placement of surplus lines insurance shall be subject to the statutory and regulatory requirements solely of the insured's home state.

Drafting Note: Section 522(d) of the federal Nonadmitted and Reinsurance Reform Act provides a workers' compensation exception to home state authority; specifically, that this section may not be construed to preempt any State law, rule, or regulation that restricts the placement of workers' compensation insurance or excess insurance for self-funded workers' compensation plans with a nonadmitted insurer. In addition, Section 527(9) of the NRRA provides that the term ''nonadmitted insurance'' means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance and is not applicable to accident and health insurance. States may consider whether to add language making these exceptions explicit when codifying Section 5D into state law.

E. Insurance procured under this section shall be valid and enforceable as to all parties.
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F. If at any time the commissioner has reason to believe that a surplus lines insurer is no longer eligible under Section 5C, the commissioner may, after notice and an opportunity for a hearing, declare it ineligible. The commissioner shall promptly publish notice of all such declarations in a timely manner reasonably calculated to reach to each surplus lines licensee or surplus lines advisory organization, for distribution to all surplus lines licensees.

Drafting Note: Individual states should consider whether such declarations of ineligibility are appropriate in view of the state's other due process and administrative procedure requirements. Eligibility criteria are independent of other considerations such as compliance with other laws, for example, 18 USC 1033, relating to felons participating in the insurance business.

G. Surplus Lines Tax

(1) In addition to the full amount of gross premium charged by the insurer for the insurance, every person licensed pursuant to Section 5I of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross premium charged, less any return premium, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be paid entirely to the home state of the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.

(2) At the time of filing the [insert monthly, quarterly, annual] report as set forth in Subsection S of this section, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.

H. Collection of Tax

If the tax owed by a surplus lines licensee under this section has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the commissioner against the surplus lines licensee and the surety on the bond filed under Subsection I of this section. The commissioner may charge interest at the rate of [insert number] percent per year for the unpaid tax.

I. Surplus Lines Licenses

(1) A person shall not procure a contract of surplus lines insurance with a surplus lines insurer unless the person possesses a current surplus lines insurance producer license issued by the commissioner.

(2) The commissioner may issue a resident surplus lines license to a qualified holder of underlying property and casualty licenses, but only when the producer has:

(a) Remitted the $[insert amount] annual fee to the commissioner;

(b) Submitted a completed license application on a form supplied by the commissioner;

(c) In the case of a resident agent, filed with the commissioner, and continues to maintain during the term of the license, in force and unimpaired, a bond or errors and omissions (E&O) policy in favor of this state in the penal sum of $[insert amount] aggregate liability, with corporate sureties approved by the commissioner. The bond or E&O policy shall be conditioned that the Surplus Lines Licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond or E&O policy shall be terminated unless at least thirty (30) days prior written notice is given to the licensee and commissioner;

Drafting Note: Under Public Law No. 106-102 (the "Gramm-Leach-Bliley Act"), it is believed that a requirement for a nonresident agent to file a bond may contravene the reciprocity provisions. The requirement for a resident agent to file a bond would not, seemingly, contravene these provisions, and there may be methodologies whereby such resident bonds could become reciprocal between states. Some states have expressed concern that their bonding requirements constitute important consumer protections, and that elimination of these simply to comply with Gramm-Leach-Bliley may result in unintended consequences, and a lack of control over possibly unscrupulous nonresident agents.

(d) If a resident, established and continues to maintain an office in this state.

(3) A nonresident person shall receive a nonresident surplus lines license if:

(a) The person is currently licensed as a surplus lines licensee and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];

(c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and

(d) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

Drafting Note: In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

(4) The insurance commissioner may verify the person's licensing status through the Producer Database maintained by the NAIC, its affiliates or subsidiaries.

(5) A nonresident surplus lines licensee who moves from one state to another state or a resident surplus lines licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(6) The insurance commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his or her home state, except the requirements imposed by this subsection, if the applicant's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(7) Each surplus lines license shall expire on [insert date] of each year, and an application for renewal shall be filed before [insert date] of each year upon payment of the annual fee and compliance with other provisions of this section. A surplus lines licensee who fails to apply for renewal of the license before [insert date] shall pay a penalty of $[insert amount] and be subject to penalties provided by law before the license will be renewed.

Drafting Note: States may wish to reference their specific licensing statutes in this section.

Drafting Note: Some states allow surplus lines licensees to hold binding authorities on behalf of surplus lines insurers. States which allow such binding authorities might want to establish minimum standards for the related agreements. In addition, states might want to consider requiring surplus lines licensees with such binding authorities to submit the related agreements to state regulators for review and approval.

J. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee's License

The commissioner may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and an opportunity for a hearing as provided under the applicable provision of this state's laws for:

(1) Violation of any provision of this Act; or

(2) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].

K. Actions Against Eligible Surplus Lines Insurers Transacting Surplus Lines Business

(1) An eligible surplus lines insurer may be sued upon a cause of action arising in this state under a surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. A policy issued by the eligible surplus lines insurer shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.

(2) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

L. Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall execute where appropriate, and file a written report regarding the insurance which shall be kept confidential by the commissioner, including the following:

(1) The name and address of the insured;

(2) The identity of the insurer or insurers;

(3) A description of the subject and location of the risk;

(4) The amount of premium charged for the insurance;

(5) Such other pertinent information as the commissioner may reasonably require; and

(6) An affidavit on a standardized form promulgated by the commissioner as to the diligent efforts to place the coverage with admitted insurers and the results of that effort or the insured is an exempt commercial purchaser. The affidavit shall be open to public inspection. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:

(a) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and

(b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Drafting Note: Surplus lines licensees will frequently communicate with the insured through a producing broker rather than communicate with the insured directly. In preparing affidavit forms, states may wish to recognize that, as a result of communications passing through the producing broker, the surplus lines licensee may not be in a position to affirm, based upon personal knowledge, that the insured received from the producing broker the written information required by this subsection.

M. Surplus Lines Advisory Organizations

(1) There is hereby created a nonprofit association to be known as the [insert name]. All surplus lines licensees shall be deemed to be members of the association. The association shall perform its functions under the plan of operation established pursuant to Paragraph (3) of this subsection and must exercise its powers through a board of directors established under Paragraph (2) of this subsection. The association shall be supervised by the commissioner. The association shall be authorized and have the duty to:

Drafting Note: The preceding paragraph provides that all surplus lines licensees are deemed to be members of the association. Some states, however, may choose not to establish a surplus lines advisory organization; in those states Subsection M would not be necessary.

(a) Receive, record, and subject to Subparagraph (b) of this paragraph, stamp all surplus lines insurance documents which surplus lines brokers are required to file with the association pursuant to the plan of operation;

Drafting Note: Subparagraph (a) of this paragraph authorizes the association to receive, record and stamp all surplus lines documents which must be submitted to the association pursuant to the plan of operation. Documents to be submitted to the association for stamping are likely to vary by state.

(b) Refuse to stamp submitted insurance documents, if the association determines that a nonadmitted insurer does not meet minimum state financial standards of eligibility, or the commissioner orders the association not to stamp insurance documents pursuant to Paragraph (9) of this subsection. The association shall notify the commissioner and provide an explanation for any refusal to stamp submitted insurance documents other than a refusal based upon the order of the commissioner;

(c) Prepare and deliver annually to each licensee and to the commissioner a report regarding surplus lines business. The report shall include a delineation of the classes of business procured during the preceding calendar year, in the form the board of directors prescribes;

(d) Encourage compliance by its members with the surplus lines law of this state and the rules and regulations of the commissioner relative to surplus lines insurance;

(e) Communicate with organizations of agents, brokers and admitted insurers with respect to the proper use of the surplus lines market;

(f) Employ and retain persons as necessary to carry out the duties of the association;

(g) Borrow money as necessary to affect the purposes of the association;

(h) Enter contracts as necessary to affect the purposes of the association; and

(i) Provide such other services to its members as are incidental or related to the purposes of the association.

(2) The association shall function through a board of directors elected by the association members, and officers who shall be elected by the board of directors.

(a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member's vote to reflect the annual surplus lines insurance premium written by the member.

(b) The board of directors shall elect officers as provided for in the plan of operation.

(3) The association shall establish a plan of operation. The plan of operation shall provide for the formation, operation and governance of the association. The plan and any amendments shall be effective upon approval by the commissioner, which shall not be unreasonably withheld or delayed. All association members shall comply with the plan of operation or any amendments to it. Failure to comply with the plan of operation or any amendments shall constitute a violation of the insurance law and the commissioner may issue an order requiring discontinuance of the violation.

(4) The association shall file with the commissioner:

(a) A copy of its plan of operation and any amendments to it;

(b) A current list of its members revised at least annually;

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served; and

(d) An agreement that the commissioner may examine the association in accordance with the provisions of Paragraph (5) of this subsection.

(5) The commissioner shall, at least once in [insert number] years, make or cause to be made an examination of the association. The reasonable cost of an examination shall be paid by the association upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association and shall notify the association that it may request a hearing within thirty (30) days on the report or on any facts or recommendations contained in it. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation. A director may be removed from the association's board of directors by the commissioner for cause, stated in writing, after an opportunity has been given to the director to be heard.

(6) There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.

(7) Within [insert number] days after a surplus lines policy is procured, a licensee shall submit to the association for recording and stamping all documents which surplus lines brokers are required to file with the association. Every insurance document submitted to the association pursuant to this subsection shall set forth:

(a) The name and address of the insured;

(b) The gross premium charged;

(c) The name of the nonadmitted insurer; and

(d) The class of insurance procured.

Drafting Note: The appropriate time limits for submitting documents required for stamping will vary by state.

(8) It shall be unlawful for an insurance agent, broker or surplus lines broker to deliver in this state any insurance document which surplus lines brokers are required to file with the association unless the insurance document is stamped by the association or is exempt from such requirements. However, a licensee's failure to comply with the requirements of this subsection shall not affect the validity of the coverage.

(9) The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured.

(10) The commissioner may declare a nonadmitted insurer ineligible and order the association not to stamp insurance documents issued by the nonadmitted insurer and issue any other appropriate order.

N. Evidence of the Insurance and Subsequent Changes to the Insurance

(1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if the policy is not then available, a certificate as described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance. The certificate described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.

(2) A surplus lines licensee shall not issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any surplus lines insurer or a nonadmitted insurer unless the licensee has authority from the insurer to cause the risk to be insured or has received information from the insurer in the regular course of business that the insurance has been granted.

(3) If, after delivery of any evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.

(4) As soon as reasonably possible after the placement of the insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

(5) The surplus lines licensee shall give the following consumer notice to every person, applying for insurance with a nonadmitted insurer. The notice shall be printed in 16-point type on a separate document affixed to the application. The applicant shall sign and date a copy of the notice to acknowledge receiving it. The surplus lines licensee shall maintain the signed notice in its file for a period of five (5) years from expiration of the policy. The surplus lines licensee shall tender a copy of the signed notice to the insured at the time of delivery of each policy the licensee transacts with a nonadmitted insurer. The copy shall be a separate document affixed to the policy.

*"**Notice**: A nonadmitted or surplus lines insurer is issuing the insurance policy that you have applied to purchase. These insurers do not participate in insurance guaranty funds. The guaranty funds will not pay your claims or protect your assets if the insurer becomes insolvent and is unable to make payments as promised. For additional information about the above matters and about the insurer, you should ask questions of your insurance agent, broker or surplus lines broker. You may also contact your insurance department consumer help line."*

Drafting Note: This notice is intended to inform personal lines customers and smaller commercial risks of the nature of the coverage they are purchasing. A state may wish to add language to this statute providing that this notice need not be given to commercial risks meeting defined criteria for size and insurance expertise.

O. Licensee's Duty to Notify Insured

(1) No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines licensee or the producing broker has notified the insured in writing, in a form acceptable to the commissioner, a copy of which shall be maintained by the licensee or the producing broker with the records of the contract and available for possible examination, that:

(a) The insurer [other than a domestic surplus lines insurer] with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and

(b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

(2) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

Drafting Note: To ensure the meaningfulness of the notice required by this subsection, the commissioner might want to establish criteria related to readability, font, and size of the notice.

P. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than itself in procuring, continuing or renewing any policy of insurance procured under this section shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

Q. Surplus Lines Licensees May Accept Business from Other Producers

A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other producing broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate the producing broker for the business.

R. Records of Surplus Lines Licensee

(1) Each surplus lines licensee shall keep a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following items applicable:

(a) Amount of the insurance, risks and perils insured;

(b) Brief description of the property insured and its location;

(c) Gross premium charged;

(d) Any return premium paid;

(e) Rate of premium charged upon the several items of property;

(f) Effective date and terms of the contract;

(g) Name and address of the insured;

(h) Name and address of the insurer;

(i) Amount of tax and other sums to be collected from the insured; and

(j) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.

(2) The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

Drafting Note: States may wish to extend the five-year period prescribed for open access to insurance records because of the long-term nature of this business.

S. Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the commissioner, on forms prescribed by the commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

(1) Aggregate gross premium written;

(2) Aggregate return premium;

(3) Amount of aggregate tax remitted to this state; and

(4) Amount of aggregate tax due or remitted to each other state for which an allocation is made pursuant to Subsection G of this section.

Drafting Note: States desiring to have taxes remitted annually may call for more frequent detailed listing of business.

T. [OPTIONAL: Domestic Surplus Lines Insurers

(1) The commissioner may designate a domestic insurer as a domestic surplus lines insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than fifteen million dollars.

(2) A domestic surplus lines insurer:

(a) Shall be limited in its authority in this state to providing surplus lines insurance.

(b) May be authorized to write any type of property and casualty [or accident and health] insurance in this state that may be placed with a surplus lines insurer pursuant to this Subpart.

(c) Be subject to the legal and regulatory requirements applicable to domestic insurers, except for the following:

(i) Premium taxes, fees, and assessments applicable to admitted insurance;

(ii) Regulation of rates and forms;

(iii) Assessment or coverage by insurance guaranty funds.]

Section 6. Insurance Independently Procured—Duty to Report and Pay Tax

A. Each insured whose home state is this state, who procures or continues or renews insurance with a nonadmitted insurer, other than insurance procured through a surplus lines licensee, shall, within [insert number] days after the date the insurance was so procured, continued or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner.

Drafting Note: Subsection A may need to be revised in those states exempting from taxation insurance procured by nonprofit educational institutions and their employers, from nonprofit educational insurers.

B. Premium charged for the insurance, less any return premium, is subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured whose home state is this state shall pay the tax on all taxable premium to the commissioner, who shall transmit the same for distribution as provided in this Act.

Drafting Note: Existing state laws and procedures may require that the tax report be forwarded to another state agency, such as the Department of the Treasury, rather than to the commissioner. In addition, some states may require the tax to be paid on a periodic basis (e.g., annually) rather than at the time of the filing required by Subsection A. Subsections A and B may need to be revised in these states.

C. Delinquent taxes hereunder shall bear interest at the rate of [insert number] percent per year.

D. This section does not abrogate or modify and shall not be construed or deemed to abrogate or modify any other provision of this Act.

Section 7. Penalties

A. A person who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a criminal act and subject to a fine not in excess of $[insert amount].

Drafting Note: Some states might want to specify "misdemeanor" or "felony" rather than "criminal act" in Section 7A.

B. In addition to any other penalty provided herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this Act shall be liable to a civil penalty not exceeding $[insert amount] for the first offense, and not exceeding $[insert amount] for each succeeding offense.

C. The above penalties are not exclusive remedies. Penalties may also be assessed under [insert citation to trade practices and fraud statute] of the insurance code of this state.

Section 8. Violations

Whenever there is evidence satisfactory to the commissioner that a person is violating or about to violate the provisions of this Act, the commissioner may cause a complaint to be filed in the [insert appropriate court] Court for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

Section 9. Service of Process

A. Any act of transacting insurance by an unauthorized person or a nonadmitted insurer is equivalent to and shall constitute an irrevocable appointment by the unauthorized person or insurer, binding upon it, its executor or administrator, or successor in interest of the [insert title of appropriate state official] or his or her successor in office, to be the true and lawful attorney of the unauthorized person or insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner and which arises out of transacting insurance in this state by the unauthorized person or insurer. Any act of transacting insurance in this state by a nonadmitted insurer shall signify its acceptance of its

agreement that any lawful process in such court action, suit or proceeding and any notice, order, pleading or process in such administrative proceeding before the commissioner so served shall be of the same legal force and validity as personal service of process in this state upon the unauthorized person or insurer.

B. Service of process in the action shall be made by delivering to and leaving with the [insert title of appropriate state official], or some person in apparent charge of the office, two (2) copies thereof and by payment to the [insert title of appropriate state official] of the fee prescribed by law. Service upon the [insert title of appropriate state official] as attorney shall be service upon the principal.

Drafting Note: Existing state laws and procedures may require that service of process be made upon either the commissioner or another state official.

C. The [insert title of appropriate state official] shall forward by certified mail one of the copies of the process or notice, order, pleading or process in proceedings before the commissioner to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on the commissioner which shall show the day and hour of service. Service is sufficient, provided:

(1) Notice of service and a copy of the court process or the notice, order, pleading or process in the administrative proceeding are sent within ten (10) days by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding; and

(2) The defendant's receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding or of the commissioner in an administrative proceeding, showing compliance are filed with the clerk of the court in which the action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond, or within such further time as the court or commissioner may allow.

D. A plaintiff shall not be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.

E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.

F. Each nonadmitted insurer assuming insurance in this state, or relative to property, risks or exposures located or to be performed in this state, shall be deemed to have subjected itself to this Act.

G. Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer may be sued upon any cause of action arising in this state, or relative to property, risks or exposures located or to be performed in this state, under any insurance contract made by it.

H. Except with regard to exempt commercial purchasers, independently procured insurance, [aviation], and wet marine and transportation insurance, conditions or stipulations in the policy or contract notwithstanding, a nonadmitted insurer subject to arbitration or other alternative dispute resolution mechanism shall conduct the arbitration or other alternative dispute resolution mechanism in the home state of the insured.

Drafting Note: Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the prior Section 9H. States should consider adoption or modification of Section 9H in light of their own laws on arbitration or other alternative dispute resolution in insurance and commercial transactions. States should cross-reference their state insurance code to verify the inclusion of "Aviation" within this provision.

I. A policy or contract issued by the nonadmitted insurer or one which is otherwise valid and contains a condition or provision not in compliance with the requirements of this Act is not thereby rendered invalid but shall be construed and applied in accordance with the conditions and provisions which would have

applied had the policy or contract been issued or delivered in full compliance with this Act.

Section 10. Legal or Administrative Procedures

A. Before any nonadmitted insurer files or causes to be filed any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in an administrative proceeding before the commissioner instituted against the person or insurer, by services made as provided in this Act, the insurer shall either:

(1) Deposit with the clerk of the court in which the action, suit or proceeding is pending, or with the commissioner of Insurance in administrative proceedings before the commissioner, cash or securities, or file with the clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in the action or administrative proceeding; or

(2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against the insurer with respect to its application if the commissioner determines that the company would otherwise comply with the requirements for a certificate of authority.

B. The commissioner of insurance, in any administrative proceeding in which service is made as provided in this Act, may in the commissioner's discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.

C. Nothing in Subsection A of this section shall be construed to prevent a nonadmitted insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that the nonadmitted insurer has not done any of the acts enumerated in the pleadings.

D. Nothing in Subsection A of this section shall apply to placements of insurance which were lawful in the home state of the insured and which were not unlawful placements under the laws of this state. Without limiting the generality of the foregoing, nothing in Subsection A shall apply to a placement made pursuant to Section 5 of this Act.

Section 11. Enforcement

A. The commissioner shall have the authority to proceed in the courts of this state or any other United States jurisdiction to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of insurance.

B. It shall be the policy of this state that the insurance commissioner shall cooperate with regulatory officials in other United States jurisdictions to the greatest degree reasonably practicable in enforcing lawfully issued orders of such other officials subject to public policy and the insurance laws of the state. Without limiting the generality of the foregoing, the commissioner may enforce an order lawfully issued by other officials provided the order does not violate the laws or public policy of this state.

Section 12. Suits by Nonadmitted Insurers

A nonadmitted insurer may not commence or maintain an action at law or in equity, including arbitration or any other dispute resolution mechanism, in this state to enforce any right arising out of any insurance transaction except with respect to:

A. Claims under policies lawfully placed pursuant to the law of the home state of the insured;

B. Liquidation of assets and liabilities of the insurer (other than collection of new premium), resulting from its former authorized operations in this state;

C. Transactions subsequent to issuance of a policy not covering domestic risks at the time of issuance, and lawfully procured under the laws of the jurisdiction where the transaction took place;

D. Surplus lines insurance placed by a licensee under authority of Section 5 of this Act;

E. Reinsurance placed under the authority of [insert citations of state's reinsurance intermediary act and other reinsurance laws];

F. The continuation and servicing of life insurance, health insurance policies or annuity contracts remaining in force as to residents of this state where the formerly authorized insurer has withdrawn from the state and is not transacting new insurance in the state;

G. Servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the company does not have a certificate of authority until the term expires;

H. Claims under policies covering wet marine and transportation insurance;

I. Placements of insurance which were lawful in the jurisdiction in which the transaction took place and which were not unlawful placements under the laws of this state.

Drafting Note: Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the opening paragraph of this section.

Section 13. Severability

If any provisions of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Section 14. Effective Date

This Act shall take effect [insert appropriate date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1994 Proc. 3rd Quarter 14, 16-17, 24, 28-46 (adopted).
1996 Proc. 3rd Quarter 9, 42, 1110, 1168, 1169-1173, 1189-1190 (amended).
1997 Proc. 4th Quarter 25, 27-28, 1004, 1029 (amended).
1999 Proc. 3rd Quarter 25, 26, 1080, 1135, 1151-1153 (amended).
2002 Proc. 2nd Quarter 14, 250-251, 344, 347, 349-350 (amended).
2023 Summer National Meeting (amended).

This model draws from and replaces three earlier NAIC models:

Model Surplus Lines Law
1983 Proc. I 6, 36, 834, 900, 913-922 (adopted).
1985 Proc. II 11, 24, 702, 722, 723-724 (amended).
1986 Proc. I 9-10, 24, 799, 813, 814-821 (amended).
1990 Proc. I 6, 30, 840-841, 897-898, 900-901 (amended).
1991 Proc. I 9, 18, 908, 949, 950, 952-961 (amended and reprinted).

Unauthorized Insurers Model Act
1969 Proc. I 168, 218, 222-227, 271 (adopted).
1978 Proc. I 13, 15, 348, 350 (amended).
1990 Proc. II 7, 13-14, 159-160, 187-191 (amended and reprinted).

Model Nonadmitted Insurance Act
1983 Proc. 1 6, 36, 834, 899-900, 923-926 (adopted).

NONADMITTED INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

NONADMITTED INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-10-1 to 27-10-3 (1963/1971); §§ 27-10-20 to 27-10-38 (1963/1994); §§ 27-10-35 to 27-10-36 (1963/1971); §§ 482-1-036-.01 to 482-1-036-.08 (2008); BULLETIN 3-18-2010 (2010); BULLETIN 2013-03 (2013).
Alaska		ALASKA STAT. §§ 21.34.010 to 21.34.900 (1984/2009).	ALASKA STAT. §§ 21.33.037 to 21.33.065 (1968/1996); ALASKA ADMIN. CODE tit. 3, §§ 25.010 to 25.900 (1991/2014); BULLETIN 2008-8 (2008); BULLETIN 2009-6 (2009); BULLETIN 2011-3 (2011); BULLETIN 2012-6 (2012); BULLETIN 2012-7 (2012); BULLETIN 2013-1 (2013); BULLETIN 2013-8 (2013).
American Samoa			AM. SAMOA CODE ANN. §§ 29.0401 to 29.0413.

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Arizona			ARIZ. REV. STAT. ANN. §§ 20-401 to 20-401.07 (1972/2011); §§ 20-407 to 20-420 (1954/2012); ARIZ. ADMIN. CODE §§ 054-00.024 (2010); BULLETIN 2011-6 (2011).
Arkansas			ARK. CODE ANN. §§ 23-65-101 to 23-65-104 (1959/2011); §§ 23-65-301 to 23-65-320 (1959/2013); BULLETIN 5-2011 (2011).
California			CAL. INS. CODE §§ 1760 to 1780 (1935/2012); CAL. REV. & TAX. CODE §§ 13201 to 13222 (1993/1994).
Colorado		COLO. REV. STAT. §§ 10-3-901 to 10-3-910 (1963/2014); COLO. REV. STAT. §§ 10-5-101 to 10-5-119 (1963/2012) (portions of model).	3 COLO. CODE REGS. § 2-4-1 (1991/2012); BULLETIN B-2.10 (2011).
Connecticut		CONN. GEN. STAT. §§ 38a-271 to 38a-278 (1970/1979).	CONN. AGENCIES REGS. §§ 38a-740-1 to 38a-740-11 (1985/1996); § 38-271 (1969/1997); BULLETIN SL-1 (2009); BULLETIN SL-2 (2011); BULLETIN SL-3 (2012); BULLETIN FS-4SL-2012; BULLETIN SL-4 (2013); BULLETIN FS-4SL-2014 (2014).
Delaware			DEL. CODE ANN. tit. 18, §§ 1901 to 1919 (1953/1995); BULLETIN 45 (2011); Surplus Lines 12 (2012).
District of Columbia			BULLETIN 2010-001-IB (2010).

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. §§ 626.901 to 626.903 (1982/1995); §§ 626.913 to 626.937 (1959/2009); §§ 626.938 to 626.939 (1959/2001); BULLETIN 2011-2 (2011); BULLETIN 2012-2 (2012); BULLETIN 2012-3 (2012).
Georgia			GA. CODE ANN. §§ 33-5-20 to 33-5-35 (1960/2011); § 33-5-33 (1933/1960); § 33-23-37 (2011); BULLETIN 11-EX-3 (2011).
Guam			GUAM GOV'T. CODE §§ 43125 to 43134; §§ 43260 to 43266 (1966) (surplus line broker or agents).
Hawaii		HAW. REV. STAT. §§ 431:8-201 to 431:8-213 (1988/2012); §§ 431:8-300 to 431:8-320 (1988/2012).	HAW. REV. STAT. § 431:8-205 (1987/2011); MEMORANDUM 2012-4 (2012); MEMORANDUM 2013-1 (2013).
Idaho			IDAHO CODE ANN. §§ 41-1211 to 41-1232 (1961/2011); §§ 44-1233 to 41-1234 (1961/1993); BULLETIN 2006-4 (2006).
Illinois		215 ILL. COMP. STAT. 5/121 to 5/121-19 (1977/1998).	215 ILL. COMP. STAT. 5/445 to 5/445.1 (1980/2012); BULLETIN 2011-9 (2011).
Indiana		IND. CODE §§ 27-4-5-1 to 27-4-5-8 (1969/2011).	
Iowa		IOWA CODE §§ 507A.1 to 507A.11 (1967/1998).	IOWA ADMIN. CODE r. 191-21.1 to 191-21.6 (1963/2009); r. 515I.1 to 515.15 (2012).
Kansas		KAN. STAT. ANN. §§ 40-2701 to 40-2709 (1969/1992).	KAN. STAT. ANN. §§ 40-246 to 40-246e (1982/2011).

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Kentucky		KY. REV. STAT. ANN. §§ 304.11-010 to 304.11-050 (1970/2010).	KY. REV. STAT. §§ 304.10-010 to 304.10-210 (1970/2014).
Louisiana		LA. REV. STAT. ANN. §§ 22:431 to 22:446 (2009/2013).	LA. REV. STAT. ANN. §§ 22:1257 to 22:1270 (1958/1999); § 44-5510 (2012); ADVISORY LETTER 2006-5 (2006); BULLETIN 7-21-2011 (2011); BULLETIN 6-14-2012 (2012).
Maine			ME. REV. STAT. ANN. tit. 24-A, §§ 2001 to 2019 (1970/2011); § 2113 (1969/1973).
Maryland		MD. CODE ANN., INS. §§ 4-201 to 4-212 (1968/1997).	MD. CODE ANN., INS. §§ 3-301 to 3-327 (1963/2011); MD. CODE REGS. 31.03.06 (2012); BULLETIN 2011-26 (2011).
Massachusetts			MASS. GEN. LAWS ANN. ch. 175, § 168 and 168A (1950/2018).
Michigan			MICH. COMP. LAWS §§ 500.1901 to 500.1955 (1981/2012); BULLETIN 2010-12-INS. (2010).
Minnesota		MINN. STAT. §§ 72A.40 to 72A.44 (1967/1994).	MINN. STAT. §§ 60A.195 to 60A.209 (1981/2009); BULLETIN 2010-3 (2010).
Mississippi			BULLETIN 2011-1 (2011); AGO No. 2006-00351 (2006); BULLETIN 2011-8 (2011); BULLETIN 2012-4 (2012); BULLETIN 2012-2 (2012); BULLETIN 2012-3 (2012).
Missouri		MO. REV. STAT. §§ 375.786 to 375.790 (1972/1998); §§ 384.011 to 384.071 (1987/2011).	MO. CODE REGS. ANN. tit. 20, §§ 200-6.100 to 200-6.400 (1987/2006) (allocation formula).

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana		MONT. CODE ANN. §§ 33-2-301 to 33-2-326 (1959/2011).	MONT. CODE ANN. § 33-2-706 (1959/1989); MONT. ADMIN. R. 6.6.2801 to 6.6.2810 (2011).
Nebraska		NEB. REV. STAT. §§ 44-2001 to 44-2008 (1969/1995).	NEB. REV. STAT. §§ 44-5501 to 44-5514 (1992/2012); BULLETIN CB-126 (2011).
Nevada		NEV. REV. STAT. §§ 685B.020 to 685B.080 (1997/2003).	NEV. REV. STAT. §§ 685A.010 to 685A.220 (1971/2012); BULLETIN 2012-005 (2012).
New Hampshire		N.H. REV. STAT. ANN. §§ 406B:1 to 406B:17 (1967/2012).	BULLETIN 11-011-AB (2011).
New Jersey			N.J. STAT. ANN. §§ 17:22-6.40 to 17:22-6.69 (1960/2003); NOTICE 4-4-2006 (# 3) (2006); BULLETIN 2010-19 (2010); 2010-27 (2010); 2011-21 (2011); 2011-11 (2011).
New Mexico		N.M. STAT. ANN. §§ 59A-15-1 to 59A-15-10 (1985).	N.M. STAT. ANN. §§ 59A-14-1 to 59A-14-18 (1985/2003).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 27.0 to 27.23 (1994/2014) (Regulation No. 41); N.Y. INS. LAW §§ 2117 to 2118 (1984/2000).
North Carolina		N.C. GEN. STAT. §§ 58-21-1 to 58-21-105 (1985/2009); §§ 58-28-1 to 58-28-40 (1967/2013).	BULLETIN 2011-B-7 (2011); MEMORANDUM 7-2-2012 (2012).
North Dakota		N.D. CENT. CODE §§ 26.1-02-05 to 26.1-02-19 (1983/1999).	N.D. CENT. CODE §§ 26.1-44-01 to 26.1-44-09 (1985/2015); N.D. ADMIN. CODE 45-09-01 to 45-09-01-05 (1982/2012).
Northern Marianas		4 N. MAR. ISLAND CODE § 7305 (1984).	4 N. MAR. ISLAND CODE § 7304 (1984).

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio		OHIO REV. CODE ANN. §§ 3901.17 to 3901.18 (1955-1956/1997).	BULLETIN 2011-8 (2011).
Oklahoma			OKLA. STAT. tit. 36, §§ 1101 to 1120 (1957/2014); BULLETIN 9-30-2011 (2011).
Oregon		OR. REV. STAT. §§ 735.400 to 735.495 (1987/2005); §§ 746.310 to 746.370 (1967/1995).	BULLETIN 2011-1 (2011).
Pennsylvania			40 PA. CONS. STAT. §§ 15-101 to 15-125 (1992/2002).
Puerto Rico			P.R. LAWS ANN. tit. 26, §§ 1001 to 1006 (1977); §§ 1007 to 1018 (1961/1980).
Rhode Island		R.I. GEN. LAWS §§ 27-16-1.1 to 27-16-2.4 (1973/2002).	R.I. GEN. LAWS §§ 27-3-38 to 27-3-42 (1959/2013); §§ 27-75-1 to 27-75-3 (2011).
South Carolina		S.C. CODE ANN. §§ 38-25-10 to 38-25-570 (1988/1998).	S.C. CODE ANN. §§ 38-45-10 to 38-45-195 (1987/2013); BULLETIN 2012-08.
South Dakota		S.D. CODIFIED LAWS §§ 58-8-1 to 58-8-5 (1966/1978).	S.D. CODIFIED LAWS §§ 58-32-1 to 58-32-58 (1966/2015); BULLETIN 2012-3 (2012).
Tennessee		TENN. CODE ANN. §§ 56-2-601 to 56-2-704 (1955/1971).	TENN. CODE ANN. §§ 56-14-101 to 56-14-117 (1969/2013).
Texas		TEX. INS. CODE ANN. §§ 101.001 to 101.301 (1999/2001).	TEX. INS. CODE ANN. §§ 225.001 to 225.013 (2005/2013).
Utah		UTAH CODE ANN. §§ 31A-15-101 to 31A-15-102 (1985/2014); §§ 31A-2-309 to 31A-2-311 (1985/1995).	UTAH CODE ANN. §§ 31A-15-103 to 31A-15-110 (1986/2003); BULLETIN 2011-4 (2011); BULLETIN 2012-4 (2012).

NONADMITTED INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont			VT. STAT. ANN. tit. 8, §§ 3368 to 3370 (1968/1996); §§ 5021 to 5040 (1979/2002); BULLETIN 163 (2011); BULLETIN 169 (2012).
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 651 to 652 (1968/1987); §§ 653 to 667 (1968/1999).
Virginia		VA. CODE ANN. §§ 38.2-4800 to 38.2-4815 (1986/2013).	14 VA. ADMIN. CODE §§ 5-350-10 to 5-350-350 (2011).
Washington			WASH. REV. CODE ANN. § 48.03.020 (2009); §§ 48.15.020 to 48.15.030 (1947/2009); §§ 48.15.040 to 48.15.170 (1947/2009); §§ 284-15-010 to 284-15-090 (2006/2013).
West Virginia		W. VA. CODE §§ 33-12C-1 to 33-12C-15 (2003).	W. VA. CODE R. §§ 114-20-1 to 114-20-4 (1984/2012).
Wisconsin			WIS. STAT. §§ 618.40 to 618.41 (1971/2012); §§ 618.47 to 618.61 (1971/2012); § 6.17 (1971/2012); BULLETIN 5-29-2012 (2012).
Wyoming			WYO. STAT. ANN. §§ 26-11-101 to 26-11-122 (1983/2012); §§ 26-12-102 to 26-12-103 (1967/1983); MEMORANDUM 02-2012 (2012).

PROJECT HISTORY - 2023

NONADMITTED INSURANCE MODEL ACT (#870)

1. Description of the Project, Issues Addressed, etc.

The 2023 revisions to the NAIC *Nonadmitted Insurance Model Act* (#870) are intended to conform Model #870 to the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), which was part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The current Model #870 was adopted in 1994 to combine three NAIC models that date as far back as 1969: 1) the Unauthorized Insurers Model Act; 2) the Model Surplus Lines Law; and 3) the Model Nonadmitted Insurance Act. Since the adoption of Model #870 on Sept. 18, 1994, the NAIC has amended it on the following dates: 1) Dec. 16, 1996; 2) March 18, 1998; 3) Dec. 6, 1999; and 4) Sept. 10, 2002. The 2002 modifications resulted from the passage of the federal Gramm-Leach-Bliley Act (GLBA) by the U.S. Congress (Congress). Currently, 31 states have adopted Model #870.

The most recent activity regarding Model #870 is related to the NRRA. Model #870 was not modified as a result of the implementation of the NRRA. On Oct. 11, 2011, the *Nonadmitted Insurance Reform Sample Bulletin* (Bulletin), which was distributed to the state insurance departments, was adopted by the Executive (EX) Committee and Plenary. The Bulletin outlined federally mandated regulatory changes that affect the placement of nonadmitted insurance. Specifically, the Bulletin addressed the scope of the NRRA, the application of "Home State" for the purposes of jurisdictional authority and paying premium tax, licensure requirements for brokers, diligent search requirements, and eligibility requirements for nonadmitted insurers.

During the implementation of the NRRA, the Surplus Lines (C) Task Force and NAIC staff were working on state tax allocation proposals. The leading proposals were the Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT), which pre-dated the NRRA, and the Nonadmitted Insurance Multistate Agreement (NIMA), which was developed by the Task Force in response to the NRRA. The SLIMPACT failed to obtain the 10 states needed to become operative. The NIMA clearinghouse operated for only a few years before the NIMA was dissolved in 2016. With the focus on achieving a system of tax allocation before the NRRA deadline in July 2012, the decision was made to draft the Bulletin rather than amend Model #870.

During the 2020 Summer National Meeting of the Task Force, the chair directed staff to develop a drafting group to produce a summary document that outlined significant updates needed to modernize Model #870 and present a recommendation to the Task Force at a future national meeting. The drafting group consisted of Tom Travis (LA), Jeff Baughman (WA), Eli Snowbarger (OK), Andy Daleo (NAIC), and Dan Schelp (NAIC). The drafting group met Sept. 30 and Oct. 27, 2020. As a result of those meetings, the drafting group outlined numerous proposed revisions to Model #870.

During the 2020 Fall National Meeting, the Task Force adopted the Request for NAIC Model Law Development. During the 2021 Spring National Meeting, the Executive (EX) Committee approved the Request for NAIC Model Law Development.

2. Name of Group Responsible for Drafting the Model and States Participating

The Surplus Lines (C) Task Force and the drafting group consisting of Louisiana, Chair; Colorado; Illinois; Texas; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

The charges of the Surplus Lines (C) Task Force state, "Develop or amend relevant NAIC model laws, regulations, and/or guidelines." Also, as described in charge #1, the Request for NAIC Model Law Development was approved by the Executive (EX) Committee during the 2021 Spring National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

During the 2021 Summer National Meeting, the Surplus Lines (C) Task Force formally developed the Model #870 Drafting Group that consisted of Travis, chair; Rolf Kaumann (CO); Marcy Savage (IL); Jamie Walker (TX); and Jeff Baughman (WA). The Drafting Group began its work on Model #870 on Aug. 19, 2021. During that call the Drafting Group discussed the overall approach to updating the model, initial comments received, and a timeline.

5. A General Description of the Due Process (e.g., exposure periods; public hearings; or any other means by which widespread input from industry, consumers, and legislators was solicited)

The Drafting Group met Aug. 19, 2021, for a regulator-only planning session. Following the initial meeting, the Drafting Group met in open session Sept. 28, Oct. 20, Nov. 4, and Dec. 1, 2021. During these sessions, interested state insurance regulators and parties submitted comment letters to the Drafting Group. The Drafting Group held regulator-only discussion and planning calls on Jan. 10, March 15, and May 3, 2022. During a Surplus Lines (C) Task Force call on May 23, 2022, Model #870 was exposed for a 60-day public comment period. Comments were received from the American Property Casualty Insurance Association (APCIA), CRC Group: Wholesale and Specialty Insurance; Lloyd's of London; McDermott Will & Emery; the National Risk Retention Association (NRRA); Surplus Line Association of Illinois (SLAI); the Council of Insurance Agents & Brokers (CIAB); and the Wholesale & Specialty Insurance Association (WSIA). The Drafting Group held a regulator-only discussion and planning call on Aug. 3, 2022 and the Task Force held a call on Oct. 17 to discuss the comments received and on Oct. 27, 2022 it exposed Model #870 for a 30-day public comment period. Comments were received from the Maine Bureau of Insurance; the APCIA; Lloyd's of London; and the WSIA. During the Fall National Meeting, the Task Force heard a summary of the comments received. The Drafting Group held a regulator-only discussion and planning call on Jan. 18, 2023 to discuss comments received and on Jan. 23 exposed a new draft of Model #870 for a 14-day public comment period. Comments were received from the California Department of Insurance; the APCIA; the CIAB; Lloyd's of London; McDermott Will & Emery; and the WSIA. On Feb. 10 the drafting group held a regulatory-only discussion and planning call and integrated edits into Model #870.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

The most significant issue raised was related to the methodology of determining the "Home State" for unaffiliated groups as outlined within Section 2 of the model. Following comments from various interested parties and discussion among Drafting Group members, an agreed-upon revision resulted in clarification via a drafting note.

7. List the Key Provisions of the Model (e.g., sections considered most essential to state adoption)

Section 5C(2)(b) – Non-U.S. Insurers

- For a Nonadmitted Insurer domiciled outside the U.S., the insurer shall be listed on the *Quarterly Listing of Alien Insurers* maintained by the International Insurers Department (IID) of the NAIC.

Section 5G – Surplus Lines Tax

- In addition to the full amount of gross Premium charged by the insurer for the insurance, every Person licensed pursuant to Section 5J of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross Premium charged, less any return Premium, for Surplus Lines Insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be paid entirely to the Home State of the insured. The tax on any portion of the Premium unearned at the termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the Surplus Lines Licensee or through the producing broker, if any. The Surplus Lines Licensee is prohibited from rebating, for any reason, any part of the tax.

Section 5T – Domestic Surplus Lines Insurer

- The commissioner may designate a domestic insurer as a domestic Surplus Lines Insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than $15 million. (Although this was added to the model as optional, it remains an important part of the model.).

8. Any Other Important Information (e.g., amending an accreditation standard)

There were no discussions held regarding making Model #870 an accreditation standard.

PROJECT HISTORY - 2002

NONADMITTED INSURANCE MODEL ACT (#870)

1. Description of the project, issues addressed, etc.

To update the provisions of the Nonadmitted Insurance Model Act to bring it into compliance with Gramm-Leach-Bliley

2. Name of group responsible for draft the model:

Nonadmitted Model Act Revision Working Group

States Participating:

New York, Chair
Alaska
California
Georgia
Illinois
Washington

3. Project authorized by what charge and date first given to the group:

The Surplus Lines Task Force was charged in 2001 and 2002 to "Review the Nonadmitted Insurance Model Act provisions relating to out of state placements and make modifications as necessary to reflect the provisions of the Gramm-Leach-Bliley Act."

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions were drafted by the working group.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Proposed revisions were extensively exposed both at National meetings and prior to one conference call. Long exposure periods were used to ensure that comment could be received.

6. A discussion of the significant issues (items of some controversy) raised during the drafting process and the group's response.

Some states believe that removing the surplus lines bonding requirement for non-resident surplus lines agents – which seemingly is necessary under Gramm-Leach-Bliley – would reduce policyholder protections and increase the risk of fraud. The working group reported these concerns to its Task Force. The Task Force has subsequently created a new working group to examine multi-state surplus lines bonds which might be allowed under the Act and thereby may ameliorate the problem.

UNFAIR TRADE PRACTICES ACT

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Prefatory Note: By adopting amendments to this model act in June 1990, the NAIC separated provisions dealing with unfair claims settlement into a newly adopted Unfair Claims Settlement Practices Model Act, to make clearer distinction between general unfair trade practices and more specific unfair claim settlement issues and to focus on market conduct practices and market conduct regulation. By doing so, the NAIC is not recommending that states repeal existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.

Section 2. Definitions

When used in this Act:

A. "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

B. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: Insert the appropriate term for the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Customer" means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family or household purposes.

D. "Depository institution" means a bank or savings association. The term depository institution does not include an insurance company.

E. "Health Insurance Lead Generator" means any person that utilizes a lead-generating device to:

(1) Publicize the availability of what is, or what purports to be, a health insurance product or service that the person is not licensed to sell directly to a customer.

(2) Identifies a customer who may want to learn more about a health insurance product; or

(3) Sells or transmits customer information to insurers or producers for follow-up contact and sales activity.

F. "Lead-generating device" means any communication directed to the public that, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of what is or what purports to be a health insurance product or service.

G. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

H. "Insurer" means any person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters and third-party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Sections [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases, a cross reference will be sufficient.

I. "Person" means a natural or artificial entity, including but not limited to, individuals, partnerships, associations, trusts, or corporations. For purposes of this act, "person" includes a health insurance lead generator operating as any such natural or artificial entity.

J. "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

K. "Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

L. "Recording" means recording of sales and verification of calls, including virtual technology calls, in their entirety, used in the marketing of insurance.

Section 3. Unfair Trade Practices Prohibited

It is an unfair trade practice for any insurer, health insurance lead generator, or person engaged in the business of insurance to commit any practice defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or of any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Trade Practices Defined

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the business of insurance:

A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

(1) Misrepresents the benefits, advantages, conditions, or terms of any policy; or

(2) Misrepresents the dividends or share of the surplus to be received on any policy; or

(3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or

(4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or

(5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(8) Misrepresents any policy as being shares of stock.

B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, electronic mail, internet advertisement or posting, or other publication, or in the form of a notice, circular, pamphlet, letter, electronic posting of any kind or poster, or over any radio or television station, or via the internet or other electronic means, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.

C. Failure to Maintain Marketing and Performance Records. Failure of a health insurance lead generator to maintain its books, records, documents and other business records in such an order that data regarding complaints and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained. Failure to do so shall constitute a violation of (insert state statute).

D. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.

E. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

F. False Statements and Entries.

(1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.

(2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.

G. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.

H. Unfair Discrimination.

(1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.

(2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

(3) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.

(6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

(7) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(8) Violation of the state's rescission laws at [insert reference to appropriate code section].

Drafting Note: A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

I. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or

(d) Engaging in an arrangement that would not violate Section 106 of the Bank Holding Company Act Amendments of 1972 (12 U.S.C. 1972), as interpreted by the Board of Governors of the Federal Reserve System, or Section 5(q) of the Home Owners' Loan Act, 12 U.S.C. 1464(q).

(e) The offer or provision by insurers or producers, by or through employees, affiliates or third-party representatives, of value-added products or services at no or reduced cost when such products or services are not specified in the policy of insurance if the product or service:

(i) Relates to the insurance coverage; and

(ii) Is primarily designed to satisfy one or more of the following:

(I) Provide loss mitigation or loss control;

(II) Reduce claim costs or claim settlement costs;

(III) Provide education about liability risks or risk of loss to persons or property;

(IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;

(V) Enhance health;

(VI) Enhance financial wellness through items such as education or financial planning services;

(VII) Provide post-loss services;

(VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or

(IX) Assist in the administration of the employee or retiree benefit insurance coverage.

(iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer's premiums or insurance coverage for the policy class.

(iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to assist the customer with questions regarding the product or service.

(v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.

(vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

Drafting Note: States may wish to consider alternative language based on their filing requirements.

(vii) If an insurer or producer does not have sufficient evidence but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year. An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

Drafting Note: This Section is not intended to limit or curtail existing value-added services in the marketplace. It is intended to promote innovation in connection with the offering of value-added services while maintaining strong consumer protections.

(f) An insurer or a producer may:

(i) Offer or give non-cash gifts, items, or services, including meals to or charitable donations on behalf of a customer, in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(ii) Offer or give non-cash gifts, items, or services including meals to or charitable donations on behalf of a customer, to commercial or institutional customers in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost is reasonable in comparison to the premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

(iii) Conduct raffles or drawings to the extent permitted by state law, as long as there is no financial cost to entrants to participate, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

Drafting Note: If a state wishes to limit (f) to a stated monetary limit the committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit, however specific prohibitions may exist related to transactions governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

(3) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use the words "free", "no cost" or words of similar import, in an advertisement.

Drafting Note: Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners' Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

Drafting Note: Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section may be expanded to cover all lines of insurance.

J. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.

K. Failure to Maintain Marketing and Performance Records. Failure to maintain its books, records, documents and other business records, including any recordings, when applicable, in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years (or insert state requirement) shall be maintained.

L. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

M. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.

N. Unfair Financial Planning Practices. An insurance producer:

(1) Holding himself or herself out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

(2) (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that

(i) He or she is also an insurance salesperson, and

(ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.

(3) (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.

(i) The services for which the fee is to be charged must be specifically stated in the agreement.

(ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

Drafting Note: This subsection is intended to apply only to persons engaged in personal financial planning.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

O. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:

(1) File with the insurance department the following material:

(a) The policy and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the insurance department; or

(2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.

P. Failure to Provide Claims History

(1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured's written request:

(a) On all claims, date and description of occurrence, and total amount of payments; and

(b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.

(2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

Drafting Note: Loss information on workers' compensation is an example in some states of loss information otherwise required by law.

(4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.

Drafting Note: This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.

Q. Violating any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the state's insurance laws deemed desirable or necessary to include as an unfair trade practice, such as cancellation and nonrenewal laws.

Section 5. Favored Agent or Insurer; Coercion of Debtors

A. No person or depository institution, or affiliate of a depository institution may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers. Further, no person or depository institution, or affiliate of a depository institution, may reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit.

B. No person or depository institution, or affiliate of a depository institution, who lends money or extends credit may:

(1) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or a particular insurer or producer. However, this provision does not prohibit a person or depository institution, or affiliate of a depository institution, from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, or that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance, or that insurance is available from the person or depository institution, or affiliate of a depository institution;

(2) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction;

(3) Require that any customer, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge, in connection with the handling of any policy required as security for a loan on real estate or pay a separate charge to substitute the policy of one insurer for that of another. This paragraph does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. Further, this paragraph does not apply to charges that would be required when the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance;

(4) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit;

(4) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution or its affiliate;

(6) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the person, depository institution or its affiliate;

(7) Act as a producer unless properly licensed in accordance with [insert appropriate statutory provisions for producer licensing];

(8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, an unlicensed person may make a referral to a licensed producer provided that the person does not discuss specific insurance policy terms and conditions. The unlicensed person may be compensated for the referral; however, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction;

Drafting Note: The last sentence of this paragraph further limits the referral for customers of personal, family and household insurance products as a result of Section 305 of the Gramm-Leach-Bliley Act and the subsequent adoption of regulations by the federal banking regulators at 12 C.F.R. 14.50, 208.85, 343.50 and 536.50. By including this language, the paragraph will be consistent with the Gramm-Leach-Bliley Act and the federal regulations while maintaining the integrity of Section 104(d)(2)(B)(iv) and (v) of the Gramm-Leach-Bliley Act.

(9) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions;

(10) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer;

(11) Solicit or sell insurance unless its insurance sales activities are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions; or

(12) Solicit or sell insurance unless it maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

Drafting Note: The Gramm-Leach-Bliley Act contains two "safe harbors" that relate to information sharing. Section 104(d)(2)(B)(vi) describes the circumstances surrounding the release of a customer's insurance information. Section 104(d)(2)(B)(vii) describes the circumstances surrounding the use of a customer's health information obtained from the insurance records of the customer. If a state has adopted the NAIC's Privacy of Consumer Financial and Health Information Model Regulation, no further action is needed. If not, language implementing the two safe harbors should be considered. It should be noted, however, that during the drafting process, there were concerns expressed about the application of the preemption provisions of the Fair Credit Reporting Act (FCRA) in circumstances involving the sharing of information with affiliates. Nothing in this Act shall be construed to modify, limit or supersede the operation of the FCRA (15 U.S.C. 1681 *et seq*.). In addition, no inference shall be drawn on the basis of the provisions of this Act regarding whether information is transaction or experience information under Section 603 of FCRA.

C. Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in Subsection B(2).

D. (1) A depository institution that solicits, sells, advertises, or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:

(a) Is not a deposit;

(b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;

(c) Is not guaranteed by the depository institution, its affiliate (if applicable) or any person that is soliciting, selling, advertising or offering insurance (if applicable); and

(d) Where appropriate, involves investment risk, including the possible loss of value.

(2) For purposes of these requirements, an affiliate of a depository institution is subject to these requirements only to the extent that it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution. These requirements apply only when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes and only to the extent that the disclosure would be accurate.

Drafting Note: The requirements of this provision are meant to apply only when the consumer may have a reasonable belief that the product is a deposit; that it is insured by the Federal Deposit Insurance Corporation; that it is guaranteed by the person or depository institution; and that, where appropriate, it involves investment risk, including the possible loss of value. This provision is not intended to require every entity or person in a financial holding company to provide the disclosure as a result of having both solicitation of insurance and extending of credit or lending of money occurring within an entity in the financial holding company group.

(3) A depository institution that solicits, sells, advertises, or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy. If the solicitation is conducted by telephone, the person or depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgment was given by the customer, and make reasonable efforts to obtain a written acknowledgment from the customer. If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person or depository institution may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.

(4) For the purposes of Paragraph (1), a person is selling, soliciting, advertising or offering insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one of the following applies:

(a) The person represents to the customer that the sale, solicitation, advertisement or offer of the insurance is by or on behalf of the depository institution;

(b) The depository institution refers a customer to the person who sells insurance, and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or

(c) Documents evidencing the sale, solicitation, advertisement or offer of insurance identify or refer to the depository institution.

E. The commissioner shall have the power to examine and investigate those insurance activities of any person, depository institution, affiliate of a depository institution or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution or insurer shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice. An affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.

F. Nothing herein shall prevent a person or depository institution, or affiliate of a depository institution, who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

G. Nothing contained in this section shall apply to credit related insurance.

Drafting Note: The consumer protection rules promulgated by the banking regulatory agencies pursuant to Section 305 of the Gramm-Leach-Bliley Act apply to retail sales practices, solicitations, advertising or offers of any insurance product or annuity. If a state has adopted the NAIC's Consumer Credit Insurance Model Act and Consumer Credit Insurance Model Regulation, no further action is needed. If not, the state should consider eliminating Subsection G.

Section 6. Power of Commissioner

The commissioner shall have power to examine and investigate the affairs of every person or insurer or health insurance lead generator in this state in order to determine whether such person, insurer, or health insurance lead generator has been or is engaged in any unfair trade practice prohibited by this Act. However, in the case of depository institutions, the commissioner shall have the power to examine and investigate the insurance activities of depository institutions, in order to determine whether the depository institution has been or is engaged in any unfair trade practice prohibited by this Act. The commissioner shall notify the appropriate federal banking agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate federal banking agency of the suspected violations of state law prior to commencing the examination or investigation.

Section 7. Hearings, Witnesses, Appearances, Production of Books, and Service of Process

A. Whenever the commissioner shall have reason to believe that any insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution has been engaged or is engaging in this state in any unfair trade practice whether or not defined in this Act, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner shall issue and serve upon such insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution, a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof. With respect to a depository institution, the commissioner's authority to call a hearing is limited to the depository institution's insurance underwriting, sales, solicitation and cross marketing activities. The commissioner shall provide a copy of the notice of hearing to the appropriate federal banking agency when a depository institution is involved.

B. At the time and place fixed for the hearing, the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.

C. Nothing contained in this Act shall require the observance at the hearing of formal rules of pleading or evidence.

D. The commissioner, at the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence or other documents the commissioner deems relevant to the inquiry, provided, however, that in the case of depository institutions, the commissioner shall have the power to require the production of books, papers, records, correspondence or other documents that the commissioner deems relevant to the inquiry only on the insurance activities of the depository institution. The commissioner may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where the person resides, on application of the commissioner, may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as contempt.

E. Statements of charges, notices, orders and other processes of the commissioner under this Act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by the statement, notice, order or other process at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, setting forth the manner of service, shall be proof of the same, and the return postcard receipt for the statement, notice, order or other process, registered and mailed as specified, shall be proof of the service of the same.

Section 8. Cease and Desist and Penalty Orders

A. If, after a hearing, the commissioner finds that an insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution has engaged in an unfair trade practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution charged with the violation, a copy of the findings in an order requiring the insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion order:

(1) Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation not to exceed an aggregate penalty of $250,000; and/or

(2) Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known that it was in violation of this Act.

B. In the case of a depository institution, the commissioner shall, if practicable, notify the appropriate federal regulator before imposing a monetary penalty on a depository institution or suspending or revoking the depository institution's insurer's license, and provide to the federal regulator a copy of the findings.

Section 9. Judicial Review of Orders

A. An insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution subject to an order of the commissioner under Section 8 or Section 11 may obtain a review of the order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and thereupon the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

B. To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file the modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgment, order or decree would not be subject to review by an appellate court provision therefor should be inserted here.

C. An order issued by the commissioner under Section 8 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 9B; or

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

D. No order of the commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Section 10. Judicial Review by Intervenor

If after any hearing under Section 7 or Section 11, the report of the commissioner does not charge a violation of this Act, then any intervenor in the proceedings may within [insert number] days after the service of the report, cause a petition [notice of appeal] [petition for writ of certiorari] to be filed in the [insert title] Court of [insert county] County for a review of the report. Upon review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of this Act, and containing penalties pursuant to Section 8.

Drafting Note: The type of procedure should conform to state procedure. See also note to Section 9 concerning review by appellate courts.

Section 11. Penalty for Violation of Cease and Desist Orders

Any insurer, health insurance lead generator, person, depository institution or affiliate of a depository institution that violates a cease and desist order of the commissioner and while such order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to:

A. A monetary penalty of not more than $25,000 for each and every act or violation not to exceed an aggregate of $250,000 pursuant to any such hearing; and/or

B. Suspension or revocation of the insurer's license.

Section 12. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. Such regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 13. Provisions of Act Additional to Existing Law

The powers vested in the commissioner by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Section 14. Immunity from Prosecution

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate or subject the person to a penalty or forfeiture, and shall notwithstanding be directed to give testimony or produce evidence, the person shall nonetheless comply with the direction, but shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the person may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against the person upon any criminal action, investigation or proceeding; provided, however, that no person so testifying shall be exempt from prosecution or punishment for any perjury committed while so testifying and the testimony or evidence so given or produced shall be admissible against the person upon any criminal action, investigation or proceeding concerning such perjury, nor shall the person be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this state. Any such person may execute, acknowledge and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter or thing specified in the statement and thereupon the testimony of the person or evidence in relation to the transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced the person shall not be entitled to any immunity or privilege on account of any testimony the person may give or evidence produced.

Section 15. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1947 Proc. 383, 392-400, 413 (adopted).
1960 Proc. II 485-487, 509-515, 516 (reprinted).
1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).
1977 Proc. I 26, 28, 211, 226-227 (amended).
1979 Proc. II 31, 34, 38, 39, 525 (amended).
1985 Proc. I 19, 39, 85-86 (amended).
1989 Proc. II 13, 21, 129-130, 132, 133-140) (amended and reprinted).
1990 Proc. I 6, 25, 122, 146 (changed name of model).
1990 Proc. II 7, 13-14, 160, 169-177 (amended and reprinted).
1991 Proc. I 9, 16, 192-193, 196-203 (amended and reprinted).
1993 Proc. I 8, 136, 242, 246-254 (amended and reprinted).
1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).
2001 Proc. 2nd Quarter 7, 9, 836, 843-853 (amended and reprinted).
2021 Spring National Meeting (amended).
2024 Spring National Meeting (amended).

The NAIC amended this model during the 2008 Summer National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2008 2nd Quarter Guideline Amendments are highlighted in grey.

UNFAIR TRADE PRACTICES ACT

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Prefatory Note: By adopting amendments to this model act in June 1990, the NAIC separated provisions dealing with unfair claims settlement into a newly adopted Unfair Claims Settlement Practices Model Act, to make clearer distinction between general unfair trade practices and more specific unfair claim settlement issues and to focus on market conduct practices and market conduct regulation. By doing so, the NAIC is not recommending that states repeal existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.

Section 2. Definitions

When used in this Act:

A. "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

B. "Commissioner" means the commissioner of insurance of this state.

Drafting Note: Insert the appropriate term for the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Customer" means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family or household purposes.

D. "Depository institution" means a bank or savings association. The term depository institution does not include an insurance company.

E. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

F. "Insurer" means any person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters and third-party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Sections [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient.

G. "Person" means a natural or artificial entity, including but not limited to, individuals, partnerships, associations, trusts or corporations.

H. "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

I. "Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

Section 3. Unfair Trade Practices Prohibited

It is an unfair trade practice for any insurer to commit any practice defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or of any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Trade Practices Defined

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the business of insurance:

A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

(1) Misrepresents the benefits, advantages, conditions or terms of any policy; or

(2) Misrepresents the dividends or share of the surplus to be received on any policy; or

(3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or

(4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or

(5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(8) Misrepresents any policy as being shares of stock.

B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.

C. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.

D. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

E. False Statements and Entries.

(1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.

(2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.

F. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.

G. Unfair Discrimination.

(1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.

(2) (a) Refusing life insurance to, refusing to continue life insurance of, or limiting the amount, extent, or kind of life insurance coverage available to an individual based on the individual's past lawful travel experiences.

(b) Refusing life insurance to, refusing to continue life insurance of, limiting the amount, extent, or kind of life insurance coverage available to an individual, or determining the premium of life insurance based on the individual's future lawful travel plans unless:

(i) (I) The risk of loss for individuals who travel to a specified destination at a specified time is reasonably anticipated to be greater than if the individuals did not travel to that destination at that time; and

(II) The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

(ii) An action shall be deemed to meet the requirements of subparagraph (i) of this paragraph if it is taken because either one of the following is true with respect to the travel destination:

(I) The Director of the Centers for Disease Control and Prevention of the Department of Health and Human Services has issued a highest level alert or warning, including a recommendation against non-essential travel, due to a serious health-related condition; or

(II) There is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

(c) (i) The commissioner may adopt regulations necessary to implement the provisions of this paragraph and may provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy.

(ii) An insurer shall make any pertinent underwriting guidelines and supporting analyses available to the commissioner on request.

(3) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

(4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(5) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(6) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.

(7) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

(8) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(9) Violation of the state's rescission laws at [insert reference to appropriate code section].

Drafting Note: A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

H. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or

(d) Engaging in an arrangement that would not violate Section 106 of the Bank Holding Company Act Amendments of 1972 (12 U.S.C. 1972), as interpreted by the Board of Governors of the Federal Reserve System, or Section 5(q) of the Home Owners' Loan Act, 12 U.S.C. 1464(q).

Drafting Note: Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners' Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.

I. Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.

J. Failure to Maintain Marketing and Performance Records. Failure of an insurer to maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained.

K. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

L. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.

M. Unfair Financial Planning Practices. An insurance producer:

(1) Holding himself or herself out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

(2) (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that

(i) He or she is also an insurance salesperson, and

(ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.

(3) (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.

(i) The services for which the fee is to be charged must be specifically stated in the agreement.

(ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

Drafting Note: This subsection is intended to apply only to persons engaged in personal financial planning.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

N. Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:

(1) File with the insurance department the following material:

(a) The policy and certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the insurance department; or

(2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.

O. Failure to Provide Claims History

(1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured's written request:

(a) On all claims, date and description of occurrence, and total amount of payments; and

(b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.

(2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

Drafting Note: Loss information on workers' compensation is an example in some states of loss information otherwise required by law.

(4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.

Drafting Note: This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.

P. Violating any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the state's insurance laws deemed desirable or necessary to include as an unfair trade practice, such as cancellation and nonrenewal laws.

Section 5. Favored Agent or Insurer; Coercion of Debtors

A. No person or depository institution, or affiliate of a depository institution may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers. Further, no person or depository institution, or affiliate of a depository institution, may reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit.

B. No person or depository institution, or affiliate of a depository institution, who lends money or extends credit may:

(1) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or a particular insurer or producer. However, this provision does not prohibit a person or depository institution, or affiliate of a depository institution, from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, or that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance, or that insurance is available from the person or depository institution, or affiliate of a depository institution;

(2) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction;

(3) Require that any customer, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge, in connection with the handling of any policy required as security for a loan on real estate, or pay a separate charge to substitute the policy of one insurer for that of another. This paragraph does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. Further, this paragraph does not apply to charges that would be required when the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance;

(4) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit;

(5) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution or its affiliate;

(6) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the person, depository institution or its affiliate;

(7) Act as a producer unless properly licensed in accordance with [insert appropriate statutory provisions for producer licensing];

(8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, an unlicensed person may make a referral to a licensed producer provided that the person does not discuss specific insurance policy terms and conditions. The unlicensed person may be compensated for the referral, however, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction;

Drafting Note: The last sentence of this paragraph further limits the referral for customers of personal, family and household insurance products as a result of Section 305 of the Gramm-Leach-Bliley Act and the subsequent adoption of regulations by the federal banking regulators at 12 C.F.R. 14.50, 208.85, 343.50 and 536.50. By including this language the paragraph will be consistent with the Gramm-Leach-Bliley Act and the federal regulations while maintaining the integrity of Section 104(d)(2)(B)(iv) and (v) of the Gramm-Leach-Bliley Act.

(9) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions;

(10) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer;

(11) Solicit or sell insurance unless its insurance sales activities are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions; or

(12) Solicit or sell insurance unless it maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

Drafting Note: The Gramm-Leach-Bliley Act contains two "safe harbors" that relate to information sharing. Section 104(d)(2)(B)(vi) describes the circumstances surrounding the release of a customer's insurance information. Section 104(d)(2)(B)(vii) describes the circumstances surrounding the use of a customer's health information obtained from the insurance records of the customer. If a state has adopted the NAIC's Privacy of Consumer Financial and Health Information Model Regulation, no further action is needed. If not, language implementing the two safe harbors should be considered. It should be noted, however, that during the drafting process, there were concerns expressed about the application of the preemption provisions of the Fair Credit Reporting Act (FCRA) in circumstances involving the sharing of information with affiliates. Nothing in this Act shall be construed to modify, limit or supersede the operation of the FCRA (15 U.S.C. 1681 *et seq*.). In addition, no inference shall be drawn on the basis of the provisions of this Act regarding whether information is transaction or experience information under Section 603 of FCRA.

C. Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in Subsection B(2).

D. (1) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:

(a) Is not a deposit;

(b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;

(c) Is not guaranteed by the depository institution, its affiliate (if applicable) or any person that is soliciting, selling, advertising or offering insurance (if applicable); and

(d) Where appropriate, involves investment risk, including the possible loss of value.

(2) For purposes of these requirements, an affiliate of a depository institution is subject to these requirements only to the extent that it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution. These requirements apply only when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes and only to the extent that the disclosure would be accurate.

Drafting Note: The requirements of this provision are meant to apply only when the consumer may have a reasonable belief that the product is a deposit; that it is insured by the Federal Deposit Insurance Corporation; that it is guaranteed by the person or depository institution; and that, where appropriate, it involves investment risk, including the possible loss of value. This provision is not intended to require every entity or person in a financial holding company to provide the disclosure as a result of having both solicitation of insurance and extending of credit or lending of money occurring within an entity in the financial holding company group.

(3) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy. If the solicitation is conducted by telephone, the person or depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgment was given by the customer, and make reasonable efforts to obtain a written acknowledgment from the customer. If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person or depository institution, may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.

(4) For the purposes of Paragraph (1), a person is selling, soliciting, advertising or offering insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one of the following applies:

(a) The person represents to the customer that the sale, solicitation, advertisement or offer of the insurance is by or on behalf of the depository institution;

(b) The depository institution refers a customer to the person who sells insurance and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or

(c) Documents evidencing the sale, solicitation, advertisement or offer of insurance identify or refer to the depository institution.

E. The commissioner shall have the power to examine and investigate those insurance activities of any person, depository institution, affiliate of a depository institution or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution or insurer shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice. An affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.

F. Nothing herein shall prevent a person or depository institution, or affiliate of a depository institution, who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

G. Nothing contained in this section shall apply to credit related insurance.

Drafting Note: The consumer protection rules promulgated by the banking regulatory agencies pursuant to Section 305 of the Gramm-Leach-Bliley Act apply to retail sales practices, solicitations, advertising or offers of any insurance product or annuity. If a state has adopted the NAIC's Consumer Credit Insurance Model Act and Consumer Credit Insurance Model Regulation, no further action is needed. If not, the state should consider eliminating Subsection G.

Section 6. Power of Commissioner

The commissioner shall have power to examine and investigate the affairs of every person or insurer in this state in order to determine whether such person or insurer has been or is engaged in any unfair trade practice prohibited by this Act. However, in the case of depository institutions, the commissioner shall have the power to examine and investigate the insurance activities of depository institutions, in order to determine whether the depository institution has been or is engaged in any unfair trade practice prohibited by this Act. The commissioner shall notify the appropriate federal banking agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate federal banking agency of the suspected violations of state law prior to commencing the examination or investigation.

Section 7. Hearings, Witnesses, Appearances, Production of Books, and Service of Process

A. Whenever the commissioner shall have reason to believe that any insurer, person, depository institution or affiliate of a depository institution has been engaged or is engaging in this state in any unfair trade practice whether or not defined in this Act, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner shall issue and serve upon such insurer, person, depository institution or affiliate of a depository institution, a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof. With respect to a depository institution, the commissioner's authority to call a hearing is limited to the depository institution's insurance underwriting, sales, solicitation and cross marketing activities. The commissioner shall provide a copy of the notice of hearing to the appropriate federal banking agency when a depository institution is involved.

B. At the time and place fixed for the hearing, the insurer, person, depository institution or affiliate of a depository institution shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the insurer, person, depository institution or affiliate of a depository institution to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.

C. Nothing contained in this Act shall require the observance at the hearing of formal rules of pleading or evidence.

D. The commissioner, at the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence or other documents the commissioner deems relevant to the inquiry, provided, however, that in the case of depository institutions, the commissioner shall have the power to require the production of books, papers, records, correspondence or other documents that the commissioner deems relevant to the inquiry only on the insurance activities of the depository institution. The commissioner, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where the person resides, on application of the commissioner, may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as contempt.

E. Statements of charges, notices, orders and other processes of the commissioner under this Act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by the statement, notice, order or other process at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, setting forth the manner of service, shall be proof of the same, and the return postcard receipt for the statement, notice, order or other process, registered and mailed as specified, shall be proof of the service of the same.

Section 8. Cease and Desist and Penalty Orders

A. If, after a hearing, the commissioner finds that an insurer, person, depository institution or affiliate of a depository institution has engaged in an unfair trade practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer, person, depository institution or affiliate of a depository institution charged with the violation, a copy of the findings in an order requiring the insurer, person, depository institution or affiliate of a depository institution to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion order:

(1) Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation not to exceed an aggregate penalty of $250,000; and/or

(2) Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known that it was in violation of this Act.

B. In the case of a depository institution, the commissioner shall, if practicable, notify the appropriate federal regulator before imposing a monetary penalty on a depository institution or suspending or revoking the depository institution's insurer's license, and provide to the federal regulator a copy of the findings.

Section 9. Judicial Review of Orders

A. An insurer, person, depository institution or affiliate of a depository institution subject to an order of the commissioner under Section 8 or Section 11 may obtain a review of the order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and thereupon the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

B. To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file the modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order, with the return of the additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgment, order or decree would not be subject to review by an appellate court provision therefor should be inserted here.

C. An order issued by the commissioner under Section 8 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 9B; or

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

D. No order of the commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Section 10. Judicial Review by Intervenor

If after any hearing under Section 7 or Section 11, the report of the commissioner does not charge a violation of this Act, then any intervenor in the proceedings may within [insert number] days after the service of the report, cause a petition [notice of appeal] [petition for writ of certiorari] to be filed in the [insert title] Court of [insert county] County for a review of the report. Upon review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of this Act, and containing penalties pursuant to Section 8.

Drafting Note: The type of procedure should conform to state procedure. See also note to Section 9 concerning review by appellate courts.

Section 11. Penalty for Violation of Cease and Desist Orders

Any insurer, person, depository institution or affiliate of a depository institution that violates a cease and desist order of the commissioner and while such order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to:

A. A monetary penalty of not more than $25,000 for each and every act or violation not to exceed an aggregate of $250,000 pursuant to any such hearing; and/or

B. Suspension or revocation of the insurer's license.

Section 12. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. Such regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 13. Provisions of Act Additional to Existing Law

The powers vested in the commissioner by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Section 14. Immunity From Prosecution

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate or subject the person to a penalty or forfeiture, and shall notwithstanding be directed to give testimony or produce evidence, the person shall nonetheless comply with the direction, but shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the person may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against the person upon any criminal action, investigation or proceeding; provided, however, that no person so testifying shall be exempt from prosecution or punishment for any perjury committed while so testifying and the testimony or evidence so given or produced shall be admissible against the person upon any criminal action, investigation or proceeding concerning such perjury, nor shall the person be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this state. Any such person may execute, acknowledge and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter or thing specified in the statement and thereupon the testimony of the person or evidence in relation to the transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced the person shall not be entitled to any immunity or privilege on account of any testimony the person may give or evidence produced.

Section 15. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1947 Proc. 383, 392-400, 413 (adopted).
1960 Proc. II 485-487, 509-515, 516 (reprinted).
1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).
1977 Proc. I 26, 28, 211, 226-227 (amended).
1979 Proc. II 31, 34, 38, 39, 525 (amended).
1985 Proc. I 19, 39, 85-86 (amended).
1989 Proc. II 13, 21, 129-130, 132, 133-140) (amended and reprinted).
1990 Proc. I 6, 25, 122, 146 (changed name of model).
1990 Proc. II 7, 13-14, 160, 169-177 (amended and reprinted).
1991 Proc. I 9, 16, 192-193, 196-203 (amended and reprinted).
1993 Proc. I 8, 136, 242, 246-254 (amended and reprinted).
1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).
2001 Proc. 2nd Quarter 7, 9, 836, 843-853 (amended and reprinted).
2008 Proc. 2nd Quarter, Vol. I, 159-162, 294, 398, 422, 569-582, 717 (guideline amendments adopted).

UNFAIR TRADE PRACTICES ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNFAIR TRADE PRACTICES ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 27-12-1 to 27-12-23 (1971/1994).
Alaska		ALASKA STAT. §§ 21.36.010 to 21.36.323 (1976/2009).	ALASKA STAT. § 21.36.500 (1992) (financial planners); § 45.50.471 (1970/2009); ALASKA ADMIN. CODE tit. 3, § 26.110 (2015); BULLETIN 2007-6 (2007).
American Samoa	NO CURRENT ACTIVITY		
Arizona		ARIZ. REV. STAT. ANN. §§ 20-441 to 20-461 (1954/2008).	BULLETIN 2019-01 (2019).
Arkansas		ARK. CODE ANN. §§ 23-66-201 to 23-66-316 (1959/2011).	CODE ARK. R. 054.00.4 (1985/2005); BULLETIN 8-2014 (2014).
California		CAL. INS. CODE §§ 790 to 790.10 (1959/2000).	CAL. INS. CODE §§ 759 to 764 (2002).
Colorado		COLO. REV. STAT. §§ 10-3-1101 to 10-3-1113 (1963/2015).	BULLETIN B-5.32 (2013); BULLETIN B-4.72 (2014).
Connecticut		CONN. GEN. STAT. §§ 38a-815 to 38a-819 (1955/2013).	CONN. GEN. STAT. §§ 38a-824 to 38a-832 (1949/1980); BULLETIN HC-69-010 (2008); BULLETIN IC-35 (2013); BULLETIN S-18 (2019).

UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware		DEL. CODE ANN. tit. 18, §§ 2301 to 2314 (1953/2013).	
District of Columbia		D.C. CODE §§ 31-2231.01 to 31-2231.25 (2000/2012).	
Florida		FLA. STAT. §§ 626.951 to 626.9641 (1982/2014).	FLA. STAT. § 626.572 (1990/2005) (rebating).
Georgia		GA. CODE ANN. §§ 33-6-1 to 33-6-14 (1972/2005).	GA. COMP. R. & REGS. 120-2-20-.03 to 120-2-20-.04 (2012).
Guam			5 GUAM CODE ANN. § 32201 (1993/2007).
Hawaii		HAW. REV. STAT. §§ 431:13-101 to 431:13-204 (1988/2014).	
Idaho		IDAHO CODE ANN. §§ 41-1301 to 41-1331 (1961/2005).	BULLETIN 88-2 (1988).
Illinois			215 ILL. COMP. STAT. 5/421 to 5/434 (1959/2015); 5/236 (1937/2004).
Indiana		IND. CODE §§ 27-4-1-1 to 27-4-1-18 (1947/2009).	
Iowa		IOWA CODE §§ 507B.1 to 507B.14 (1955/2010).	IOWA ADMIN. CODE r. 191-15.11 (2011); BULLETIN 13-07 (2013); BULLETIN 2014-2 (2014).
Kansas		S.B. 448 (2022); KAN. STAT. ANN. §§ 40-2401 to 40-2421 (1955/2007).	
Kentucky		KY. REV. STAT. ANN. §§ 304.12-010 to 304.12-230 (1970/2010).	KY. REV. STAT. ANN. § 304.17A-150 (1994/2012) (health benefit plans); ADVISORY OPINION 2014-1 (2014); ADVISORY OPINION 2020-003 (2020).

UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Louisiana		LA. REV. STAT. ANN. §§ 22:1961 to 22:1973 (1966/2014).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 2151 to 2182 (1970/2001).	BULLETIN 384 (2012).
Maryland		MD. CODE ANN., INS. §§ 27-101 to 27-219 (1957/2014).	MD. CODE REGS. 31.15.01.01 to 31.15.14.9999 (1970/2014); BULLETIN 2014-23 (2014) BULLETIN 19-21 (2019).
Massachusetts		MASS. GEN. LAWS ch. 176D, §§ 1 to 14 (1972/2012).	BULLETIN B-2010-10 (2010).
Michigan		MICH. COMP. LAWS §§ 500.2001 to 500.2093 (1957/2011).	BULLETIN 2006-07 (2006).
Minnesota		MINN. STAT. §§ 72A.17 to 72A.32 (1967/2013).	BULLETIN 2013-3 (2013).
Mississippi		MISS. CODE ANN. §§ 83-5-29 to 83-5-51 (1956/2009).	BULLETIN 2020-14 (2020).
Missouri		MO. REV. STAT. §§ 375.930 to 375.948 (1978/2004).	MO. REV. STAT. § 376.502 (2009); MO. CODE REGS. ANN. tit. 20, § 100-2.100 (2008) (financial planners).
Montana		MONT. CODE ANN. §§ 33-18-101 to 33-18-1006 (1959/2015).	MEMORANDUM 1-29-2014 (2014).
Nebraska		NEB. REV. STAT. §§ 44-1522 to 44-1535 (1973/2003).	
Nevada		NEV. REV. STAT. §§ 686A.010 to 686A.280 (1971/2013).	BULLETIN 2014-009 (2014).
New Hampshire		N.H. REV. STAT. ANN §§ 417:1 to 417:17 (1947/2010).	
New Jersey		N.J. REV. STAT. §§ 17:29B-1 to 17:29B-14 (1947/2001).	

UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Mexico		N.M. STAT. ANN. §§ 59A-16-1 to 59A-16-30 (1985/1999) (portions of model).	BULLETIN 2021-014 (2021).
New York		N.Y. INS. LAW §§ 2401 to 2409 (1984); §§ 2602 to 2612 (1984/2013).	
North Carolina		N.C. GEN. STAT. §§ 58-63-1 to 58-63-60 (1949/1999).	
North Dakota		N.D. CENT. CODE §§ 26.1-04-01 to 26.1-04-19 (1983/2011).	BULLETIN 2021-3 (2021).
Northern Marianas		4 N. MAR. ISLAND CODE § 7302 (1984).	
Ohio		OHIO REV. CODE ANN. §§ 3901.19 to 3901.26 (1955-1956/2013); OHIO ADMIN. CODE § 3901-1-07 (1975/2011).	BULLETIN 2019-04 (2019); BULLETIN 2019-05 (2019).
Oklahoma		OKLA. STAT. tit. 36, §§ 1201 to 1220 (1957/2012); § 1250.5 (2012).	
Oregon			OR. REV. STAT. §§ 746.005 to 746.270 (1967/2010); OR. ADMIN. R. 836-080-0235 (1980/2010).
Pennsylvania		40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).	40 PA. CONS. STAT. §§ 1171.3 to 1171.5 (2014).
Rhode Island		R.I. GEN. LAWS §§ 27-29-1 to 27-29-13 (1958/2015).	HEALTH BULLETIN 2013-5 (Revised) (2014).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 2701 to 2740 (1974/1987).	
South Carolina		S.C. CODE ANN. §§ 38-57-10 to 38-57-310 (1988); §§ 38-59-10 to 38-59-50 (1988/1999).	S.C. CODE ANN. § 38-55-50 (1987/2004) (rebating).

UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
South Dakota		S.D. CODIFIED LAWS §§ 58-33-1 to 58-33-46.1 (1966/2000); §§ 58-33-66 to 58-33-69 (1986/1989).	
Tennessee		TENN. CODE ANN. 56-8-104 (2012).	
Texas		TEX. INS. CODE ANN. §§ 541.001 to 541.454 (2005/2013).	28 TEX. ADMIN. CODE §§ 21.1 to 21.122 (1981/2010).
Utah			UTAH ADMIN. CODE r. 590-154 (1993/2013) (unfair marketing practices); BULLETIN 2013-5 (2013); BULLETIN 2015-8 (2015).
Vermont		VT. STAT. ANN. tit. 8, §§ 4721 to 4726 (1974/2007).	
Virgin Islands			V.I. CODE ANN. tit. 22, §§ 1201 to 1228 (1968).
Virginia		VA. CODE ANN. §§ 38.2-500 to 38.2-516 (1986/2013).	
Washington		WASH. REV. CODE ANN. §§ 48.30.010 to 48.30.270 (1947/2015).	
West Virginia		W. VA. CODE §§ 33-11-1 to 33-11-10 (1957/2005); INS. BULLETIN NO. 20-02 (2020).	
Wisconsin			WIS. STAT. §§ 628.31 to 628.46 (1975/1998); WIS. ADMIN. CODE INS. § 6.68 (1979/1984).
Wyoming		WYO. STAT. ANN. §§ 26-13-101 to 26-13-124 (1967/1986).	33 WYO. CODE R. §§ 1 to 5 (1980/1997).

PROJECT HISTORY - 2024

AMENDMENTS TO THE *UNFAIR TRADE PRACTICES MODEL ACT* (#880)

1. Description of the project, issues addressed, etc.

In July 2021, the Market Regulation and Consumer Affairs (D) Committee adopted a new charge and appointed the Improper Marketing of Health Insurance (D) Working Group under the Antifraud (D) Task Force. The Working Group was assigned two charges:

A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance on monitoring the improper marketing of health plans and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.

B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

As a result of the Working Group's discussions in 2021 regarding current marketplace practices and enforcement actions concerning the improper marketing of health plans, the Working Group adopted amendments to the *Unfair Trade Practices Act* (#880):

- Section 2: Definitions. This section was amended to include a definition of health insurance lead generator and lead-generating device.

- Section 3: Unfair Practices Prohibited. This section was amended to specify it is unfair trade practice for any insurer, health insurance lead generator, or person engaged in the business of insurance to commit any practices defined in Section 4 of Model #880.

- Section 4: Unfair Trade Practices Defined. Subsection 4.B (false information and advertising) was amended to encompass the use of email, internet advertisement, or electronic posting of any kind via the internet or other electronic means.

2. Name of group responsible for drafting the model and states participating.

The Improper Marketing of Health Insurance (D) Working Group of the Antifraud (D) Task Force was responsible for drafting the revisions.

3. Project authorized by what charge and date first given to the group.

The project was authorized in 2021 by the following charge: Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

The Executive (EX) Committee unanimously adopted the Request for NAIC Model Law Development for revising Model #880 at the 2023 Spring National Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

In the fall of 2021, the Improper Marketing of Health Insurance (D) Working Group began its work to address its charge to review existing models and guidelines that need to be updated or developed to address the use of lead generators for the sale of health insurance products. The first draft of amendments to Model #880 was distributed to interested regulators and interested parties for review and comment in August 2022. The second draft of amendments to Model #880 was distributed in November 2022.

During the 2023 Spring National Meeting, the Working Group reviewed the second draft and the comments received. Following the Spring National Meeting, a small group of subject matter experts (SMEs) completed the drafting of amendments, and the Working Group circulated a third draft of the model in July 2023.

All drafts were posted on the NAIC website. Written regulator comments were received from Hawaii, Maine, Missouri, Ohio, and Rhode Island. Written industry comments were received from the American Council of Life Insurers (ACLI), the American Health Insurance Policies (AHIP), The Health Benefits Institute, and the National Association of Health Underwriters (NAHU). NAIC consumer representatives also submitted a joint comment letter.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited).

The first draft of the proposed amendments was exposed on Aug. 31, 2022, for a 30-day public comment period that ended Sept. 30, 2022. The Working Group met on Nov. 3, 2022, to adopt the model law development request and review the comments received. The second draft was exposed on Nov. 8, 2022, for a public comment period that ended Nov. 18, 2022. The comment period was then extended until March 10, 2023. The Working Group met on March 23, 2023, during the Spring National Meeting to discuss the comments received. The Working Group continued to meet through virtual meetings to discuss comments received, and a third draft was exposed on June 29, 2023, for a public comment period that ended July 21, 2023.

The Improper Marketing of Health Insurance (D) Working Group adopted revisions to Model #880 on Aug. 14, 2023, during the Summer National Meeting. The Antifraud (D) Task Force made technical edits to the model and adopted revisions to the model on Dec. 2, 2023, during the Fall National Meeting. The Market Regulation and Consumer Affairs (D) Committee adopted revisions to the model on Dec. 3, 2023, during the Fall National Meeting.

6. A discussion of the significant issues (items of some controversy raised during the due process and the group's response).

The Improper Marketing of Health Insurance (D) Working Group decided that Model #880 should be the first model for review and amendment to provide greater regulatory oversight for entities that are improperly marketing health insurance. The Working Group believed amending Model #880 would provide states with a quicker legislative option than amending other NAIC models, and amending Model #880 would not preclude future discussions of possible amendments to other NAIC models.

The Working Group discussed the review of the following models for possible amendment in addition to Model #880: *Producer Licensing Model Act* (#218), *Advertisements of Accident and Sickness Insurance Model Regulation* (#40), and *NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines* (#660).

7. Any other important information (e.g., amending an accreditation standard).

Addressing the improper marketing in health insurance is a strategic priority for the NAIC. This strategy includes modifying NAIC model laws to grant regulatory power over health insurance lead generators.

The amendments do not impact any accreditation standards.

PROJECT HISTORY - 2021

UNFAIR TRADE PRACTICES ACT (#880)

1. Description of the Project, Issues Addressed, etc.

The NAIC's Innovation and Technology (EX) Task Force began discussing rebating issues in 2018 during the NAIC Summer National Meeting in Boston, MA, particularly because of the increased interest in offering value-added products and services such as risk mitigation devices and related services that are not necessarily addressed within the applicable insurance policy language. After finding that state interpretation and application of anti-rebating laws varies and after reviewing the history of the NAIC's *Unfair Trade Practices Act* (#880) along with the history and the intent of the anti-rebating portion, it became clear that applying the anti-rebating laws to the innovation of new insurance products and services could be challenging. The Task Force received presentations and testimony from many stakeholders, including state insurance regulators, producers, consumers, insurance companies and the startup community regarding a wide array of opinions and concerns. They also offered various suggestions for improving uniform application of anti-rebating statutes in the states. Based on this research and hearing from stakeholders, the Task Force members determined it would be appropriate to review Model #880, specifically Section 4(H)(2).

2. Name of Group Responsible for Drafting the Model and States Participating

The Innovation and Technology (EX) Task Force was responsible for the drafting of the revisions to Model #880. The process began with the formation of a drafting group. The group was led by Superintendent Elizabeth Kelleher Dwyer (RI). Seven other states participated in the drafting process: Alaska, Alabama, Iowa, Missouri, North Dakota, Ohio and Washington. Also participating were six industry representatives, including one startup; one state legislator (Rep. Matt Lehman (IN), the president of National Council of Insurance Legislators—NCOIL); and a consumer representative.

3. Project Authorized by What Charge and Date First Given to the Group

The mission of the Innovation and Technology (EX) Task Force is to: 1) provide a forum for state insurance regulator education and discussion of innovation and technology in the insurance sector: 2) monitor technology developments that affect the state insurance regulatory framework; and 3) develop regulatory guidance, as appropriate. This work was done under the specific charge:

The Innovation and Technology (EX) Task Force will:
Develop regulatory guidance, model laws or model law revisions, and white papers or make other recommendations to the Executive (EX) Committee, as appropriate.

At its meeting during the 2019 Summer National Meeting, the Task Force voted to move forward with the Request for NAIC Model Law Development to open Model #880 to amend or add to the language in Section 4(H)(2). The request was adopted by the Task Force in October 2019 and subsequently by the NAIC Executive (EX) Committee in December during the 2019 Fall National meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The drafting group met twice at the beginning of 2020, in January and February, and then stopped meeting for a period of time because of the COVID-19 pandemic. However, it regrouped to meet two more times in May and June. Given the Task Force had already received considerable input from stakeholders regarding this topic, the drafting group was able to move forward expeditiously and disbanded prior to the 2020 Summer National Meeting.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The first draft published out of the drafting group was posted for comment on June 23. Twenty-one comment letters were submitted, and Superintendent Dwyer reviewed the changes made based on those comments during the Task Force's meeting on Aug. 7. A new draft was posted and exposed for comment on Aug. 10. Seventeen comments were reviewed, and a new draft was posted on Oct. 30. During the Task Force's meeting on Nov. 4, Superintendent Dwyer again reviewed each substantive comment, noting whether it was accepted or rejected in the latest draft. Comments regarding the Oct. 30 draft were again requested and accepted. Seven comments were reviewed, and interested parties were given an opportunity to present their

points orally. Additionally, Task Force members and interested parties had the opportunity to ask questions or pose challenges to those points during a meeting on Nov. 30. Five presentations were made. Following the meeting on Nov. 30, another draft was posted on Dec. 2. During its meeting on Dec. 4 and with 44 members of the Task Force in attendance, the revised language was adopted, with Nevada dissenting and California, Hawaii, Idaho and New Jersey abstaining.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

While the genesis for drafting this revised language was primarily the need to clarify intentions related to the acceptability of the offering of things of value in the best interests of the consumer and to mitigate risk associated with what is being underwritten, value-added products and services, Section H(2)(e), the group also took on drafting clarifying language related to producer and insurer marketing including non-cash gifts meals, charitable donations on behalf of a customer, raffles and drawings, Section H(2)(f).

Since the term "value-added" is relatively new, there was considerable discussion regarding its use. Ultimately, the drafters and most of the state insurance regulators and interested parties agreed it was the appropriate term and needed no further defining.

There was considerable debate and discussion regarding the list in Section H(2)(e)(ii). The term "primarily designed" was discussed very thoroughly as the early use of the term "primarily intended" gave some state insurance regulators concern given the difficulty in determining "intent." There seemed to be consensus that "designed" was a much better term to use in this case. The list itself was heavily debated both in terms of it being comprehensive and there not being a "catch-all," as well as in terms of the value-added product or service needing to satisfy at least one of the listed criteria.

The cost discussed in Section H(2)(e)(iii) was also heavily debated. In the end, in addition to other language in that section, it was determined to be appropriate to include a drafting note that notes states may consider alternative language depending on their filing requirements. There was great care given to there being deference or to acknowledging some states may already have statute or regulation language that addresses or sets out permitted practices.

There was also a lot of discussion regarding Section H(2)(e)(vii). The debate was primarily around differences of opinion regarding whether offering the value-added product or service would need to be preapproved by the Department of Insurance (DOI). The concern on the part of industry was slowing down the ability to move forward with a pilot or testing something new, which led, ultimately, to the decision to require notification to the DOI, with a 21-day time period for the DOI to object.

In Section H(2)(f), great care was given to the specific terms used in this section. Given the history with this issue specific to the dollar amount, a drafting note was included to offer a suggested monetary amount but ultimately left to the state. In addition, this section addresses commercial or institutional customers as there was a great deal of discussion around excluding commercial lines from this section altogether, considering the notion that a transaction between sophisticated purchasers and sellers does not require this type of oversight.

Lastly, Section H(3) is intended to make clear that original rebating language intended to prevent abuses related to inducement to purchase or renew is still in effect, and this new language should not be construed to change that.

7. List the key provisions of the model (sections considered most essential to state adoption)

Section H(2)(e), Section H(2)(f) and Section H(3)

8. Any Other Important Information (e.g., amending an accreditation standard)

No other items are identified at this time.

PROJECT HISTORY - 2008

UNFAIR TRADE PRACTICES ACT (#880)
(Travel Underwriting Revisions)

1. Description of the project, issues addressed, etc.

The revisions address the issue of underwriting in life insurance based on past lawful travel experiences and future lawful travel plans. The revisions prohibit an insurer from refusing life insurance to, refusing to continue life insurance of, or limiting the amount, extent or kind of life insurance available to an individual based on past lawful travel experiences. The revisions also prohibit an insurer from taking the same action based on future lawful travel plans unless such an action is based on sound actuarial principles and actual or reasonably anticipated experience related to a specific destination or the action is taken because, with respect to the specific travel destination, the Centers for Disease Control and Prevention has issued certain alerts or there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

2. Name of group responsible for draft the model and states participating:

Travel to Foreign Countries (A) Working Group and the Life Insurance and Annuities (A) Committee

States Participating during the drafting process:

Alabama
California
Connecticut
District of Columbia
Florida
Iowa
Minnesota
Missouri
Nebraska
New Mexico
New York
North Dakota
Ohio
Pennsylvania
Texas
Utah
Wisconsin

3. Project authorized by what charge and date first given to the group:

The following charge was given in 2006:

Analyze issues related to underwriting practices and/or policy exclusions in life insurance policies relating to lawful travel to foreign countries and draft guidelines for interpretation of the Unfair Trade Practices Act or model legislation to address the issues, as necessary.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the Working Group. The Working Group adopted a draft of proposed revisions in December 2006, which was then forwarded to the Committee for its consideration. The Committee decided to reopen the draft for additional comments. The Committee reviewed and discussed all comments received. All drafts were distributed to over 100 interested parties and posted on the NAIC Web site. Interested parties that commented on the drafts included industry groups such as the American Council of Life Insurance (ACLI) and MetLife; the American Academy of Actuaries (AAA); and consumer groups, such as the Center for Economic Justice (CEJ) and Anti-Defamation League.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of the proposed revisions to the model was circulated to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments. The Working Group and Committee reviewed and considered all comments received. Please see below.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

The main issue that arose during the drafting process concerned the approach to be used to address the issue and in what manner, if at all, insurers could underwrite life insurance policies based on past or future lawful travel. Among the more controversial provisions in the different approaches debated, was a proposed revision that would have required insurers to file with the commissioner a complete description of any underwriting guidelines based on an individual's future lawful travel plans and the supporting actuarial analysis. Another approach offered that also was controversial concerned what exceptions should be included in the revisions that would allow an insurer to underwrite based on future lawful travel to a specific travel destination if certain specified conditions exist at that travel destination or certain alerts have been issued concerning that specific travel destination. Another approach offered suggested that the revisions were not necessary, but if revisions were made that such revisions apply to future lawful travel plans only. The Committee extensively debated these approaches and others offered. The final revisions represent a compromise reached between all of the impacted stakeholders.

7. Any other important information (e.g., amending an accreditation standard).

None.

Travel Underwriting UTPA Revisions Development Timeline

Date	Action
March 5, 2006	At the NAIC 2006 Spring National Meeting, the Life Insurance and Annuities Committee (Committee) decides to form a working group to work on the Committee's 2006 charge on travel underwriting.
Sept. 9, 2006	At the NAIC 2006 Fall National Meeting, the Working Group holds a public hearing. Congresswoman Debbie Wasserman Schultz (FL) provided taped testimony. Other participants were: Arnold Dicke (American Academy of Actuaries); Karen Aroesty (Anti-Defamation League); Robbie Meyer (American Council of Life Insurers); and Birny Birnbaum (Center for Economic Justice).
Nov. 27, 2006	1st Draft of proposed revisions to the Unfair Trade Practices Model Act (UTPA) to address travel underwriting is distributed for comment to over 100 interested parties. Draft also posted on the NAIC Web site.
Dec. 4, 2006	The Working Group holds a conference call to discuss the comments received on the Nov. 27, 2006, draft. Interested parties, including ACLI, CEJ, and AAA, discuss their comments. The Committee directs NAIC staff to prepare and distribute for comment a new draft of revisions to reflect the conference call discussion.
Dec. 15, 2006	2nd Draft of proposed revisions to the UTPA is distributed for comment to over 100 interested parties. Draft also posted on the NAIC Web site.
Dec. 20, 2006	Working Group holds a conference call to discuss the comments received on the Dec. 15, 2006, draft. Interested parties, including ACLI, CEJ, and AAA discuss their comments. Working Group adopts with amendments to send to the Committee for its consideration. The Working Group directs NAIC staff to prepare and distribute for comment the revised draft.
Dec. 20, 2006	3rd Draft of proposed revisions, as adopted by the Working Group, distributed to over 100 interested parties. Draft posted on the NAIC Web site.
March 5, 2007	Committee holds a conference call to discuss the comments received on the Dec. 20, 2006, draft. Interested parties, including ACLI, CEJ, and AAA, discuss their comments. The Committee took the comments under advisement.
March 11, 2007	At the NAIC 2007 Spring National Meeting, the Committee adopts revisions to Dec. 20, 2006, draft based on Alabama comments (with a tie vote and Chair breaking the tie in favor the revisions). Committee decides to hold draft.
March 11, 2007	4th Draft of proposed revisions is distributed for comment to over 100 interested parties. Draft posted on NAIC Web site.
June 12, 2007	5th draft of proposed revisions is distributed for comment to over 100 interested parties. Draft posted on NAIC Web site.
Aug. 28, 2007	Committee holds a conference call to discuss model law development or guideline status for UTPA revisions. Committee decides on guideline status.
Sept. 30, 2007	At the NAIC 20007 Fall National Meeting, the Committee discusses the UTPA revisions. Interested parties comment on the major issues. Discussion of a dual-option approach.
Nov. 27, 2007	Committee holds a conference call to discuss the approach to the UTPA revisions. Decides to again pursue single-option approach and to try to reach a consensus. Announces plans to continue discussion at NAIC 2007 Winter National Meeting.
Dec. 3, 2007	At the NAIC 2007 Winter National Meeting, the Committee decides to re-circulate the June 12, 2007, draft with a new comment period of Jan. 10, 2008, particularly for Committee members

Date	Action
	wishing to submit additional comments.
Jan. 15, 2008	NAIC staff re-distributes June 12, 2007, draft and comments received to over 100 interested parties. Asks for additional comments by Feb. 22, 2008.
Feb. 25, 2008	NAIC staff distributes all additional comments received by the Feb. 22, 2008, deadline to over 100 interested parties. All comments posted on NAIC Web site.
March 24, 2008	Committee holds a conference call and, again, discusses the travel underwriting revisions to UTPA.
March 27, 2008	6th draft of proposed revisions is distributed for comment to over 100 interested parties.
March 30, 2008	At NAIC 2008 Spring National Meeting, Committee discusses March 27, 2008, draft and adopts unanimously.
April 17, 2008	The Committee holds a conference call on April 17, 2008, and adopts clarifying revisions to the version the Committee adopted at the NAIC 2008 Spring National Meeting.

MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

Table of Contents

Preface

This regulation is designed to implement provisions of the Unfair Trade Practices Act regarding complaint recordkeeping. A proper record of complaints serves a dual purpose. It assists the Insurance Department in overseeing the performance of its licensees. In addition, it can serve as a valuable management tool. It permits management to quickly determine how well the company is doing in its dealings with its policyholders and the public. It can identify those areas where improvement is necessary and management can direct its attention accordingly. The recordkeeping procedures specified in the regulation are minimum requirements. Insurers are urged, however, to supplement these procedures and to provide for periodic review of the records in order to maximize the value of its complaint records as a management tool.

While "complaint" is defined both in the Act and in this regulation, it will be necessary on occasion to distinguish an inquiry or other communication from a "complaint." Not every contact by a policyholder or claimant questioning some action by the insurer will constitute a "complaint." Differentiating an "inquiry" from a "complaint" will in many cases involve judgment, which we expect to be applied reasonably. The essential question is: has the writer expressed a grievance? One person who calls your attention to a typographical error in the spelling of his name on a policy may merely be passing on information. Another may be expressing a grievance. The distinction lies in the language used in the letter and in a reasonable interpretation of that language.

Section 1. Authority

This regulation is promulgated pursuant to the authority granted by Section [insert applicable section] of the Unfair Trade Practices Act.

Section 2. Purpose

Section [insert applicable section] of the Unfair Trade Practices Act makes it an unfair trade practice for a person subject to the Act to fail to maintain a record of complaints as specified in such section. The purpose of this regulation is to prescribe the minimum information required to be maintained in such a record of complaints in order to comply with the statute and to set forth a format for such record which may be used by any person subject to this regulation.

Section 3. Content of Complaint Record

Attachment A of this Regulation sets forth the minimum information required to be contained in a person's complaint record in order for it to comply with the statute. Refinements and additions to the information specified therein may, of course, be maintained in such complain record. Attachment B of this regulation contains an explanation of the various headings, codes and other notations contained in Attachment A. The codes are used in order to simplify both the identification of the action underlying the complaint and the keeping of the records.

Section 4. Format of Complaint Record

Attachment A is the suggested format for the complaint record required to be maintained by the statute and this regulation. Refinements, deviations from or additions to this suggested format are permitted so long as the minimum information contemplated by such format can be obtained for Insurance Department review within a reasonable time following a request therefore by an authorized representative of the Department.

Section 5. Maintenance of the Record

The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reasons, disposition, and state of origin shall be complied not less frequently than annually.

The complaint record required by this regulation shall be maintained on and after the date sixty (60) days after the effective date of this regulation.

Section 6. Definitions

As used herein:

A. "Person" shall have the meaning set forth in Section [insert applicable section] of the Unfair Trade Practices Act;

B. "Complaint" shall mean a written communication primarily expressing a grievance;

C. "Insurance department complaint" shall mean a written communication regarding a complaint transmitted by the Insurance Department.

Section 7. Effective Date

This regulation is effective on [insert date].

ATTACHMENT A
Complaint Record Format

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number (Agent's Number) (Staff Adjuster's Number) (Independent Adjuster)	Function Code	Reason Code	Line Type	Company Disposition after Complaint Receipt	Date Received	Date Closed	Insurance Department Complaint	State of Origin

ATTACHMENT B

Explanation

Column

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number or other means of identifying any licensee of the Insurance Department (such as agent, staff adjuster or independent adjuster) that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.

Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1. Underwriting

   a. Company underwriting

   b. Individual's application underwriting (this refers to any complaint where misrepresentations or declarations in an application for insurance resulted in company action involved in the complaint)

   c. Cancellation

   d. Recision

   e. Nonrenewal

   f. Premiums and rating

   g. Delays

   h. Refusal to insure

   i. Miscellaneous (not covered by above)

2. Marketing and Sales

   a. General advertising

   b. Mass marketing advertising - (advertising which is essentially directed to reach more people than in a one to one relationship)

   c. Agent handling

   d. Replacement

   e. Dividend illustration

   f. Delays

   g. Alleged misleading statement or misrepresentation

h. Miscellaneous (not covered by above)

3. Claims

a. Claims procedure

b. Delays

c. Unsatisfactory settlements

d. Natural disaster adjusting (hurricane or flood situations or other situations which produce a large number of claims)

e. Unsatisfactory settlement offers

f. Denial of claim

g. Miscellaneous (not covered by above)

4. Policyholder service

a. Failure to respond

b. Delays

c. Miscellaneous (not covered by above)

5. Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved, as follows:

1. Automobile

2. Fire

3. Homeowners--Farmowners

4. Crop

5. Inland Marine

6. Individual Life

7. Group Life

8. Annuities

9. Individual Health -- Accident & Sickness

10. Group Health -- Accident & Sickness

11. Workmen's Compensation

12. Liability Insurance other than Automobile

13. Mobile Homeowners

14. Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.

The following examples illustrate the type of information called for, but are not intended to be required language or to exhaust the possibilities:

1. Corrective action was taken.

2. No action was deemed necessary.

3. Satisfactory explanation was given to the complainant.

The complaint record need not note the specific action taken with respect to the complaint, so long as the action was appropriate to the circumstances. If the company wishes, it may use a code for entries in this column.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the origin of the complaint was from an Insurance Department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 140, 170, 171-172 (adopted).
1973 Proc. II 18, 21, 370, 404, 405-409 (amended).
1974 Proc. I 12, 14, 272, 281, 282-286 (amended and reprinted).

MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

What are the state pages?

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MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.36.185 (1997).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE R. § 44 (1989).		
California	NO CURRENT ACTIVITY		
Colorado			BULLETIN B-1.13 (2013).
Connecticut	CONN. AGENCIES REGS. §§ 38a-819-50 to 38a-819-57 (1978).		
Delaware			18 DEL. CODE REGS. § 907 (2005).
District of Columbia	NO CURRENT ACTIVITY		

MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	ILL. ADMIN. CODE tit. 50, §§ 926.20 to 926.50 (1977/1999).		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-15.13 (2003).
Kansas	NO CURRENT ACTIVITY		
Kentucky			806 KY. ADMIN. REGS. 2:060 to 2:070 (1975).
Louisiana			LA. REV. STAT. ANN. § 22:43 (1990).
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		

MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE Ch. 21 (1973/1994).		
Nevada			NEV. ADMIN. CODE §§ 689A.605 (1999/2002).
New Hampshire			BULLETIN 2005-052-AB (2005).
New Jersey	N.J. ADMIN. CODE §§ 11:4-17.6 to 11:4-17.8 (1980/1996).		
New Mexico	N.M. ADMIN. CODE 13.7.3.1 to 13.7.3.12 (1997).		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 731.288 (1965/2010).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		

MODEL REGULATION FOR COMPLAINT RECORDS TO BE MAINTAINED PURSUANT TO THE NAIC UNFAIR TRADE PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY		
Texas	28 TEX. ADMIN. CODE §§ 21.2501 to 21.2507 (1999).		
Utah	NO CURRENT ACTIVITY		
Vermont	76 VT. CODE R. § 1 (1976).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT

Table of Contents

Section 1. Authority

This regulation is promulgated pursuant to the authority granted by [cite law enacting Section 12 of the NAIC Model Unfair Trade Practices Act].

Drafting Note: The Model Regulation On Unfair Discrimination In Life and Health Insurance On The Basis Of Physical Or Mental Impairment is designed to implement Section 4G of the Model Unfair Trade Practices Act. This section prohibits "any unfair discrimination between individuals of the same class and equal expectation of life in ... any contract of life insurance or of life annuity" and "any unfair discrimination between individuals of the same class and essentially same hazard in ... any policy or contract of health insurance ..."

Section 2. Purpose

The purpose of this regulation is to identify specific acts or practices in life and health insurance which are prohibited by Section 4G(1) and (2) of the Unfair Trade Practices Act cited in Section 1 of this regulation.

Drafting Note: The need for a model regulation has arisen because of questions as to whether life and health insurers are, in all cases, making fair determinations of which individuals are "of the same class and equal expectation of life" (or "essentially the same hazard"). The main purpose of the model regulation is to make clear that life and health insurers cannot classify individuals arbitrarily without a rational basis for each decision.

Section 3. Unfairly Discriminatory Acts or Practices

The following are hereby identified as acts or practices in life and health insurance which constitute unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

Drafting Note: This model regulation sets forth standards which require that life and health insurers be objective and fair in placing individuals with physical or mental impairments in various risk classifications.

The model regulation does not restrict a life or health insurer's choice of the number and size of rating classes which it will use. Many life and health insurer's have a number of extra premium classes. Some life and health insurers, however, have relatively simple underwriting procedures and only two risk classes: accept and reject. In group insurance elaborate underwriting procedures and a multiplicity of rating classes are not available because this is not consistent with the overall aim of group insurance of providing insurance to many people at low administrative cost. Similar simplicity is desirable in some other marketing situations (e.g., individual policy pension plans and direct mail business).

The regulation is not intended to mandate the inclusion of particular coverages, such as benefits for normal pregnancy, or of levels of benefits such as for mental illness, in a company's policies or contracts. In virtually every state, mandates of any coverages or benefits are the subject of separate legislation. The model unfair trade practices act has never been interpreted to provide the basis for such mandates but rather to assure that such coverage and benefits as are offered by insurers are provided on a basis which is not unfairly discriminatory among individuals of the same class.

To make life and health insurance available to as many individuals as possible, the regulation does not restrict the use of riders ("waivers") which exclude from coverage risks related to impairments which existed prior to the date on which the individual's coverage became effective. Also, it does not restrict the use of preexisting condition limitations in health insurance contracts.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1979 Proc. II 31, 34, 252, 258, 262-263 (adopted).

MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. ADMIN. CODE 054.00.28. (1984).		
California	CAL. INS. CODE § 10144 (1984/2013).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. § 627.644 (1982).
Georgia			GA. CODE ANN. § 33-6-5(8) (1985).

MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/364 (1981).
Indiana	NO CURRENT ACTIVITY		
Iowa	IOWA ADMIN. CODE r. 191-15.11(2)(2009).		
Kansas			KAN. STAT. ANN. § 40-2,109 (1980/1986).
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2159-A (1980/1985).		
Maryland			MD. CODE ANN., INS. § 27-208 (1979/1997).
Massachusetts	MASS. GEN. LAWS ch. 175, § 193T (1981/1985).		
Michigan			MICH. COMP. LAWS § 500.2027 (1977).
Minnesota			MINN. STAT. § 72A.20(8) (1983).
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 100-2.200 (1978/1985).		
Montana	NO CURRENT ACTIVITY		

MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. ADMIN. CODE §§ 11:4-20.1 to 11:4-20.2 (1979/1985).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. INS. LAW § 4224 (2013).		
North Carolina			N.C. GEN. STAT. § 58-51-35 (1973) (minor children).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3999.16 (1976).
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 746.015(2) (1979).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS § 27-2-23 (1981).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee			BULLETIN 4-22-93 (#2) (1993).
Texas	28 TEX. ADMIN. CODE §§ 21.702 to 21.703 (1983/1992).		

MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Utah	UTAH ADMIN. CODE r. 590-129 (1989).		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-508 (1986/2013).
Washington			WASH. REV. CODE ANN. § 48.30.300 (1976/2005).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	WIS. ADMIN. CODE INS. § 6.67 (1980/1987).		WIS. STAT. § 628.34(3) (1975).
Wyoming	NO CURRENT ACTIVITY		

MODEL REGULATION ON UNFAIR DISCRIMINATION ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS

Table of Contents

Section 1. Authority

This regulation is promulgated pursuant to the authority granted by Section 12 of the Unfair Trade Practices Act.

Section 2. Purpose

The purpose of this regulation is to identify specific acts or practices that are prohibited by Section 4G of the Unfair Trade Practices Act.

Section 3. Unfairly Discriminatory Acts or Practices

The following are hereby identified as acts or practices that constitute unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

Drafting Note: With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his or her eyesight.

However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when the condition existed at the time the policy was issued.

Drafting Note: States which have not adopted Section 4G or Section 12 of the NAIC Model Unfair Trade Practices Act may not be able to adopt the proposed regulation. The NAIC Task Force on Unfair Discrimination Against The Blind has developed the following statutory language designed to accomplish the same result as the proposed regulation, but which is not an official NAIC model act:

"Section 1. Unfair methods of competition and unfair or deceptive acts or practices in the business of life or accident or health insurance or annuities include: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

Section 2. This law shall apply to life or accident or health insurance policies or insurance contracts or annuities delivered or issued for delivery in this state by an insurer ninety (90) days after the effective date of this law."

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1978 Proc. II 31, 34, 266, 268, 273 (adopted).
1985 Proc. I 19, 37-38, 572-573 (amended).

MODEL REGULATION ON UNFAIR DISCRIMINATION ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS

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Alabama	ALA. ADMIN. CODE 482-1-074-.03 (1985).		
Alaska	ALASKA ADMIN. CODE tit. 3, § 26.410 (1990).		
American Samoa			
Arizona	ARIZ. ADMIN. CODE R 20-6-211 (1978/2007).		
Arkansas	ARK. ADMIN. CODE 054.00.37 (1985).		
California	CAL. INS. CODE § 10145 (1986).		
Colorado	NO CURRENT ACTIVITY		
Connecticut	CONN. REV. STAT. § 38a-816(13) (1982/1986).		
Delaware			DEL. CODE ANN. tit. 18, § 2316 (1977).
District of Columbia	NO CURRENT ACTIVITY		

MODEL REGULATION ON UNFAIR DISCRIMINATION ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 626.9705 (1975/1982).
Georgia	GA. CODE ANN. § 33-6-5(10) (1985).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	215 ILL. COMP. STAT. 5/236 (1981/1985).		
Indiana	IND. CODE § 27-4-1-4(15) (1981/1983); 760 IND. ADMIN. CODE 1-34-1 to 1-34-3 (2007/2013).		
Iowa			IOWA ADMIN. CODE r. 191-15.11(2) (2009).
Kansas	KAN. STAT. ANN. § 40-2404(7)(c) (1987).		
Kentucky			KY. REV. STAT. ANN. §§ 304.12-080 to 304.12-085 (1986).
Louisiana			LA. REV. STAT. ANN. § 22:1097 (1982).
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2159-A (1985).		
Maryland			MD. CODE ANN., INS. § 27-208 (1979/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 108A (1974); § 120B (1974); § 193T (1981).

MODEL REGULATION ON UNFAIR DISCRIMINATION ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	NO CURRENT ACTIVITY		
Minnesota	MINN. R. 2700.3200(11) (1986).		
Mississippi	19 CODE MISS. R. PT. 1, R. 14 (87-101) (1987).		
Missouri	MO. CODE REGS. ANN. tit. 20, § 100-2.200 (1985).		
Montana	MONT. ADMIN. R. 6.6.2106 (1979/2009).		
Nebraska	210 NEB. ADMIN. CODE § 35 (1978/1994).		
Nevada	NEV. ADMIN. CODE § 686A.160 (1984/1994).		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	N.J. CODE ADMIN. R. ANN. INS. 11:4-20.1 to 11:4-20.2 (1979/1985).		
New Mexico	N.M. STAT. ANN. § 59A-16-13.2 (1993).		
New York	NO CURRENT ACTIVITY		
North Carolina	N.C. GEN. STAT. § 58-3-25 (1985).		
North Dakota	N.D. CENT. CODE § 26.1-04-03 (1987).		N.D. CENT. CODE § 26.1-04-05.1 (1983/1987).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 3901.21(Q) (1987).		OHIO REV. CODE ANN. § 3999.16 (1976) (unfair discrimination against handicapped).

MODEL REGULATION ON UNFAIR DISCRIMINATION ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. ADMIN. CODE § 365:10-1-5 (1985).		
Oregon	OR. ADMIN. R. 836-081-0020 to 836-081-0030 (1985).		OR. REV. STAT. § 746.015(2) (1973).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	S.C. CODE ANN. REGS. 69-32 (1980/1986).		
South Dakota	S.D. CODIFIED LAWS ANN. § 58-33-12.1 (1983).		
Tennessee	TENN. COMP. R. & REGS. ch. 0780-1-34-.04 (1985).		
Texas	28 TEX. ADMIN. CODE § 21.702 (1992).		
Utah	UTAH ADMIN. CODE r. 590-129-1 to 590-129-5 (1989/2009).		
Vermont	VT. CODE R. § 78-2 (1978).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-508 (1986) (includes mental or physical impairments).		
Washington			WASH. REV. CODE ANN. § 48.30.300 (1976); BULLETIN 86-6 (1986).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin			WIS. ADMIN. CODE INS. § 6.67 (1980/1987).
Wyoming	NO CURRENT ACTIVITY		

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

Table of Contents

Section 1. Application

This Act relates to criminal penalties for the unlawful transaction of insurance or health coverage.

Section 2. Definitions

A. "Authorized insurer" defined. Includes a person that is authorized to transact insurance in this State by a valid certificate of Authority issued by the commissioner of insurance [insert appropriate title if different]. An "unauthorized" insurer is one not so authorized.

B. "Certificate of authority" defined. Means a license issued by the commissioner of insurance [insert appropriate title if different], authorizing the holder to act as an insurer. [Or, insert reference to existing definition if appropriate].

C. "Controlling person" defined. Includes a person who has control of a person as defined by Section 1C of the National Association of Insurance Commissioners (NAIC) Insurance Holding Company System Regulatory Act.

D. "Person" defined. Except as otherwise expressly provided in a particular statute or required by the context, "person" includes a natural person, an individual, corporation, limited liability company, partnership, association, joint stock company, trust, unincorporated organization or any form of business or social organization and any other nongovernmental legal entity or combination thereof.

E. "Represent or aid" defined. The term "represent or aid" has the meaning provided in [insert reference to state's applicable insurance code definition].

F. "Transaction of insurance" defined. The term "transaction of insurance" has the meaning provided by Section 3P of the NAIC Nonadmitted Insurance Model Act.

Drafting Note: Cross-reference definitions to your State's existing insurance code definitions.

Section 3. Certificate of Authority Required

A. A person shall not engage in a transaction of insurance in this State unless the person is an authorized insurer or unless the transaction of insurance is exempt under [insert reference to applicable exemptions, such as surplus lines law or the Liability Risk Retention Act of 1986].

B. A person shall not act as an officer, director or controlling person for a person who is engaged in a violation of Paragraph A.

C. A person shall not directly or indirectly represent or aid an unauthorized insurer to transact insurance in this state. [Insert reference to applicable exemption in state and/or federal law, such as surplus lines or the Liability Risk Retention Act of 1986; and line and individual procurement exemption laws that permit the placement of policies of unlicensed insurers].

Drafting Note: Nothing in this model shall be construed to apply to insurance transactions made in compliance with the provisions of the Surplus Line Law of this state or the Liability Risk Retention Act of 1986.

Section 4. Penalty for Unauthorized Transaction of Insurance; Penalty for Assisting an Unauthorized Insurer

In addition to any other penalties provided in the insurance code:

A. Any person who knowingly engaged in or reasonably should have known he or she was engaged in the unauthorized transaction of insurance as set forth in Subsection A of Section 3 of this Act commits a felony of the [insert reference to state's applicable degree of felony] degree and shall be punished as provided in [insert State's applicable reference to sentencing terms].

B. Any person who knowingly acted as or reasonably should have known he or she was acting as an officer, director or controlling person as set forth in Subsection B of Section 3 of this Act commits a felony of the [insert reference to State's applicable degree of felony] degree and shall be punished as provided in [insert state's applicable reference to sentencing terms].

C. Any person who knowingly represented or aided or reasonably should have known he or she was representing or aiding an unauthorized insurer as set forth in Subsection C of Section 3 of this Act commits a felony of the [insert reference to state's applicable degree of felony] degree and shall be punished as provided in [insert state's applicable reference to sentencing terms.

Drafting Note: The intent for the penalties in Section 4 is that the degree of the felony (or sentencing) be increased from Subsection C, to Subsection B, to Subsection A, such that Subsection A imposes the most severe penalty of the three subsections.

Section 5. Penalty for Subsequent Violations

In addition to any other penalties provided in the Insurance Code:

Any person who has been convicted pursuant to Section 4 of this Act and commits a subsequent violation pursuant to Section 4 of this Act commits a felony of the [insert reference to State's applicable degree of felony] degree and shall be punished as provided in [insert State's applicable reference to sentencing terms].

Section 6. Liability for Payment of Claims

In addition to the penalties provided in Sections 4 and 5 of this Act and in addition to any other penalties provided in the Insurance Code:

Any person who violates this Act shall be personally liable, with any other person liable therefore for the payment of any claims arising under any purported coverages or contracts used in violation of this Act.

Chronological Summary of Actions (All references are to the Proceedings of the NAIC)

2006 Proc. 4th Quarter 44, 123-126 (adopted).

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska			ALASKA STAT. § 21.36.360 (felony) (1984/2015).
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		ARIZ. REV. STAT. ANN. §§ 20-401.01 to 20-401.06 (felony) (1972/1992).
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida			FLA. STAT. §§ 626.901 to 626.902 (felony) (2005).
Georgia			GA. CODE ANN. §§ 33-5-1 to 33-5-3 (misdemeanor) (1960).

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA CODE §§ 507A.1 to 507A.11 (felony) (1967/2004).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. §§ 27-401 to 27-408 (felony) (1957/2013).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska			NEB. REV. STAT. §§ 44-2001 to 44-2008 (misdemeanor) (1969).
Nevada	NO CURRENT ACTIVITY		NEV. REV. STAT. §§ 685B.020 to 685B.087 (felony) (1971/2005).

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina			S.C. CODE ANN. §§ 38-25-120 to 38-25-130; § 38-25-360 (felony) (1987/1998).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. §§ 101.101 to 101.106 (felony) (1999/2009).
Utah			UTAH CODE ANN. §§ 31A-15-101 to 31A-15-102 (felony) (1985/2014).
Vermont	NO CURRENT ACTIVITY		

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE §§ 33-44-1 to 33-44-13 (felony) (2001).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2006

UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT (#890)

1. Description of the Project, Issues Addressed, etc.

This act relates to criminal penalties for the unlawful transaction of insurance or health coverage.

2. Name of Group Responsible for Drafting the Model and States Participating

This model was developed by the MEWA Subgroup of the Producer, Company, Unauthorized Entities and Unlawful Activity Working Group of the Antifraud (D) Task Force and first presented at the March 14, 2004, NAIC National Meeting in New York.

3. Project Authorized by What Charge and Date First Given to the Group

Develop a program to enhance recognition, investigation and prosecution of current unauthorized entities' fraud in the marketplace and current regulatory and law enforcement responses; identify or develop recommendations for coordination and cooperation between state insurance department and law enforcement authorities on unauthorized issues.

Develop methods to enhance the investigation and prosecution of financial services fraud.

Establish guidelines on the investigative and prosecutorial resources necessary to investigate insider insurance industry fraud.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open to comments and participation by all interested parties. Representatives from the producer, life, health and consumer areas participated in the process and discussion. Comments were received on each draft of the model and considered by the working grouping in open session.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Copies of each draft were posted on the NAIC website and ample time provided for comments on each draft. Beginning with the March 2004 NAIC National Meeting the MEWA Subgroup presented the first draft to the working group. A new draft was introduced at the 2005 NAIC Summer National Meeting and further discussion and comments were received from all parties. A new draft was introduced in of April 2006 and open for comment. After the 2006 NAIC Summer National Meeting a new draft was introduced in July of 2006 and open for comment. On August 31, 2006, a final draft was introduced at the 2006 NAIC Fall National Meeting. After the working group and Antifraud (D) Task Force adopted the model, a hearing was held at the (D) committee.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

1) The definition of "Certificate of authority" was changed to a "license issued by the Commissioner of Insurance, authorizing to act as an insurer."

2) The definition of "Represent or aid" was added to the model to have the meaning provided from a state's applicable Insurance Code definition.

3) State Department of Insurance shall preempt local regulation of insurance. Interested parties wanted to make sure that the preemption was for local and not federal regulation and that jurisdiction was defined.

4) The non-admitted or surplus lines insurers wanted explicit language in the context of the model to give specific recognition for surplus lines transaction or exemption from sanctions. The working group decided to address the issue with a drafting note.

5) Industry wanted a "knowingly" standard in Section 4 and the working group agreed on "knowingly acted as or reasonably should have known".

6) Industry urged the working group to create a new section to provide producers a "safe harbor" from prosecution if they receive verification from the state department of insurance that an entity was authorized. The working group expressed concern about producers claiming they contacted the state department of insurance without a way to verify or refute these claims. The working group wanted to maintain the responsibility for producers to conduct their own due diligence on the companies and products they wish to sell. The working group felt that inadvertent acts would not equate to knowingly or intentional acts. Because of this, the working group decided a producer could argue in a court about the steps they took to determine if a company or product was valid and why they should not have known about a company or product being unauthorized.

7. Any Other Important Information (e.g., amending an accreditation standard).

Congress and the General Accounting Office (GAO) have expressed interest in unauthorized activity by licensed and unlicensed producers taking advantage of unsuspecting consumers. Many states have enacted legislation criminalizing the sale and marketing of unauthorized products.

AFTER MARKET PARTS MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted pursuant to Section [insert reference to the state Unfair Trade Practices Act].

Section 2. Purpose

The purpose of the proposed regulation is to set forth standards for the prompt, fair and equitable settlements applicable to automobile insurance with regard to the use of after market parts. It is intended to regulate the use of after market parts in automobile damage repairs which insurers pay for on their insured's vehicle. The regulation requires disclosure when any use is proposed of a non-original manufacturer part. It also requires that all after market parts, as defined in the regulation, be identified and be of the same quality as the original part.

Section 3. Definitions

A. "Insurer" includes a person authorized to represent the insurer with respect to a claim who is acting within the scope of the person's authority.

B. "Non-original manufacturer" means a manufacturer other than the original manufacturer of the part.

C. "After market part" for purposes of this regulation, means sheet metal or plastic parts that generally constitute the exterior of a motor vehicle, including inner and outer panels.

Section 4. Identification

An after market part that is subject to this regulation and manufactured after the effective date of this regulation shall carry sufficient permanent identification to identify its manufacturer. The identification shall be accessible to the extent possible after installation.

Section 5. Like Kind and Quality

An insurer shall not require the use of after market parts in the repair of an automobile unless the after market part is at least equal in kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of after market parts shall consider the cost of any modifications that may become necessary when making the repair.

Section 6. Disclosure

The insurer must disclose to the claimant in writing, either on the estimate or on a separate document attached to the estimate, the following information in no smaller print than 10 point type:

> **THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING.**

All after market parts installed on the vehicle shall be clearly identified on the estimate of the repair.

Section 7. Enforcement

A violation of this regulation shall be enforced through the state's Unfair Trade Practices Act by the penalties provided for in that Act.

Note: A state may wish to consider incorporating the text of this regulation directly into its existing unfair trade practices act.

Section 8. Severability

If any section or portion of a section of this regulation, or its applicability to any person or circumstance is held invalid by a court, the remainder of this regulation, or the applicability of the provision to a person shall not be affected thereby.

Section 9. Effective Date

This regulation shall become effective on [insert date].

Note: It is recommended that states allow appropriate lead time to comply with this regulation. No regulation should take effect prior to January 1, 1988 at which time it is expected that most parts manufacturers will have had sufficient notice and time to mark their parts for identification.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1987 Proc. II 15, 21-22, 90, 125-127, 145-146 (adopted).

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NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE §§ 32-17A-1 to 32-17A-3 (1989).
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	ARK. CODE ANN. §§ 4-90-302 to 4-90-307 (1991/1997) (portions of model).		
California			CAL. BUS. & PROF. CODE §§ 9875 to 9875.2 (1989).
Colorado	COLO. REV. STAT. §§ 10-3-1301 to 10-3-1307 (1989) (portions of model).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		

AFTER MARKET PARTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. §§ 501.30 to 501.34 (1990) (portions of model).		
Georgia	GA. CODE ANN. § 33-6-5 (13) (1989) (disclosure provisions only); GA. COMP. R. & REGS. 120-2-52 (1993) (portions of model).		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	IDAHO CODE ANN. §§ 41-1328A to 41-1328D (1990) (portions of model).		
Illinois	215 ILL. COMP. STAT. 5/155.29 (1991) (portions of model); ILL. ADMIN. CODE. tit. 50, § 919.80(d)(5) (1989).		
Indiana	IND. CODE §§ 27-4-1.5-1 to 27-4-1.5-13 (1991).		
Iowa	NO CURRENT ACTIVITY		
Kansas			KAN. STAT. ANN. §§ 50-660 to 50-661 (1989) (disclosure provisions only).
Kentucky			806 KY. ADMIN. REGS. 12:095 (1992) (provision from model 902).
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. § 27-906 (1988/1997) (provide copy of warranty of non-OEM parts).

AFTER MARKET PARTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts	MASS. GEN. LAWS ch. 90, § 34R (1990) (portions of model).		
Michigan			MICH. COMP. LAWS §§ 257.1361 to 257.1364 (1992) (notification requirement).
Minnesota			MINN. STAT. § 72A.201 subd. 6 (1989) (prohibits insurer from requiring non-OEM parts).
Mississippi			MISS. CODE ANN. §§ 63-27-1 to 63-27-7 (1990) (notification).
Missouri	MO. REV. STAT. § 407.295 (1989); MO. CODE REGS. ANN. tit. 20, § 100-1.050 (1987/1997).		
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. CODE R. § 45 (1988/1994).		
Nevada			NEV. ADMIN. CODE § 686A.240 (1992) (disclosure).
New Hampshire	N.H. REV. STAT. §§ 407-D:1 to 407-D:5 (1989).		BULLETIN No. 99-014-AB.
New Jersey	N.J. ADMIN. CODE § 11:2-17.3 (1988); §§ 11:2-17.10 to 11:2-17.13 (1988).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, § 216.7 (Regulation 64) (1993/2014).		

AFTER MARKET PARTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	11 N.C. ADMIN. CODE 4.0425 to 4.0427 (1989/2004) (portions of model).		N.C. GEN. STAT. § 58-36-95 (2004) (disclosure); § 58-36-41 (2004) (may sell policy with only original parts).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO REV. CODE ANN. § 1345.81 (1990) (portions of model).		
Oklahoma	OKLA. STAT. tit. 15, §§ 951 to 956 (1991) (without Sec. 5).		
Oregon			OR. REV. STAT. §§ 746.287 to 746.292 (1988); OR. ADMIN. R. §§ 836-080-210 to 836-080-240 (1987).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS §§ 27-10.2-1 to 27-10.2-3 (1987/2003).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	S.D. CODIFIED LAWS §§ 58-33-70 to 58-33-71 (1990) (portions of model).		
Tennessee			
Texas	NO CURRENT ACTIVITY		
Utah	UTAH CODE ANN. §§ 31A-22-316 to 31A-22-319 (1990/1995) (portions of model).		
Vermont	NO CURRENT ACTIVITY		

AFTER MARKET PARTS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia			W. VA. CODE §§ 46A-6B-1 to 46A-6B-6 (1988/1995) (notification).
Wisconsin			WIS. STAT. § 632.38 (1993) (notification).
Wyoming	WYO. ADMIN. CODE 044.0002.19 (1988).		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

Table of Contents

Introductory Note: In addition to this model act, the NAIC drafted the following model acts regarding the unfair discrimination against subjects of abuse: The Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act, The Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act, and The Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act.

Section 1. Purpose

The purpose of this Act is to prohibit unfair discrimination by health carriers and insurance professionals on the basis of abuse status. Nothing in this Act shall be construed to create or imply a private cause of action for a violation of this Act.

Drafting Note: Consideration was given to including a private cause of action for a violation of this Act. It was concluded that a private cause of action is not inconsistent with the model and that a state legislature could find that a private cause of action is appropriate for that state.

Section 2. Scope

This Act applies to all health carriers and insurance professionals involved in issuing or renewing in this state a policy or certificate of health insurance.

Section 3. Definitions

Drafting Note: Each state may wish to ensure that the definition of "abuse" for the purposes of this Act does not conflict with the terminology descriptive of abusive behavior in state civil or criminal statutes in such a way as to lead to unintended meanings.

A. "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(1) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(2) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person or minor child without proper authority, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;

(3) Subjecting another person to false imprisonment; or

(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

Drafting Note: States should include appropriate corrective or clarifying language if their ordinary Statutory meaning of "person" can be construed as implying legal capacity, since many subjects of abuse are minors and other subjects of abuse may be incapacitated.

B. "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of an act or pattern of abuse.

C. "Abuse status" means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, a person's medical condition that the carrier knows or has reason to know is abuse-related, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

F. "Health benefit plan" or "plan" means a policy, contract, certificate or agreement offered by a carrier or insurance professional to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health benefit plan includes accident only, credit health, dental, vision, Medicare supplement or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health benefit plan does not include workers' compensation or similar insurance.

Drafting Note: States should examine their statutes and insurance products to determine if additional exemptions, such as for blanket disability, are required depending upon how those products are classified under state insurance statutes.

G. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: The intent of this subsection is to encompass all state-regulated entities in the business of providing health benefits, however those entities are defined and characterized under the laws of a particular state. Appropriate state-specific terminology should be used.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" or "health insurance" for purposes of this Act if the state's present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient.

H. "Insurance professional" means an agent, broker, adjuster or third party administrator as defined in the insurance laws of this state.

Drafting Note: Many states license other categories of insurance professionals such as agencies, consultants and producers. Each state should review this definition for consistency with the terminology used in its licensing law.

Drafting Note: Unfairly discriminatory underwriting or claims handling practices of a company writing life insurance may be committed by insurance professionals when they refuse to process an application or a claim in violation of this act. There is no intent, however, to hold insurance professionals liable for the acts of health carriers over which they have no control.

I. "Insured" means a party named on a health benefit plans as the person with legal rights to the benefits provided by the health benefit plan. For group plans, "insured" includes a person who is a beneficiary covered by a group health benefit plan.

J. "Subject of abuse" means a person against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or protection, court-ordered protection or shelter from abuse.

Section 4. Unfairly Discriminatory Acts Relating to Health Benefit Plans

Drafting Note: Because of the nature and consequences of the prohibited acts, this model provides that a single instance of prohibited conduct is a violation rather than defining a violation as a general business practice of prohibited conduct. States that choose to incorporate this model into their version of the Unfair Trade Practices Act (or other statute) under which those states define a violation as a general business practice should consider whether that approach provides sufficient protection to subjects of abuse.

A. It is unfairly discriminatory to:

(1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health benefit plan, or restrict or exclude health benefit plan coverage or add a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status; or

(2) Exclude or limit coverage for losses or deny a claim incurred by an insured on the basis of the insured's abuse status;

B. When the health carrier or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of the confidential abuse information, as defined in this Act, by a person employed by or contracting with a health carrier or insurance professional for any purpose or to any person is unfairly discriminatory, except:

(1) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(2) To a health care provider for the direct provision of health care services;

(3) To a licensed physician identified and designated by the subject of abuse;

(4) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law; or

(5) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of this Act in all respects and to be subject to the enforcement of this Act by the courts of this state for the benefit of the applicant or the insured, and only to the following persons:

(a) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(b) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the health carrier or insurance professional;

(c) Medical or claims personnel contracting with the health carrier or insurance professional, only where necessary to process an application or perform the health carrier's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the health carrier or insurance professional that have service agreements with the health carrier or insurance professional); or

(d) With respect to address and telephone number, to entities with whom the health carrier or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(6) To an attorney who needs the information to represent the health carrier or insurance professional effectively, provided the health carrier or insurance professional notifies the attorney of its obligations under this Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the health carrier or insurance professional;

(7) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(8) To any other entities deemed appropriate by the commissioner.

C. It is unfairly discriminatory to request information relating to acts of abuse or an applicant's or insured's abuse status, or make use of that information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a subject of abuse.

D. It is unfairly discriminatory to terminate group coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily. Nothing in this subsection prohibits the health carrier or insurance professional from requiring the subject of abuse to pay the full premium for coverage under the health plan or from requiring as a condition of coverage that the subject of abuse reside or work within its service area, if the requirements are applied to all insureds of the health carrier or insurance professional. The health carrier or insurance professional may terminate group coverage after the continuation coverage required by this subsection has been in force for eighteen (18) months, if it offers conversion to an equivalent individual plan. The continuation coverage required by this section shall be satisfied by coverage required under P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, provided to a subject of abuse and is not intended to be in addition to coverage provided under COBRA.

E. Subsection B does not preclude a subject of abuse from obtaining his or her insurance records.

F. Subsection D does not prohibit a health carrier or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under this Act and other applicable law.

Section 5. Justification of Adverse Insurance Decisions

A health carrier or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the health carrier or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable plan provision:

A. Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

B. Is not based upon any actual or perceived correlation between a medical condition and abuse;

C. Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

D. Except for claim actions, is based on a determination, made in conformance with sound actuarial principles and supported by reasonable statistical evidence, that there is a correlation between the medical condition and a material increase in insurance risk.

Drafting Note: It is not the intent of this Act to permit any medical underwriting not otherwise permitted by law. Subjects of abuse may currently be subject to this type of underwriting. States may wish to consider whether it is appropriate to adopt the restrictions contained within the NAIC's Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out) or the NAIC's Small Employer and Individual Health Insurance Availability Model Act or Individual Health Insurance Portability Model Act to restrict underwriting in this market for the benefit of subjects of abuse and consumers generally.

Section 6. Insurance Protocols for Subjects of Abuse

Health carriers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with, for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of this Act when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

Drafting Note: States may wish to consider requiring health carriers to develop procedures in consultation with domestic violence advocacy groups.

Section 7. Enforcement

The commissioner shall conduct a reasonable investigation based on a written and signed [add any means by which the commissioner receives complaints] complaint received by the commissioner and issue a prompt determination as to whether a violation of this Act may have occurred. If the commissioner finds from the investigation that a violation of this Act may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 8. Effective Date

This Act is effective [insert date], and applies to all actions taken on or after the effective date, except where otherwise explicitly stated. Nothing in this Act shall require a health carrier or insurance professional to conduct a comprehensive search of its contract files existing on the effective date solely to determine which applicants or insureds are subjects of abuse.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 8, 22, 762, 763-765 (adopted).
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UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

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Alabama			ALA. CODE ANN. § 27-55-3 (2000).
Alaska			ALASKA STAT. § 21.36.430 (1997/2001); § 21.54.100 (1997).
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Arizona			ARIZ. REV. STAT. ANN. § 20-448 (1996/2001).
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California			CAL. INS. CODE § 10198.9 (1996/1998); CAL. HEALTH & SAFETY CODE § 1374.75 (1995); § 1357.503 (2015).
Colorado			COLO. REV. STAT. § 10-3-1104.8 (1998).
Connecticut			CONN. GEN. STAT. § 38a-816(18) (1995/2003).
Delaware			DEL. CODE ANN. tit. 18, § 2302; § 2304(24); § 2304(25) (1996).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. CODE § 31-2231.11 (2012); BULLETIN 09-005-IB (2009).
Florida			FLA. STAT. § 626.9541 (1976/2014); § 627.65625 (1997); § 641.31073 (1997).
Georgia			GA. CODE ANN. § 33-6-4 (1972/2002).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:10-217.5 (1998).
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/155.22a (1997/2004).
Indiana			IND. CODE §§ 27-8-24.3-1 to 27-8-24.3-10 (1996).
Iowa			IOWA CODE § 507B.4 (1955/2002); § 513B.9A (1997).
Kansas	KAN. STAT. ANN. § 40-2404 (1955/2001).		
Kentucky			KY. REV. STAT. ANN. § 304.12-211 (2000); § 304.17a-155 (1998); § 304.17A-200 (2015).
Louisiana			LA. REV. STAT. ANN. § 22:1078 (2010).
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2159-B (1996/2001).
Maryland			MD. CODE ANN., INS. § 27-504 (1957/1997).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ch. 176A, § 3A; ch. 176B, § 5A; ch. 176G, § 19 (1996); BULLETIN NO. B-96-01 (1996).
Michigan			MICH. COMP. LAWS § 500.2246 (1956/1998); § 500.3406j (1956/1998); § 550.1401 (1980/2003).
Minnesota			MINN. STAT. § 72A.20 (1967/2002).
Mississippi	MISS. CODE ANN. §§ 83-71-1 to 83-71-15 (2010).		
Missouri			MO. REV. STAT. § 375.1312 (1999/2013) (group); § 376.451 (2008).
Montana			MONT. CODE ANN. § 33-18-216 (1997).
Nebraska	NEB. REV. STAT. §§ 44-7401 to 44-7410 (1998) (portions of model).		
Nevada			NEV. REV. STAT. § 689B.068 (1997); § 689A.413 (1997); § 695C.203 (1997); § 689C.196 (1997); § 689B.550 (2001); § 689C.193 (2014).
New Hampshire			N.H. REV. STAT. ANN. § 417:4 (1947/2004).
New Jersey			N.J. REV. STAT. §§ 17:29B-16 to 17:29B-19 (2003); N.J. ADMIN. CODE §§ 11:4-42.1 to 11:4-42.5 (1996/2004) (group).
New Mexico	N.M. STAT. ANN. §§ 59A-16B-1 to 59A-16B-10 (1997).		N.M. STAT. ANN. § 59A-23E-11 (1998); N.M. ADMIN. CODE 13.7.5.1 to 13.7.5.17 (1999) (insurers' duty regarding confidential abuse information).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
New York			N.Y. INS. LAW § 2612 (1996).
North Carolina			N.C. GEN. STAT. § 58-68-35 (1997); 11 N.C. ADMIN. CODE 12.1901 (2017).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3901.21 (1970/1999).
Oklahoma			OKLA. STAT. tit. 36, § 6060.10A (2010); § 4502 (2015).
Oregon			OR. REV. STAT. § 746.015 (1967/2013).
Pennsylvania			40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 10371 to 10377 (2011).		
Rhode Island	R.I. GEN. LAWS §§ 27-60-1 to 27-60-7 (1997).		
South Carolina			S.C. CODE ANN. § 38-71-860 (1997).
South Dakota			S.D. CODIFIED LAWS § 58-33-13.3 (2010); § 58-18B-27 (1995/1997) (small group).
Tennessee	TENN. CODE ANN. §§ 56-8-201 to 56-8-206 (1996).		
Texas			TEX. INS. CODE ANN. §§ 544.151 to 544.158 (2003/2005).
Utah			UTAH CODE ANN. §§ 31a-21-501 to 31a-21-506 (1997/2013).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH BENEFIT PLANS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-508 (1986/2013).
Washington			WASH. REV. CODE ANN. § 48.18.550 (1998).
West Virginia			W. VA. CODE § 33-4-20 (1997).
Wisconsin			WIS. STAT. § 631.95 (2000).
Wyoming			WYO. STAT. ANN. § 26-19-107 (1967/2006).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE MODEL ACT

Table of Contents

Introductory Note: In addition to this model act, the NAIC drafted the following model acts regarding the unfair discrimination against subjects of abuse: The Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act, The Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act, and The Unfair Discrimination Against Subjects of Abuse in Health Insurance Model Act.

Section 1. Purpose

The purpose of this Act is to prohibit unfair discrimination by life insurers or insurance professionals on the basis of abuse status. Nothing in this Act shall be construed to create or imply a private cause of action for a violation of this Act.

Drafting Note: Consideration was given to including a private cause of action for a violation of this Act. It was concluded that a private cause of action is not inconsistent with the model and that a state legislature could find that a private cause of action is appropriate for that state.

Section 2. Scope

This Act applies to all life insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of life insurance.

Section 3. Definitions

Drafting Note: Each state may wish to ensure that the definition of "abuse" for the purposes of this Act does not conflict with the terminology descriptive of abusive behavior in state civil or criminal statutes in such a way as to lead to unintended meanings.

A. "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner, or caretaker:

(1) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(2) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(3) Subjecting another person to false imprisonment; or

(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

Drafting Note: States should include appropriate corrective or clarifying language if their ordinary statutory meaning of "person" can be construed as implying legal capacity, since many subjects of abuse are minors and other subjects of abuse may be incapacitated.

B. "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of an act or pattern of abuse.

C. "Abuse status" means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse, or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

F. "Insurance professional" means an agent, broker, adjuster or third party administrator as defined in the insurance laws of this state.

Drafting Note: Many states license other categories of insurance professionals such as agencies, consultants and producers. Each state should review this definition for consistency with the terminology used in its licensing law.

Drafting Note: Unfairly discriminatory underwriting or claims handling practices of a company writing life insurance may be committed by insurance professionals when they refuse to process an application or a claim in violation of this act. There is no intent, however, to hold insurance professionals liable for the acts of insurers over which they have no control.

G. "Insured" means the person whose life is covered under an insurance policy.

H. "Insurer" means a person or other legal entity engaged in the business of life insurance in this state.

Drafting Note: States may wish to consider whether residual market mechanisms should be included in the definition of insurer.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" or "life insurance" for purposes of this Act if the state's present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient.

I. "Policy" or "certificate" means a contract of insurance or annuity, including endorsements, riders or binders issued, proposed for issuance, or intended for issuance by an insurer or insurance professional.

J. "Subject of abuse" means a person against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or protection, court-ordered protection or shelter from abuse.

Section 4. Unfairly Discriminatory Acts Relating to Life Insurance

Drafting Note: Because of the nature and consequences of the prohibited acts, this model provides that a single instance of prohibited conduct is a violation rather than defining a violation as a general business practice of prohibited conduct. States that choose to incorporate this model into their version of the Unfair Trade Practices Act (or other statute) under which those states define a violation as a general business practice should consider whether that approach provides sufficient protection to subjects of abuse.

A. It is unfairly discriminatory to:

(1) deny, refuse to issue, renew or reissue, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to a policy for an applicant or insured on the basis of the applicant's or insured's abuse status; or

(2) exclude, limit or deny benefits on a life insurance policy on the basis of an insured's abuse status except as otherwise permitted or required by the laws of this state relating to acts of abuse committed by a life insurance beneficiary.

B. When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information, as defined in this Act, by a person employed by or contracting with an insurer or insurance professional for any purpose or to any person is unfairly discriminatory, except:

(1) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(2) To a health care provider for the direct provision of health care services;

(3) To a licensed physician identified and designated by the subject of abuse;

(4) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(5) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of this Act in all respects and to be subject to the enforcement of this Act by the courts of this state for the benefit of the applicant or the insured, and only to the following persons:

(a) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(b) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(c) Medical or claims personnel contracting with the insurer or insurance professional, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer or insurance professional that have service agreements with the insurer or insurance professional); or

(d) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(6) To an attorney who needs the information to represent the insurer or insurance professional effectively, provided the insurer or insurance professional notifies the attorney of its obligations under this Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(7) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(8) To any other entities deemed appropriate by the commissioner.

D. It is unfairly discriminatory to request information about acts of abuse or abuse status, or make use of that information, however obtained.

E. Subsection B does not preclude a subject of abuse from obtaining his or her insurance records.

F. Subsection A does not prohibit a life insurer or insurance professional from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and if:

(1) The applicant or prospective owner of the policy lacks an insurable interest in the insured;

(2) The applicant or prospective owner of the policy is known, on the basis of medical, police or court records, to have committed an act of abuse against the proposed insured; or

(3) The insured or prospective insured is a subject of abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

G. Subsection D does not prohibit a life insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under this Act and other applicable law.

H. A life insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from any action taken in a good faith effort to comply with the requirements of this Act. However, this subsection does not prevent an action to investigate or enforce a violation of this Act or to assert any other claims authorized by law.

Section 5. Justification of Adverse Insurance Decisions

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

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Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with ,for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of this Act when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

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The commissioner shall conduct a reasonable investigation based on a written and signed [add any means by which the commissioner receives complaints] complaint received by the commissioner and issue a prompt determination as to whether a violation of this Act may have occurred. If the commissioner finds from the investigation that a violation of this Act may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

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This Act is effective [insert date], and applies to all actions taken on or after the effective date, except where otherwise explicitly stated. Nothing in this Act shall require the insurer or insurance professional to conduct a comprehensive search of its contract files existing on the effective date solely to determine which applicants or insureds are subjects of abuse.

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UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 626.9541 (1976/2014).
Georgia			GA. CODE ANN. § 33-6-4 (1972/2002).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:10-217.5 (1998).
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/155.22a (1997/2004).
Indiana			IND. CODE §§ 27-8-24.3-1 to 27-8-24.3-10 (1996).
Iowa			IOWA CODE § 507B.4 (1955/2002).
Kansas	KAN. STAT. ANN. § 40-2404 (1955/2001).		
Kentucky			KY. REV. STAT. ANN. § 304.12-211 (2000); § 304.17a-155 (1998).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2159-B (1996/2001).
Maryland			MD. CODE ANN., INS. § 27-504 (1957/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 95B (1996); § 108G, § 120D ch. 176A, § 3A, ch. 176B, § 5A, ch. 176G, § 19 (1996).
Michigan			MICH. COMP. LAWS § 500.2246 (1956/1998); § 500.3406j (1956/1998); § 550.1401 (1980/2003).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. § 72A.20 (1967/2002).
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. § 375.1312 (1999/2013) (group).
Montana			MONT. CODE ANN. § 33-18-216 (1997).
Nebraska	NEB. REV. STAT. §§ 44-7401 to 44-7410 (1998) (portions of model).		
Nevada			NEV. REV. STAT. § 689B.068 (1997).
New Hampshire			N.H. REV. STAT. ANN. § 417:4 (1947/2004).
New Jersey			N.J. REV. STAT. §§ 17:29B-16 to 17:29B-19 (2003); N.J ADMIN. CODE §§ 11:4-42.1 to 11:4-42.5 (1996/2004) (Group).
New Mexico	N.M. STAT. ANN. §§ 59A-16B-1 to 59A-16B-10 (1997).		N.M. ADMIN. CODE 13.7.5.1 to 13.7.5.17 (1999) (insurers' duty in regard to confidential abuse information).
New York			N.Y. INS. LAW § 2612 (1996).
North Carolina			N.C. GEN. STAT. § 58-68-35 (1997).
North Dakota			N.D. CENT. CODE § 26.1-39-24 (1999).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3901.21 (1970/1999).
Oklahoma	NO CURRENT ACTIVITY		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon			OR. REV. STAT. § 746.015 (1967/2010).
Pennsylvania			40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-60-1 to 27-60-7 (1997).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-18B-27 (1995/1997) (small group).
Tennessee	TENN. CODE ANN. §§ 56-8-201 to 56-8-206 (1996).		
Texas			TEX. INS. CODE ANN. §§ 544.151 to 544.158 (2005).
Utah			UTAH CODE ANN. §§ 31a-21-501 to 31a-21-506 (1997/2013).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-508 (1986/2013).
Washington			WASH. REV. CODE ANN. § 48.18.550 (1998).
West Virginia			W. VA. CODE § 33-4-20 (1997).
Wisconsin			WIS. STAT. § 631.95 (2000).
Wyoming	NO CURRENT ACTIVITY		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE MODEL ACT

Table of Contents

Introductory Note: In addition to this model act, the NAIC drafted the following model acts regarding the unfair discrimination against subjects of abuse: The Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act, The Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act, and The Unfair Discrimination Against Subjects of Abuse in Health Insurance Model Act.

Section 1. Purpose

The purpose of this Act is to prohibit unfair discrimination by disability income insurers and insurance professionals on the basis of abuse status. Nothing in this Act shall be construed to create or imply a private cause of action for a violation of this Act.

Drafting Note: Consideration was given to including a private cause of action for a violation of this Act. It was concluded that a private cause of action is not inconsistent with the model and that a state legislature could find that a private cause of action is appropriate for that state.

Section 2. Scope

This Act applies to all disability income insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of disability income insurance.

Section 3. Definitions

Drafting Note: Each state may wish to ensure that the definition of "abuse" for the purposes of this Act does not conflict with the terminology descriptive of abusive behavior in state civil or criminal statutes in such a way as to lead to unintended meanings.

A. "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner, or caretaker:

(1) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(2) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(3) Subjecting another person to false imprisonment; or

(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

Drafting Note: States should include appropriate corrective or clarifying language if their ordinary statutory meaning of "person" can be construed as implying legal capacity, since many subjects of abuse are minors and other subjects of abuse may be incapacitated.

B. "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of an act or pattern of abuse.

C. "Abuse status" means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse, or the status of an applicant or insured as a family member, employer or associate of, or a person, in a relationship with, a subject of abuse.

F. "Insurance professional" means an agent, broker, adjuster or third party administrator as defined in the insurance laws of this state.

Drafting Note: Many states license other categories of insurance professionals such as agencies, consultants and producers. Each state should review this definition for consistency with the terminology used in its licensing law.

Drafting Note: Unfairly discriminatory underwriting or claims handling practices of a company writing disability income insurance may be committed by insurance professionals when they refuse to process an application or a claim in violation of this act. There is no intent, however, to hold insurance professionals liable for the acts of insurers over which they have no control.

G. "Insured" means a party named on a disability income policy or certificate as the person with legal rights to the benefits provided by the policy or certificate. For group insurance, "insured" includes a person who is a beneficiary covered by a group policy or certificate.

H. "Insurer" means a person or other legal entity engaged in the business of disability income insurance in this state.

Drafting Note: States may wish to consider whether residual market mechanisms should be included in the definition of insurer.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" or "disability income insurance" for purposes of this Act if the state's present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient.

I. "Policy" or "certificate" means a contract of insurance or indemnity, including endorsements, riders or binders issued, proposed for issuance, or intended for issuance by an insurer or insurance professional.

J. "Subject of abuse" means a person against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or protection, court-ordered protection or shelter from abuse.

Section 4. Unfairly Discriminatory Acts Relating to Disability Income Insurance

Drafting Note: Because of the nature and consequences of the prohibited acts, this model provides that a single instance of prohibited conduct is a violation rather than defining a violation as a general business practice of prohibited conduct. States that choose to incorporate this model into their version of the Unfair Trade Practices Act (or other statute) under which those states define a violation as a general business practice should consider whether that approach provides sufficient protection to subjects of abuse.

A. It is unfairly discriminatory to:

(1) Deny, refuse to issue or renew, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to any disability income insurance policy on the basis of the applicant's or insured's abuse status; or

(2) Exclude or limit coverage for losses or denying a claim under a disability income insurance policy on the basis of an insured's abuse status.

B. When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information, as defined in this Act, for any purpose or to any person is unfairly discriminatory, except:

(1) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(2) To a health care provider for the direct provision of health care services;

(3) To a licensed physician identified and designated by the subject of abuse;

(4) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(5) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship, confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of this Act in all respects and to be subject to the enforcement of this Act by the courts of this state for the benefit of the applicant or insured, and only to the following persons:

(a) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(b) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(c) Medical or claims personnel contracting with the insurer, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer that have service agreements with the insurer or insurance professional); or

(d) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(6) To an attorney who needs the information to represent the insurer or insurance professional effectively, provided the insurer or insurance professional notifies the attorney of its obligations under this Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(7) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about the abuse status; or

(8) To any other entities deemed appropriate by the commissioner.

C. It is unfairly discriminatory to request information about acts of abuse or abuse status, or make use of that information, however obtained.

D. Subsection B does not preclude a subject of abuse from obtaining his or her insurance records.

E. Subsection D does not prohibit a disability income insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer knows or has reason to know is abuse-related, to the extent otherwise permitted under this Act and other applicable law.

F. A disability income insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from an action taken in a good faith effort to comply with the requirements of this Act. However, this subsection does not prevent an action to investigate or enforce a violation of this Act or to assert any other claims authorized by law.

Section 5. Justification of Adverse Insurance Decisions

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

A. Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

B. Is not based upon any actual or perceived correlation between a medical condition and abuse;

C. Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or disability without regard to whether the condition is abuse-related; and

D. Except for claims actions, is based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

Section 6. Insurance Protocols for Subjects of Abuse

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with ,for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of this Act when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

Drafting Note: States may wish to consider requiring insurers to develop procedures in consultation with domestic violence advocacy groups.

Drafting Note: States are advised that these policies and procedures should be subject to review as part of a market conduct examination or otherwise at the request of the commissioner.

Section 7. Enforcement

The commissioner shall conduct a reasonable investigation based on a written and signed [add any means by which the commissioner receives complaints] complaint received by the commissioner and issue a prompt determination as to whether a violation of this Act may have occurred. If the commissioner finds from the investigation that a violation of this Act may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 8. Effective Date

This Act is effective [insert date], and applies to all actions taken on or after the effective date, except where otherwise explicitly stated. Nothing in this Act shall require an insurer to conduct a comprehensive search of its contract files existing on the effective date solely to determine which applicants or insureds are subjects of abuse.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1996 Proc. 4th Quarter 9, 44, 281, 309-312 (adopted).
1998 Proc. 3rd Quarter 14, 83, 88-89, 101-104 (amended and reprinted).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABIITY INCOME INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE ANN. § 27-55-3 (2000).
Alaska			ALASKA STAT. § 21.36.430 (1997/2001).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-448 (1996/2001).
Arkansas			ARK. CODE ANN. § 23-86-306 (1998).
California			CAL. INS. CODE §§ 10144.2 to 10144.3 (1996/1998).
Colorado			COLO. REV. STAT. § 10-3-1104.8 (1998).
Connecticut			CONN. GEN. STAT. § 38a-816 (18) (1995/2003).
Delaware			DEL. CODE ANN. tit. 18, § 2302 (1996); § 2304(24) (1996); § 2304(25) (1996).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia			D.C. CODE § 31-2231.11 (2012); BULLETIN 09-005-IB (2009).
Florida			FLA. STAT. § 626.9541 (1976/2014).
Georgia			GA. CODE ANN. § 33-6-4 (1972/2002).
Guam	NO CURRENT ACTIVITY		
Hawaii			HAW. REV. STAT. § 431:10-217.5 (1998).
Idaho	NO CURRENT ACTIVITY		
Illinois			215 ILL. COMP. STAT. 5/155.22a (1997/2004).
Indiana			IND. CODE §§ 27-8-24.3-1 to 27-8-24.3-10 (1996).
Iowa			IOWA CODE § 507B.4 (1955/2002).
Kansas	KAN. STAT. ANN. § 40-2404 (1955/2001).		
Kentucky			KY. REV. STAT. ANN. § 304.12-211 (2000); § 304.17a-155 (1998).
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2159-B (1996/2001).
Maryland			MD. CODE ANN. INS. § 27-504 (1957/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 95B (1996); § 108G; § 120D; ch. 176A, § 3A; ch. 176B, § 5A; ch. 176G, § 19 (1996).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABIITY INCOME INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan			MICH. COMP. LAWS § 500.2246 (1956/1998); § 500.3406j (1956/1998);§ 550.1401 (1980/2003).
Minnesota			MINN. STAT. § 72A.20 (1967/2002).
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. § 375.1312 (1999/2013) (group).
Montana			MONT. CODE ANN. § 33-18-216 (1997).
Nebraska	NEB. REV. STAT. §§ 44-7401 to 44-7410 (1998) (portions of model).		
Nevada			NEV. REV. STAT. § 689B.068 (1997).
New Hampshire			N.H. REV. STAT. ANN. § 417:4 (1947/2004).
New Jersey			N.J. REV. STAT. §§ 17:29B-16 to 17:29B-19 (2003); N.J. ADMIN. CODE §§ 11:4-42.1 to 11:4-42.5 (1996/2004) (group).
New Mexico	N.M. STAT. ANN. §§ 59A-16B-1 to 59A-16B-10 (1997).		N.M. ADMIN. CODE 13.7.5.1 to 13.5.7.17 (1999) (insurers' duty in regard to confidential abuse information).
New York			N.Y. INS. LAW § 2612 (1996).
North Carolina			N.C. GEN. STAT. § 58-68-35 (1997).
North Dakota			N.D. CENT. CODE § 26.1-39-24 (1999).
Northern Marianas	NO CURRENT ACTIVITY		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Ohio			OHIO REV. CODE ANN. § 3901.21 (1970/1999).
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 746.015 (1967/2010).
Pennsylvania			40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-60-1 to 27-60-7 (1997).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-18B-27 (1995/1997) (small group).
Tennessee	TENN. CODE ANN. §§ 56-8-201 to 56-8-206 (1996).		
Texas			TEX. INS. CODE ANN. §§ 544.151 to 544.158 (2005).
Utah			UTAH CODE ANN. §§ 31a-21-501 to 31a-21-506 (1997/2013).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-508 (1986/2013).
Washington			WASH. REV. CODE ANN. § 48.18.550 (1998).
West Virginia			W. VA. CODE § 33-4-20 (1997).
Wisconsin			WIS. STAT. § 631.95 (2000).
Wyoming	NO CURRENT ACTIVITY		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

Table of Contents

Introductory Note: In addition to this model act, the NAIC drafted the following model acts regarding the unfair discrimination against subjects of abuse: The Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act, The Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act, and The Unfair Discrimination Against Subjects of Abuse in Health Insurance Model Act.

Section 1. Purpose

The purpose of this Act is to prohibit unfair discrimination by property and casualty insurers and insurance professionals on the basis of abuse status. Nothing in this Act shall be construed to create or imply a private cause of action for a violation of this Act.

Drafting Note: Consideration was given to including a private cause of action for a violation of this Act. It was concluded that a private cause of action is not inconsistent with the model and that a state legislature could find that a private cause of action is appropriate for that state.

Section 2. Scope

This Act applies to all property and casualty insurers and insurance professionals involved in issuing or renewing in this state a policy of property and casualty insurance.

Section 3. Definitions

Drafting Note: Each state may wish to ensure that the definition of "abuse" for the purposes of this Act does not conflict with the terminology descriptive of abusive behavior in state civil or criminal statutes in such a way as to lead to unintended meanings.

A. "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(1) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(2) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(3) Subjecting another person to false imprisonment; or

(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

Drafting Note: States should include appropriate corrective or clarifying language if their ordinary statutory meaning of "person" can be construed as implying legal capacity, since many subjects of abuse are minors and other subjects of abuse may be incapacitated.

B. "Abuse-related claim" means a claim under a property and casualty policy for a loss resulting from an act of abuse.

C. "Abuse status" means the fact or perception that a natural person is, has been, or may be a subject of abuse, irrespective of whether the natural person has incurred abuse-related claims.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

F. "Insurance professional" means an agent, broker, adjuster or third party administrator as defined in the insurance laws of this state.

Drafting Note: Many states license other categories of insurance professionals such as agencies, consultants and producers. Each state should review this definition for consistency with the terminology used in its licensing law.

Drafting Note: Unfairly discriminatory underwriting or claims handling practices of a company writing property and casualty insurance may be committed by insurance professionals when they refuse to process an application or a claim in violation of this act. There is no intent, however, to hold insurance professionals liable for the acts of insurers over which they have no control.

G. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

H. "Insurer" means a person or other entity engaged in the business of property and casualty insurance in this state.

Drafting Note: States may wish to consider whether residual market mechanisms should be included in the definition of insurer.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" or "property and casualty insurance" for purposes of this Act if the state's present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient.

I. "Policy" means a contract of insurance, including endorsements, riders or binders issued, proposed for issuance, or intended for issuance by an insurer or insurance professional.

J. "Subject of abuse" means a natural person against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse; or protection, court-ordered protection or shelter from abuse.

Section 4. Unfairly Discriminatory Acts Relating to Property and Casualty Insurance

Drafting Note: Because of the nature and consequences of the prohibited acts, this model provides that a single instance of prohibited conduct is a violation rather than defining a violation as a general business practice of prohibited conduct. States that choose to incorporate this model into their version of the Unfair Trade Practices Act (or other statute) under which those states define a violation as a general business practice should consider whether that approach provides sufficient protection to subjects of abuse.

A. It is unfairly discriminatory to deny, refuse to issue, renew or reissue; to cancel or otherwise terminate; restrict or exclude coverage on or to add a premium differential to a property and casualty insurance policy on the basis of the applicant's or insured's abuse status.

B. (1) It is unfairly discriminatory to:

(a) Exclude or limit payment for a covered loss or deny a covered claim incurred as a result of abuse by a person other than a co-insured; or

(b) Fail to pay losses arising out of abuse to an innocent first party claimant to the extent of such claimants' legal interest in the covered property if the loss is caused by the intentional act of an insured, or using other exclusions or limitations on coverage which the commissioner has determined unreasonably restrict the ability of subjects of abuse to be indemnified for such losses.

(2) This section shall not require payment in excess of the loss or policy limits.

(3) Nothing in this Act shall be construed to prohibit an insurer or insurance professional from applying reasonable standards of proof to claims under this section.

Drafting Note: Abuse-related claims are an indication of abuse status. States may choose to consider the use of abuse related claims history as an underwriting criterion prohibited as underwriting on the basis of abuse status.

Drafting Note: Insurers may include policy provisions providing that any payment required by this subsection may be recovered by the insurer from an insured if that abuse-related claim arose out of that insured's act of abuse.

Drafting Note: State law may differ regarding the payments to innocent first party claimants. When adopting this model, a state may want to consider this provision with regard to existing law.

C. When the insurer or insurance professional has information in its possession that clearly indicates that the insured, applicant or claimant is a subject of abuse, it is unfairly discriminatory, by a person employed by or contracting with an insurer, to disclose or transfer confidential abuse information, as defined in this Act, for any purpose or to any person, except:

(1) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(2) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(3) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship, confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of this Act in all respects and to be subject to the enforcement of this Act by the courts of this state for the benefit of the applicant or the insured, and only to the following persons:

(a) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(b) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(c) Medical or claims personnel contracting with the insurer or insurance professional, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer or insurance professional that have service agreements with the insurer or insurance professional); or

(d) With respect to address and telephone number, to entities with whom the insurer transacts business when the business cannot be transacted without the address and telephone number;

(4) To an attorney who needs the information to represent the insurer or insurance professional effectively, provided the insurer or insurance professional notifies the attorney of its obligations under this Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional; or

(5) To any other entities deemed appropriate by the commissioner.

D. It is unfairly discriminatory to request information relating to acts of abuse or an applicant's or insured's abuse status, or to make use of that information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a subject of abuse.

E. Subsection C does not preclude a subject of abuse from obtaining his or her insurance records.

F. Subsection D does not prohibit a property and casualty insurer from asking an applicant or insured about a property and casualty claim, even if the claim is abuse-related, or from using information thereby obtained in evaluating and carrying out its rights and duties under the policy, to the extent otherwise permitted under this Act and other applicable law.

Section 5. Justification of Adverse Insurance Decisions

An insurer or insurance professional that takes an action not prohibited by Section 4 that adversely affects an applicant or insured on the basis of claim or other underwriting information that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

A. Does not have the purpose of treating abuse status as an underwriting criterion; and

B. Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar claim or claims history without regard to whether the claims are abuse-related.

Section 6. Insurance Protocols for Subjects of Abuse

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with, for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of this Act when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

Drafting Note: States may wish to consider requiring insurers to develop procedures in consultation with domestic violence advocacy groups.

Drafting Note: States are advised that these policies and procedures should be subject to review as part of a market conduct examination or otherwise at the request of the commissioner.

Section 7. Enforcement

The commissioner shall conduct a reasonable investigation based on a written and signed [add any means by which the commissioner receives complaints] complaint received by the commissioner and issue a prompt determination as to whether a violation of this Act may have occurred. If the commissioner finds from the investigation that a violation of this Act may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 8. Effective Date

This Act is effective [insert date], and applies to all actions taken on or after the effective date, except where otherwise explicitly stated. Nothing in this Act shall require an insurer or insurance professional to conduct a comprehensive search of its contract files existing on the effective date solely to determine which applicants or insureds are subjects of abuse.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1997 Proc. 4th Quarter 25, 27-28, 168-169, 194-197 (adopted).
1998 Proc. 3rd Quarter 14, 83, 88-92 (amended and reprinted).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

What are the state pages?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. CODE § 27-55-3 (2000).
Alaska			ALASKA STAT. § 21.36.430 (1997/2001).
American Samoa	NO CURRENT ACTIVITY		
Arizona			ARIZ. REV. STAT. ANN. § 20-448 (1996/2001).
Arkansas			ARK. CODE ANN. § 23-86-306 (1998).
California			CAL. INS. CODE §§ 10144.2 to 10144.3 (1996/1998).
Colorado			COLO. REV. STAT. § 10-3-1104.8 (1998).
Connecticut			CONN. GEN. STAT. § 38a-816 (18) (1995/2003).
Delaware			DEL. CODE ANN. tit. 18, § 2302(5); § 2304(24); § 2304(25) (1996).
District of Columbia			D.C. CODE § 31-2231.11 (2012); BULLETIN 09-005-IB (2009).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida			FLA. STAT. § 626.9541 (1976/2014).
Georgia			GA. CODE ANN. § 33-6-4 (1972/2002).
Guam		NO CURRENT ACTIVITY	
Hawaii			HAW. REV. STAT. § 431:10-217.5 (1998).
Idaho		NO CURRENT ACTIVITY	
Illinois			215 ILL. COMP. STAT. 5/155.22a (1997/2004).
Indiana			IND. CODE §§ 27-8-24.3-1 to 27-8-24.3-10 (1996).
Iowa			IOWA CODE § 507B.4 (1955/2002).
Kansas	KAN. STAT. ANN. § 40-2404 (1955/2001).		
Kentucky			KY. REV. STAT. ANN. § 304.12-211 (2000); § 304.17a-155 (1998).
Louisiana		NO CURRENT ACTIVITY	
Maine			ME. REV. STAT. ANN. tit. 24-A, § 2159-B (1996/2001).
Maryland			MD. CODE ANN., INS. § 27-504 (1957/1997).
Massachusetts			MASS. GEN. LAWS ch. 175, § 95B (1996); § 108G; § 120D; ch. 176A, § 3A; ch. 176B, § 5A; ch. 176G, § 19 (1996).
Michigan			MICH. COMP. LAWS § 500.2246 (1956/1998); § 500.3406j (1956/1998); § 550.1401 (1980/2003).

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. § 72A.20 (1967/2002).
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. REV. STAT. § 375.1312 (1999/2013) (group).
Montana			MONT. CODE ANN. § 33-18-216 (1997).
Nebraska	NEB. REV. STAT. §§ 44-7401 to 44-7410 (1998) (portions of model).		
Nevada			NEV. REV. STAT. § 689B.068 (1997).
New Hampshire			N.H. REV. STAT. ANN. § 417:4 (1947/2004).
New Jersey			N.J. STAT. ANN. §§ 17:29B-16 to 17:29B-19 (2003); N.J. ADMIN. CODE §§ 11:4-42.1 to 11:4-42.5 (1996/2004) (group).
New Mexico	N.M. STAT. ANN. §§ 59A-16B-1 to 59A-16B-10 (1997) (portions of model).		N.M. CODE R. §§ 13.7.5.1 to 13.7.5.17 (1999) (insurers' duty in regard to confidential abuse information).
New York			N.Y. INS. LAW § 2612 (1996).
North Carolina			N.C. GEN. STAT. § 58-68-35 (1997).
North Dakota			N.D. CENT. CODE § 26.1-39-24 (1999).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. § 3901.21 (1970/1999).
Oklahoma	NO CURRENT ACTIVITY		

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN PROPERTY AND CASUALTY INSURANCE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon			OR. REV. STAT. § 746.015 (1967/2010).
Pennsylvania			40 PA. CONS. STAT. §§ 1171.1 to 1171.15 (1974/2014).
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	R.I. GEN. LAWS §§ 27-60-1 to 27-60-7 (1997).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota			S.D. CODIFIED LAWS § 58-18B-27 (1995/1997) (small group).
Tennessee	TENN. CODE ANN. §§ 56-8-201 to 56-8-206 (1996).		
Texas			TEX. INS. CODE ANN. §§ 544.151 to 544.158 (2005).
Utah			UTAH CODE ANN. §§ 31a-21-501 to 31a-21-506 (1997/2013).
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. §§ 38.2-508 (1986/2013).
Washington			WASH. REV. CODE ANN. § 48.18.550 (1998).
West Virginia			W. VA. CODE § 33-4-20 (1997).
Wisconsin			WIS. STAT. § 631.95 (2000).
Wyoming	NO CURRENT ACTIVITY		

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

Table of Contents

Prefatory Note: By adopting this model act in June 1990, the NAIC separated issues regarding unfair claims settlement practices into a free-standing act apart from the NAIC Model Unfair Trade Practices Act. This change focuses more attention on unfair claims as a function of market conduct surveillance separate and apart from general unfair trade practices. By doing so, the NAIC is not recommending that states repeal their existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of [insert state]. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this Act.

Drafting Note: A jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This Act is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has promulgated the Unfair Property/Casualty Claims Settlement Practices and the Unfair Life, Accident and Health Claims Settlement Practices Model Regulations pursuant to this Act.

Section 2. Definitions

When used in this Act:

A. "Commissioner" means the Commissioner of Insurance of this state;

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by the policy;

C. "Insurer" means a person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Section [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance;

D. "Person" means a natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations;

E. "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, or annuity issued. "Policy" or "certificate" for purposes of this Act, shall not mean contracts of workers' compensation, fidelity, suretyship or boiler and machinery insurance.

Drafting Note: The term "policy" is intended to cover the product issued by medical, health or hospital service plans and should be changed to conform to the laws of each state.

The Federal Employee Retirement Income Security Act (ERISA) preempts certain entities and some activities of those entities from the application of state laws. The purpose of these definitions is to include within this Act and regulations issued pursuant to it, all entities and activities to the extent not preempted by ERISA.

Section 3. Unfair Claims Settlement Practices Prohibited

It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

E. Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

F. Refusing to pay claims without conducting a reasonable investigation;

G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

H. Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

I. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

K. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

L. Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;

M. Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;

N. Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

Section 5. Statement of Charges

Whenever the commissioner has reasonable cause to believe that an insurer doing business in this state is engaging in any unfair claims practice and that a proceeding in respect thereto would be in the public interest, the commissioner shall issue and serve upon the insurer a statement of the charges in that respect and a notice of hearing, which shall set a hearing date not less than thirty (30) days from the date of the notice.

Drafting Note: If a formal hearing procedure exists, states may wish to incorporate the timeframes from that existing procedure.

Section 6. Cease and Desist and Penalty Orders

If, after hearing, the commissioner finds an insurer has engaged in an unfair claims practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer charged with the violation a copy of the findings and an order requiring the insurer to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion, order:

A. Payment of a monetary penalty of not more than $1,000 for each violation but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly and in conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation, but not to exceed an aggregate penalty of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known it was in violation of this Act.

Section 7. Penalty for Violation of Cease and Desist Orders

An insurer that violates a cease and desist order of the commissioner and, while the order is in effect, may, after notice and hearing and upon order of the commissioner, be subject, at the discretion of the commissioner, to:

A. A monetary penalty of not more than $25,000 for each and every act or violation not to exceed an aggregate of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license.

Section 8. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. The regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1972 Proc. I 15, 16, 443-444, 491, 495-496 (claims settlement practices made part of Unfair Trade Practices Act).
1990 Proc. II 7, 13-14, 160, 177-179 (adopted free-standing claims settlement practices act).
1991 Proc. I 9, 16, 192-193, 203-206 (amended and reprinted).

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

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UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama			ALA. ADMIN. CODE r. 482-1-124 to 482-1-125 (2003/2014).
Alaska	ALASKA STAT. §§ 21.36.125 (1976).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. REV. STAT. ANN. § 20-461 (1981/2004).		
Arkansas	ARK. CODE ANN. § 23-66-206 (1959/2009).		BULLETIN 8-2014 (2014).
California	CAL. INS. CODE § 790.03 (1959/1989).		CAL. CODE REGS. tit. 10, § 2695.85 (2003/2009).
Colorado	COLO. REV. STAT. § 10-3-1104 (1963/2014).		BULLETIN B-6.3 (#3) (2012/2013).
Connecticut	CONN. GEN. STAT. § 38a-816 (1955/2013).		
Delaware	18 DEL. ADMIN. CODE § 902 (1977/2003).		
District of Columbia	NO CURRENT ACTIVITY		

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Florida	FLA. STAT. § 626.9541 (1976/2014).		FLA. STAT. §§ 626.9743 to 626.9744 (2004) (motor vehicle settlements).
Georgia	GA. CODE ANN. §§ 33-6-30 to 33-6-37 (1992).		
Guam	NO CURRENT ACTIVITY		
Hawaii	HAW. REV. STAT. § 431:13-103 (1988/1989).		
Idaho	IDAHO CODE ANN. § 41-1329 (1977/1987).		
Illinois	215 ILL. COMP. STAT. 5/154.6 (1997).		
Indiana	IND. CODE § 27-4-1-4.5 (1983/1987).		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. STAT. ANN. § 40-2404 (1955/1992).		
Kentucky	KY. REV. STAT. ANN. § 304.12-230 (1984/1988).		
Louisiana	LA. REV. STAT. ANN. § 22:1964 (1958/2009).		LA. REV. STAT. ANN. § 22:1973 (2009) (duty of P/C insurers); § 22:1892 (2009).
Maine	ME. REV. STAT. ANN. tit. 24-A, § 2164-D (1987) (portions of model).		
Maryland	MD. CODE ANN., INS. §§ 27-301 to 27-306 (1986/2012).		MD. CODE REGS. 31.15.08 (2009).
Massachusetts	MASS. GEN. LAWS ch. 176D, § 3 (1972/1986).		
Michigan	MICH. COMP. LAWS § 500.2026 (1951/1977).		

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota	MINN. STAT. § 72A.20 subd. 12 (1967/2006).		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. REV. STAT. §§ 375.1000 to 375.1018 (1991/1993).		
Montana	MONT. CODE ANN. § 33-18-201 (1977).		MEMORANDUM 1-29-2014 (2014).
Nebraska	NEB. REV. STAT. §§ 44-1536 to 44-1544 (1991/2002).		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. § 417:4 (1947/1991).		N.H. CODE ADMIN. R. ANN. INS. §§ 1001.01 to 1001.11 (1982/2015).
New Jersey	N.J. REV. STAT. § 17:29B-4 (1947/2001).		
New Mexico	N.M. STAT. ANN. § 59A-16-20 (1985/1993).		
New York	N.Y. INS. LAW § 2601 (1984).		CIRCULAR LETTER 2009-3 (2009); CIRCULAR LETTER 2008-14 (2008); CIRCULAR LETTER 2011-13 (2011).
North Carolina	N.C. GEN. STAT. § 58-63-15 (1949/1987).		
North Dakota	N.D. CENT. CODE §§ 26.1-04-03 (1983/2003).		
Northern Marianas	4 N. MAR. ISLAND CODE § 7302(g) (1984).		
Ohio	OHIO ADMIN. CODE § 3901-1-07 (1975).		
Oklahoma			OKLA. STAT. tit. 36, §§ 1250.1 to 1250.16 (1986/2009).
Oregon	OR. REV. STAT. § 746.230 (1967/1989).		OR. ADMIN. R. 836-080-0235 (1980/2006).

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Pennsylvania	40 PA. STAT. ANN. § 1171.5(a)(10) (1974/2006).		
Puerto Rico	P.R. LAWS ANN. tit. 26, § 2716a (1974).		
Rhode Island	R.I. GEN. LAWS §§ 27-9.1-1 to 27-9.1-9 (1993/2013).		
South Carolina	S.C. CODE ANN. §§ 38-59-10 to 38-59-50 (1987).		
South Dakota	S.D. CODIFIED LAWS § 58-33-67 (1986/1989).		
Tennessee	TENN. CODE ANN. §§ 58-8-101 to 58-8-113 (2008) (portions of model).		
Texas	TEX. ADMIN. CODE § 21.203 (1976/1985).		TEX. INS. CODE ANN. §§ 542.001 to 542.014 (2005).
Utah	UTAH CODE ANN. §§ 31A-26-303 to 31A-26-313 (1986).		
Vermont	VT. STAT. ANN. tit. 8, § 4724 (1955/1987).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	VA. CODE ANN. § 38.2-510 (1986/2001).		VA. CODE ANN. § 38.2-517 (1992/1999).
Washington	WASH. ADMIN. CODE 284-30-300 to 284-30-390 (1978/2016).		
West Virginia	W. VA. CODE § 33-11-4 (1957/1985).		
Wisconsin	WIS. ADMIN. CODE INS. § 6.11 (1971/2000).		
Wyoming	WYO. STAT. ANN. § 26-13-124 (1986).		

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of property and casualty claims arising under contracts or certificates issued to residents of the State. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create nor imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate any change of position.

Drafting Note: Any jurisdiction which may choose to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has separately promulgated an Unfair Life, Accident and Health Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

B. "Claim file" means any retrievable electronic file, paper file or combination of both;

C. "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

D. "Days" means calendar days;

E. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

F. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

G. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.

I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

J. "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

K. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by the Commissioner's duly appointed designees. To aid in such examination:

A. The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.

B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

C. Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.

D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Section 5. Misrepresentation of Policy Provisions

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

C. A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions in the claim file.

D. No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition, or claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

E. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

F. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Section 6. Failure to Acknowledge Pertinent Communications

A. Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

B. Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within twenty-one (21) days of receipt of such inquiry, furnish the department with an adequate response to the inquiry in duplicate.

C. An appropriate reply shall be made within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within fifteen (15) days of notification of a claim shall constitute compliance with Subsection A of this section.

Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

A. Within twenty-one (21) days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by Section 4.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

B. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within twenty-one (21) days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

C. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

D. No insurer shall continue negotiations for settlement of a claim directly with a claimant who is not legally represented, if the claimant's rights may be affected by a statute of limitations, unless the insurer has given the claimant written notice of such limitation. Notice shall be given to first party claimants at least thirty (30) days and to third party claimants at least sixty (60) days before the date on which such time limit may expire.

E. No insurer shall make statements indicating that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

F. The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute and where the payee is known should be tendered within thirty (30) days if such payment would terminate the insurer's known liability under that individual coverage.

G. No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

H. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

A. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

(a) The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or

(b) The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to Subparagraph (a); or

(c) One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to (a) and (b) above; or

(d) Any source for determining statistically valid fair market values that meet all of the following criteria:

(i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years taking into account the values of all major options for such vehicles; and

(iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.

(e) Right of Recourse—If the insurer is notified within thirty-five (35) days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for the market value, the company shall reopen its claim file and the following procedures shall apply:

(i) The company may locate a comparable vehicle by the same manufacturer, same year, similar body style and similar options and price range for the insured for the market value determined by the company at the time of settlement. Any such vehicle must be available through licensed dealers;

(ii) The company shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;

(iii) The company may elect to offer a replacement in accordance with the provisions set forth in Section 8A(1); or

(iv) The company may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The company is not required to take action under this subsection if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same year, similar body style and similar options in as good or better condition as the total loss vehicle which could have been purchased for the market value determined by the company before applicable deductions. The documentation shall include the vehicle identification number.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in Subsection A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for the settlement shall be fully explained to the first party claimant.

B. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy.

C. Insurers shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

D. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

E. Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which he obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repairers, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications.

F. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

G. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

H. Storage and Towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges and documentation of the denial as required by Section 4. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured.

I. Betterment deductions are allowable only if the deductions:

(1) (a) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle;

(b) Reflect the general overall condition of the vehicle, considering its age, for either or both:

(i) The wear and tear or rust, limited to no more than a deduction of $1,000;

(ii) Missing parts, limited to no more of a deduction than the replacement costs of the part or parts.

(2) Any deductions set forth in (1)(a) or (b) above must be measurable, itemized, specified as to dollar amount and documented in the claim file.

(3) No insurer shall require the insured or claimant to supply parts for replacement.

J. Replacement Crash Parts

(1) Purpose

The purpose of this subsection is to set forth standards for the prompt, fair and equitable settlements applicable to automobile insurance with regard to the use of replacement crash parts. It is intended to regulate the use of replacement crash parts in automobile damage repairs which insurers pay for on their insured's vehicle. It also requires that all replacement crash parts, as defined in this section, be identified and be of the same quality as the original part.

(2) "Replacement crash part," for purposes of this regulation, means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

(3) Identification

All replacement crash parts, which are subject to this section and manufactured after the effective date of this section, shall carry sufficient permanent non-removable identification so as to identify its manufacturer. Such identification shall be accessible to the extent possible after installation.

(4) Like Kind and Quality

No insurer shall require the use of replacement crash parts in the repair of an automobile unless the replacement crash part is at least equal in kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of replacement crash parts shall consider the cost of any modifications which may become necessary when making the repair.

Drafting Note: Subsection J incorporates the fundamental provisions of the NAIC 1987 "After Market Parts Model Regulation" and makes requirements applicable to all replacement crash parts. Adoption of this subsection is the recommended approach.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

A. When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss. The insured shall not have to pay for betterment nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible, if any.

B. Actual Cash Value:

(1) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.

(2) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 179-184 (adopted).
1991 Proc. I 9, 16, 192-193, 206-211 (amended and reprinted).

This document replaces a model named "Unfair Claims Settlement Practices Model Regulation."

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).
1980 Proc. II 22, 26, 906, 930, 936 (amended).
1981 Proc. I 47, 51, 255, 258, 263 (amended).

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-125 (2003/2014).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.010 to 26.300 (1989/2015).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-801 (1981).		
Arkansas	CODE ARK. R. 054.00.43 (1989/2001).		
California			CAL. CODE REGS. tit. 10, §§ 2695.1 to 2695.14 (1993/2013).
Colorado			COLO. CODE REGS. 702-5:5-1-1 to 702-5:5-1-15 (2001); 702-5:5-2-15 (2004).
Connecticut	NO CURRENT ACTIVITY		
Delaware			18 DEL. CODE REGS. § 903 (2001/2003).

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-166.021 to 69O-166.031 (1992/2004).		FLA. STAT. §§ 626.9743 to 626.9744 (2004).
Georgia			GA. COMP. R. & REGS. 120-2-52 (1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 50, §§ 919.10 to 919.100 (1974/2004).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	KAN. ADMIN. REGS. §§ 40-1-34 (1981/2003) (with exceptions).		
Kentucky	806 KY. ADMIN. REGS. 12:095 (1992/2001).		
Louisiana			LA. REV. STAT. ANN. § 22:1892 (2021).
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE ANN., INS. § 27-304.1 (2003) (authority to adopt rules about claims involing a total loss of auto); MD. CODE REGS. §§ 31.15.07.03 to 31.15.07.10 (1990/2010).
Massachusetts	NO CURRENT ACTIVITY		

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Michigan	NO CURRENT ACTIVITY		
Minnesota			MINN. STAT. § 72A.201 (1967/2006); BULLETIN 2006-2 (2006).
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 100-1.010 to 100-1.100 (1974/2011).		
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE § 60 (1992/1994).		
Nevada	NEV. ADMIN. CODE §§ 686A.600 to 686A.680 (1980/2006).		
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. 1002.01 to 1002.21 (1982/2015).
New Jersey	N.J. ADMIN. CODE §§ 11:2-17.1 to 11:2-17.15 (1981/2013).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 216.0 to 216.13 (Regulation 64) (1972/2014).		CIRCULAR LETTER 2011-13 (2011).
North Carolina			11 N.C. ADMIN. CODE §§ 4.0418 to 4.0427 (1979).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE 3901-1-54 (1993/2004).		

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:15-3-1 to 365:15-3-9 (1989/1994).		
Oregon	OR. ADMIN. R. 836-080-0205 to 836-080-0250 (1980/1992).		
Pennsylvania	31 PA. CODE §§ 146.1 to 146.10 (1978).		
Puerto Rico			P.R. RULE XLVII (1975).
Rhode Island	230 R.I. Code R. 20-40-2.1 to 20-40-2.10 (2014).		BULLETIN 2004-3 (2004).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	TENN. COMP. R. & REGS. 0780-0 05-.01 to 0780-01-05-.16 (2017).		
Texas			TEX. ADMIN. CODE §§ 21.201 to 21.205 (1976/1998); §§ 21.2801 to. 21.2816 (2000).
Utah	UTAH ADMIN. CODE r. 590-190 (1999/2014).		
Vermont	79 VT. CODE R. § 2 (1979).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-400-10 to 5-400-110 (1978).		
Washington	WASH. ADMIN. CODE 284-30-300 to 284-30-450 (1978/2013).		
West Virginia	W. VA. CODE R. §§ 114-14-1 to 114-14-10 (1981/2005).		INFORMATIONAL LETTER 189 (2014).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of life, accident and health claims arising under policies or certificates issued pursuant to State law. It is not intended to cover claims involving workers' compensation insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create or imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate of any change of position.

Drafting Note: Any jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. The NAIC has separately promulgated an Unfair Property/Casualty Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

B. "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured;

C. "Claim file" means any retrievable electronic file, paper file or combination of both;

D. "Claimant" means an insured, the beneficiary or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy;

E. "Days" means calendar days;

F. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

G. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate certificates or policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.

I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

J. "Proof of loss" means written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of all insureds or beneficiaries submitting the claims;

K. "Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;

L. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. Claims Practices

A. Every insurer, upon receiving due notification of a claim shall, within fifteen (15) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.

B. Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within fifteen (15) days.

C. The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

D. The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.

E. With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits.

F. An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.

G. If a claim remains unresolved for thirty (30) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice shall be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

H. The insurer shall acknowledge and respond within fifteen (15) days to any written communications relating to a pending claim.

I. When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

J. No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

K. Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into.

L. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

M. No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:

(1) The insurer has in its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure, or

(2) The insurer has in its files clear, documented evidence that:

(a) The overpayment was clearly erroneous under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts;

(b) The error that resulted in the payment is not a mistake of the law;

(c) The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notified the insured within fifteen (15) days after the date the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued; and

(d) The notice stated clearly the nature of the error and the amount of the overpayment.

N. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 5. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by his or her duly appointed designees. To aid in the examination:

A. The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data shall be available for all open and closed files for the current year and the two (2) preceding years.

B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

C. Each document within the claim file shall be noted as to date received, date processed or date mailed.

D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 185-187 (adopted).
1991 Proc. I 9, 16, 192-193, 212-214 (amended and reprinted).

This document replaces a model named "Unfair Claims Settlement Practices Model Regulation."

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).
1980 Proc. II 22, 26, 906, 930, 936 (amended).
1981 Proc. I 47, 51, 255, 258, 263 (amended).

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

What are the state pages?

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UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

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NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-124 (2003); 482-1-125 (2003/2014).		
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.010 to 26.300 (1989/2004).		
American Samoa	NO CURRENT ACTIVITY		
Arizona	ARIZ. ADMIN. CODE R20-6-801 (1981).		
Arkansas	CODE ARK. R. 054.00.43 (1989/2001).		
California			CAL. CODE REGS. tit. 10, §§ 2695.1 to 2695.14 (1993/2013).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware			18 DEL. CODE REGS. § 903 (2001/2003); § 1310 (1998/2005).

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
District of Columbia	NO CURRENT ACTIVITY		
Florida	FLA. ADMIN. CODE ANN. r. 69O-166.021 to 69O-166.031 (1992/2004).		FLA. STAT. §§ 626.9743 to 626.9744 (2004).
Georgia			GA. COMP. R. & REGS. 120-2-52 (1993).
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois			ILL. ADMIN. CODE tit. 50, §§ 919.10 to 919.100 (1974/2004).
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas		KAN. ADMIN. REGS. §§ 40-1-34 (1981/2003).	
Kentucky	806 KY. ADMIN. REGS. 12:095 (1992/2001); 12:092 (1990).		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland			MD. CODE REGS. 31.15.08 (1989/2014).
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Minnesota			MINN. STAT. § 72A.201 (1967/2006); BULLETIN 2006-2 (2006).
Mississippi	NO CURRENT ACTIVITY		
Missouri			MO. CODE REGS. ANN. tit. 20, §§ 100-1.010 to 100-1.100 (1974/2011).
Montana	NO CURRENT ACTIVITY		
Nebraska	210 NEB. ADMIN. CODE § 60 (1992/1994); § 61 (1992/1994).		
Nevada	NEV. ADMIN. CODE §§ 686A.600 to 686A.680 (1980/2006).		
New Hampshire			N.H. CODE ADMIN. R. ANN. INS. §§ 1001.01 to 1001.11 (1982/2015).
New Jersey	N.J. ADMIN. CODE §§ 11:2-17.1 to 11:2-17.15 (1981/2013).		
New Mexico	NO CURRENT ACTIVITY		
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 216.0 to 216.13 (Regulation 64) (1972/2014).		
North Carolina			11 N.C. ADMIN. CODE § 4.0319 (1979); §§ 4.0418 to 4.0427 (1979/1989).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	OHIO ADMIN. CODE § 3901-1-54 (1993/2004); OHIO ADMIN. CODE 3901-8-11 (1994).		

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:15-3-1 to 65:15-3-9 (1989/1994).		
Oregon	OR. ADMIN. R §§ 836-080-0205 to 836-080-0250 (1980/2006).		
Pennsylvania	31 PA. CODE §§ 146.1 to 146.10 (1978).		
Puerto Rico			P.R. RULE XLVII (1975).
Rhode Island	230 R.I. CODE R. 20-40-1.1 to 20-40-1.6 (2005).		BULLETIN 2004-3 (2004).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			28 TEX. ADMIN. CODE §§ 21.201 to 21.205 (1976/1998); §§ 21.2801 to 21.2816 (2000).
Utah	UTAH ADMIN. CODE r. 590-191 (1999/2008); r. 590-192 (1999/2009).		UTAH ADMIN. CODE r. 590-190 (1999).
Vermont	79 VT. CODE R. § 2 (1979).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	14 VA. ADMIN. CODE §§ 5-400-10 to 5-400-110 (1978).		
Washington	WASH. ADMIN. CODE 284-30-300 to 284-30-770 (1978/2013).		

UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	W. VA. CODE R. §§ 114-14-1 to 114-14-10 (1981/2005).		INFORMATIONAL LETTER 189 (2014).
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

MARKET CONDUCT RECORD RETENTION AND PRODUCTION MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated pursuant to the authority granted by [cite state law equivalent to the NAIC Unfair Trade Practices Model Act or the NAIC Unfair Claims Settlement Practices Model Act or the state examination authority statute.] Nothing herein shall be construed to create or imply a private cause of action for violation of this Act.

Section 2. Purpose

This regulation implements [cite law enacting Section 4 of the NAIC Unfair Trade Practices Model Act or the NAIC Unfair Claims Settlement Practices Model Act or the state examination authority statute] regarding the retention and maintenance of records required for market conduct purposes as contained in Section 4 of this regulation.

Drafting Note: Regarding Sections 1 and 2, a state may wish to refer to other examination or rate and form filing laws for authority and purpose. In regard to the Unfair Trade Practices and Unfair Claims Settlement Practices Model Acts, states may have combined or separate acts.

Section 3. Definitions

All definitions contained in the Unfair Trade Practices Model Act are hereby incorporated by reference. In addition, for purposes of this regulation:

A. "Application and accompanying records" means any written or electronic application form, any enrollment form, any document or record thereof, used to add coverage under any existing policy, questionnaire, telephone interview form, paramedical interview form or any other document used to question or underwrite an applicant for any policy issued by an insurer or for any declination of coverage by an insurer.

B. "Claim file and accompanying records" means the file maintained so as to show clearly the inception, handling and disposition of each claim. The claim file shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

Drafting Note: States may have a definition of "claim file" in their administrative rules under the Unfair Claims Settlement Practices Act for property/casualty or life/accident and health.

C. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

D. "Complaint" means a written communication primarily expressing a grievance.

E. "Declination" or "declined underwriting file" means all written or electronic records concerning coverage for which an application has been completed and submitted to the insurer or its producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested.

Drafting Note: If this is a new requirement a state may want to consider allowing a phase-in period for companies to begin tracking this information.

F. "Examiner" means a market conduct examiner or any other examiner authorized or designated by the commissioner to conduct an examination pursuant to [insert citation to examination authority].

G. "Grievance" for health insurance purposes, means a written complaint submitted by or on behalf of a covered person regarding the:

(a) Availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between a covered person and a health carrier.

H. "Inquiry" means a specific question, criticism or request made in writing to an insurer by an examiner.

I. "Related entity" shall include a person authorized to act on behalf of the insurer in connection with the business of insurance.

Drafting Note: A state may wish to add definitions for purposes of this regulation, if terminology is not defined in its existing Unfair Trade Practices Act.

Section 4. Records Required for Market Conduct Purposes

A. An insurer or related entity licensed to do business in this state shall maintain its books, records and documents in a manner so that the commissioner can readily ascertain during an examination the insurer's compliance with state insurance laws and rules and with the standards outlined in the *NAIC Market Conduct Examiners Handbook*, including, but not limited to, company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint/grievance handling, and claims practices.

B. For a health insurer, the insurer or related entity shall maintain its books, records, and documents in a manner so that the practices of the insurer regarding network adequacy, utilization review, quality assessment and improvement and provider credentialing may be ascertained during a market conduct examination.

C. These records shall be retained for the current year plus three (3) years.

D. The producer of record shall maintain a file for each policy sold, and the file shall contain all work papers and written communications in his or her possession pertaining to the policy documented therein. These records shall be retained for the current year plus three (3) years.

Drafting Note: Regarding the retention time period, states should review their current market conduct examination laws and specify a time period that is consistent with the commissioner's market conduct examination authority. For some states this time period may be five (5) years.

Drafting Note: There may be other statutory or regulatory requirements for records to be maintained that a state may wish to reference.

E. During an examination of the insurer, the insurer shall provide a copy of the written contract entered into with each third party vendor or service provider as requested by an examiner within the time frames set forth in Section 11 of this regulation.

Section 5. Policy Record File

A. A policy record file shall be maintained for each policy issued, and shall be maintained for the duration of the current policy term plus three (3) years, or for life insurance policies and annuity contracts, for the time the policy or contract is in force and three (3) years thereafter. Policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as the records are readily available to market conduct examiners as required under this regulation.

Drafting Note: States should review their market conduct examination laws and specify a time period that is consistent with the commissioners market conduct examination authority. For some states this time period may be five (5) years.

Drafting Note: There may be other statutory or regulatory requirements for records to be maintained that a state may wish to reference.

B. Policy records shall include the following:

(1) Any application and accompanying records for each contract. The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with information clearly identitifying the producer involved in the transaction.

(2) Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, and any written or electronic correspondence to or from the insured pertaining to the coverage. If any of these records has already been filed with the commissioner, a separate copy of the record need not be maintained in the individual policy files to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to the policy, as well as the actual policy issued to the insured, can be retrieved or recreated;

(3) Any binder; and

(4) Any guidelines, manuals or other information necessary for the reconstruction of the rating, underwriting, policy owner service and claims handling of the policy. The maintenance at the site of a market conduct examination of a single copy of each of the above shall satisfy this requirement. These types of records include, but are not limited to, the application, the policy form including any amendments or endorsements, rating manuals, underwriting rules, credit reports or scores, claims history reports, previous insurance coverage reports (e.g., MIB), questionnaires, internal reports, and underwriting and rating notes.

C. A declined underwriting file shall be maintained and shall include include an application, any documentation substantiating the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation substantiating the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application for coverage need not be maintained for purposes of this regulation. The insurer shall retain declined underwriting files for the current year plus three (3) years.

Section 6. Claim File

A. A claim file and accompanying records shall be maintained for the calendar year in which the claim is closed plus three (3) years. The claim file shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim files shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A claim file shall, at a minimum, include the following items:

Drafting Note: States should review their current market conduct examination laws and specify a time period that is consistent with the commissioner's market conduct examination authority. For some states this time period may be five (5) years.

Drafting Note: There may be other statutory or regulatory requirements for records to be maintained that a state may wish to reference.

(1) For property and casualty: the file or files containing the notice of claim, claim forms, proof of loss or other form of claim submission, settlement demands, accident reports, police reports, adjustors logs, claim investigation documentation, inspection reports, supporting bills, estimates and valuation worksheets, medical records, correspondence to and from insureds and claimants or their representatives, notes, contracts, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment or denial of the claim, copies of claim checks or drafts, or check numbers and amounts, releases, all applicable notices, correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, any other documentation created and maintained in a paper or electronic format, necessary to support claim handling activity, and any claim manuals or other information necessary for reviewing the claim.

(2) For life and annuity: the file or files containing the notice of claim, claim forms, proofs of loss, medical records, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, claim handling logs, copies of checks or drafts, check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

(3) For health: the file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation of benefit statements, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, copies of checks or drafts, or check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

B. Where a particular document pertains to more than one file, insurers may satisfy the requirements of this section by making available, at the site of an examination, a single copy of each document.

C. Documents in a claim file received from an insured, the insured's agent, a claimant, the department or any other insurer shall bear the initial date of receipt by the insurer, date stamped in a legible form in ink, in an electronic format, or some other permanent manner. Unless the company provides the examiners with written procedures to the contrary, the earliest date indicated on a document will be considered the initial date of receipt.

D. If an insurer, as its regular business practice, places the responsibility for handling certain types of claims upon company personnel other than its claims personnel, the insurer need not duplicate its files for maintenance by claims personnel. These claims records shall be maintained as part of the records of the insurer's operations and shall be readily available to examiners.

Section 7. Licensing Records

Records to be maintained relating to the insurer's compliance with licensing requirements shall include the licensing records of each producer associated with the insurer. Licensing records shall be maintained so as to show clearly the licensing status of the producer at the time of solicitation, negotiation or procurement, as well as the dates of the appointments and terminations of each producer. A screenprint from the Producer Database (PDB) may serve to provide adequate proof only of a producer's current licensing status.

Drafting Note: States may want to amend this section to allow for the maintenance of a screen print from the state's website as meeting the requirements of this section.

Section 8. Complaint Records

The complaint records required to be maintained under Section [cite reference to Unfair Trade Practices Act; Regulation for Complaint Records; or other appropriate state statute] shall include a complaint log or register, or grievance log or register for health insurers, in addition to the actual written complaints. The complaint log or register shall show clearly the total number of complaints for the current year plus the immediately preceding three (3) years, the classification of each complaint by line of insurance and by complainant (i.e., insured, Department of Insurance, third party, etc.), the nature of each complaint, the insurer's disposition of each complaint, and the complaint number assigned by the Department of Insurance, if applicable. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating the documentation shall be an identifier such as the policy number or other code. The codes shall be provided to the examiners at the time of an examination.

Section 9. Format of Records

A. Any record required to be maintained by an insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium; or any process that accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document. Documents that are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the document and a copy of the template. Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above provided evidence of the signature is preserved in that format.

B. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude the alteration of the record after the initial transfer to a computer format. Upon request of an examiner, all records shall be capable of duplication to a hard copy that is as legible as the original document. The records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available to the commissioner during an examination.

C. Photographs, microfilms, or other image-processing reproductions of records shall be equivalent to the originals and may be certified as the same in actions or proceedings before the commissioner unless inconsistent with [insert citation to administrative procedures law].

Section 10. Location of Files

A. All records required to be maintained under this regulation shall be kept in a location that will allow the records to be produced for examination within the time period required. When, under normal circumstances, someone other than the insurer maintains a required record or type of record, the other person's responsibility to maintain the records shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and shall be available to the examiners for purposes of examination.

B. If required by law or otherwise available, the insurer shall maintain disaster preparedness or disaster recovery procedures that include provisions for the maintenance or reconstruction of original or duplicate records at another location. These procedures shall be provided for review during the examination.

Section 11. Time Limits to Provide Records and to Respond to Examiners

A. Initial data requests should be submitted to a company at least thirty (30) days prior to the commencement of the on-site examination, desk audit or other form of review to provide ample time for the company to prepare the materials requested by the examining state. Subsections B and C below apply to requests for supplemental data and information not anticipated at the time of the initial request as specified in Subsection A.

B. As a means to facilitate the examination and to aid in the examination in accordance with [statute regarding examination authority] an insurer shall provide any requested document or written response to an inquiry submitted by an examiner within five (5) working days, or such other time period as mutually agreed upon by the examiner and the insurer. When the requested document or response is not produced by the insurer within the specified time period, a violation shall be deemed to have occurred unless the insurer can demonstrate to the satisfaction of the commissioner that the requested record cannot reasonably be provided within the specified time period of the request.

Drafting Note: States may want to consider extending the time period for when a response is due if that request consists of a data run, request for statistical information, or information that cannot logistically be obtained without additional time. The time allowed for such an extension must be a mutually agreed upon time period.

C. Additional records requested by the commissioner shall be made available for the examination upon the date specified by the Examiner in Charge.

Drafting Note: States are encouraged to refer to the guidelines of the Market Regulation and Consumer Affairs (D) Committee regarding market conduct examination uniformity standards. The standards include providing notification to a company of an examination with a sufficient amount of time provided for the company to prepare the materials requested by the examining state. Compliance with the lead times recommended by the uniformity standards will facilitate a company's ability to meet the record production times included in this regulation.

Drafting Note: The current version of the Uniformity Outline encourages a state to provide a company at least thirty (30) days notice for data calls prior to the initiation of an examination. While some states may not be able to comply with this recommendation given their current statutory requirements, all states are encouraged to provide a company with as much lead time as possible.

Section 12. Confidential Materials

Original records required to be provided during a market conduct examination shall be returned to the insurer following the examination. If the records relate to an inquiry made by an examiner copies of the records shall become a part of the work papers of the examination. [insert citation for examination authority statute or other state statute that addresses the issue of access to workpapers and their confidentiality] shall govern the public access to the work papers of the examination.

Section 13. Effective Date

This regulation shall become effective [insert date or length of time following promulgation].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. 4th Quarter 16, 31, 130, 151, 154-156 (adopted).
2003 Proc. 3rd Quarter 434, 510, 514-519 (amended and reprinted, adopted by parent committee).
2003 Proc. 4th Quarter 17 (adopted by Plenary).

MARKET CONDUCT RECORD RETENTION AND PRODUCTION MODEL REGULATION

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American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California	NO CURRENT ACTIVITY		
Colorado	3 COLO. CODE REGS. § 702-1:1-1-7 (2014).		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		

MARKET CONDUCT RECORD RETENTION AND PRODUCTION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa			IOWA ADMIN. CODE r. 191-15.13(507B) (2021).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. 22:68 (1991/2010).
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	MO. CODE REGS. ANN. tit. 20, § 100-8.040 (2019).		
Montana	NO CURRENT ACTIVITY		
Nebraska			NEB. REV. STAT. ANN. § 44-5905 (1993).
Nevada	NO CURRENT ACTIVITY		
New Hampshire	N.H. REV. STAT. ANN. §§ 400-B:1 to 400-B:13 (2005/2014).		
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. ADMIN. CODE 13.7.3 (2001).
New York			N.Y. COMP. CODES R. & REGS. tit. 11, §§ 243.0 to 243.3 (1996).

MARKET CONDUCT RECORD RETENTION AND PRODUCTION MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina			11 N.C. ADMIN. CODE §§ 19.0102 to 19.0108 (1993/2008).
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	230 R.I. CODE R. 20-60-4.1 to 20-60-4.13 (2007).		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia	NO CURRENT ACTIVITY		
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY – 2003

MARKET CONDUCT RECORD RETENTION AND PRODUCTION MODEL REGULATION (#910)

1. Project Description

The Market Conduct Record Retention and Production Model Regulation has been revised to address the electronic retention of records along with methods for retention using a variety of media forms. The model was previously titled Market Conduct Record Retention Model Regulation (#910). Since the model includes some standards related to the time frames to produce records, the term "production" was added to the title of this regulation.

2. Group Responsible for Drafting Model and States Participating

The Market Conduct Record Retention Working Group of the Market Regulation (D) Task Force was responsible for reviewing the model and overseeing its development. The working group includes: Missouri (Chair), Alabama, Arizona, Florida, Hawaii, Illinois, Kentucky, Maryland, Nebraska, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington and Wisconsin.

3. Charge Authorizing Project

The 2003 charge of the working group is, "The Market Regulation Task Force shall review and update the NAIC Market Conduct Record Retention Model Regulation. Report by the NAIC 2003 Winter National Meeting." This charge or similar language was first authorized in March 2000.

4. General Description of Drafting Process

The drafting process was open as the Record Retention Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group produced 10 versions of the model before it was adopted by conference call on February 27, 2003. All of the meetings and conference calls of the working group were open to all interested parties. All revised drafts of the paper were posted on the NAIC Website and circulated for public comment. The working group received and reviewed numerous comments from interested parties and made substantive revisions to the model based on those comments.

5. Significant Issues Raised

The most significant issues raised and discussed by the working group and interested parties include (1) the definitions incorporated in the model and clarification of the intent to retain various types of comments; and (2); the time frame for the production of documents. The working group and interested parties developed mutually agreeable definitions. There continue to be concerns about the time frame for record production (5 days) but the working group determined a change to lengthen the time frame for production was not necessary. The primary rationale for not increasing the time frame concerns criticism that market conduct examinations are too lengthy and too costly. If the time frame for production of documents is increased, there will be an impact on the cost and length of examinations. In addition, the current emphasis to follow standard market regulatory guidelines as outlined by the Uniformity (D) Working Group supports a shorter time frame. The uniformity guidelines promote a minimum of 60 days advance notice to a company of the examination and the records required for the examiners. The working group believes the advance notice is sufficient to allow companies the ability to provide records within 5 days. If a company is unable to produce the records in the allotted time frame, the model provides for an extension request by the company.

The Executive Committee requested that this model be reconsidered by the Record Retention Model Working Group in light of concerns about potential conflicts in the model language with the requirements of the Uniformity (D) Working Group's uniformity outline. As a result, some changes were made to Section 11. This language was considered with input from interested parties, including the trade association that voiced the concerns about the potential conflict.

6. Other Pertinent Information

This model is another piece of the project to reform market regulatory activities. By adopting the regulation, states will provide details to companies for the retention of information for use by market regulators. In addition, the adoption of this model will promote further consistency by states in the market regulatory area.

IMPROPER TERMINATION PRACTICES MODEL ACT

Section 1. Purpose

The purpose of this Act is to protect policyholders from improper terminations of insurance coverage and to set forth standards for the regulation and disposition of terminations of policies or certificates of insurance. Nothing in this Act shall be construed to create or imply a private cause of action for violation of this Act except that a named insured may appeal the termination of the named insured's policy pursuant to Section 16.

Section 2. Scope

This Act shall apply to all insurers issuing or renewing in this state any policy or certificate of insurance as defined in Section 3I.

Section 3. Definitions

For the purposes of this Act:

A. "Cancellation" or "canceled" means the termination of a policy by an insurer prior to the expiration date of the policy.

B. "Concealed or misrepresented a material fact or circumstance" means falsification or omission of a material fact that, had the insurer known the truth, it would not have insured the risk; would not have issued the policy; would have charged a higher premium, other than an incidental amount, for insuring the risk; or would not have issued a policy in as large an amount or under the same terms.

Drafting Note: States may wish to include the words "intentionally or knowingly" in the first sentence before the word "concealed" and modify a similar provision in Section 9B(2).

C. "Improper termination" means a termination which violates any section of this Act or regulations promulgated thereunder.

D. "Insurer" means a person, reciprocal exchange, interinsurer, Lloyd's insurer, or other legal entity licensed to engage in the business of insurance in this state.

E. "Lapse" means a policy which expires by its own terms on the policy expiration date unless premiums are received by the insurer for succeeding policy periods on or before the policy expiration date.

F. "Nonpayment of premium" means failure of the named insured to discharge, when due, any obligations in connection with the payment of premium. "Premium" means the payment that is due for a policy. "Premium" includes audit premium due on the preceding policy and additional premium due on retrospectively rated policies, but does not include membership dues or other consideration required to be a member of an organization in order to be eligible for the policy.

G. "Nonrenewal" means the termination of a policy by an insurer at the expiration date of the policy.

H. "Policy delivered or issued for delivery in this state" shall include but not be limited to all binders of insurance, whether written or oral, and all applications bound for future delivery.

I. "Policy" or "certificate" means a contract of insurance, except allocated and unallocated annuities, life, accident and health, fidelity, suretyship, mortgage guaranty, boiler and machinery, reinsurance, umbrella if the underlying coverages have been terminated, ocean marine policies, dealers policies written as inland marine insurance under the Nationwide Inland Marine Definition and contracts of insurance procured pursuant to the excess and surplus lines laws of this state. For purposes of this Act, "policy" or "certificate" does not include contracts issued to a commercial insured having:

(1) Total insured property values of $5 million or more;

(2) Total annual gross revenues of $10 million or more; or

(3) Total annual premiums in excess of $25,000 written under a single policy.

Drafting Note: States may wish to include a provision allowing the commissioner to adjust these amounts annually by regulation to reflect changes in the Consumer Price Index (CPI).

Drafting Note: States that have worker's compensation laws addressing terminations may wish to exempt worker's compensation from this Act. States may wish to exclude other coverages from the provisions of this model, including insurance on accounts receivable.

J. "Producer" means a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance to which this Act applies on risks residing, located or to be performed in this state.

K. "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy for the same or similar coverage superseding at the end of the policy period a policy previously issued and delivered by the same insurer or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. A policy shall not be considered "renewed" if the insurer imposes a substantial increase in deductibles or a substantial reduction in coverage at renewal.

L. "Rescission" or "rescinded" means the unilateral action by an insurer to declare an insurance contract void from its inception as though it never existed.

M. "Residual market mechanism" means an arrangement, either expressly authorized or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through the voluntary market.

N. "Termination" or "terminated" means any practice or act by an insurer which has the effect of discontinuing an insurance policy including cancellation, nonrenewal, and rescission.

Section 4. Termination Provisions

A. A policy shall not be delivered or issued for delivery in this state unless it contains provisions setting out the manner in which the policy may be terminated.

B. If a policy or certificate is used as evidence of financial responsibility for a license or permit, and a statute or regulation requires that notice of termination of the policy or certificate be provided to the government agency that issued the license or permit, the time period for advance notice of the termination shall be the longer of the time period required by this Act or the time period required by the statute or regulation that establishes the financial responsibility requirement.

Drafting Note: Some states prohibit revealing the existence of arson or fraud investigations to persons who are targets of these investigations. In these states, it may be appropriate to modify the requirement that the termination notices required by this Act provide specific reasons for termination if there is information available for review by the commissioner alleging that the insured contributed to the loss by arson or fraud. The state may wish to allow a more general reason for the termination to be given in these situations.

Drafting Note: A state may require that the termination notices required by this Act also be provided in a language other than English where appropriate.

Section 5. Unfair Discrimination in Termination Provisions

A. An insurer shall not terminate a policy because of the insured's race, color, creed, national origin, ancestry, gender, sexual orientation or marital status.

B. An insurer shall not terminate a policy because of the insured's age or disability, or because of the geographic location or age of the insured risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

Section 6. Termination of Lines of Insurance

An insurer shall not terminate all or substantially all of a line of the insurer's business for the purpose of withdrawing from a market in this state without notifying the commissioner of the action, as well as the reasons for the action, at least one year before the termination of any policy due to the withdrawal is effective, unless the insurer has filed a plan of action for the orderly cessation of the insurer's business within a shorter time period and received approval from the commissioner.

Section 7. Rescission

Nothing in this Act limits an insurer's right to rescind a policy if an insured or an applicant for insurance has intentionally or knowingly concealed or misrepresented a material fact or circumstance concerning the risk assumed by the insurer. However, a policy or policy renewal shall not be rescinded after the policy has been in effect for 180 days or one policy period, whichever is greater.

Section 8. Notice of Cancellation

A. A notice of cancellation shall not be effective unless mailed or delivered by the insurer to the first named insured's last known address. The information contained on the notice of cancellation shall also be either mailed, delivered or electronically transmitted to the producer of record's last known address. The insurer shall maintain proof of mailing of the notice to the first named insured's last known address.

B. All notices of cancellation of insurance shall be mailed or delivered at least thirty (30) days prior to the effective date of cancellation during the first sixty (60) days of coverage. After the coverage has been effective for sixty-one (61) days or more, or if the policy is a renewal, all notices shall be mailed or delivered at least forty-five (45) days prior to the effective date of cancellation. However, where cancellation is for one of the reasons permitted in Sections 9B or 9C, at least ten (10) days notice of cancellation shall be given. All notices shall clearly state the specific reason or reasons for cancellation.

Section 9. Cancellation—Reasons

A. After a policy has been in effect for sixty (60) days or more, or if the policy is a renewal, it may be canceled with forty-five (45) days notice, for one or more of the following reasons:

(1) An insured violated any terms or conditions of the policy to the detriment of the insurer;

(2) The risk originally accepted has increased, and, if the increased risk had been present at the time the policy was originally issued, the insurer would have increased the premium originally charged, other than an incidental amount, or declined to issue the policy;

(3) A determination by the commissioner that continuation of the policy would threaten the financial solvency of the insurer;

(4) A determination by the commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state; or

(5) The failure to repair or rehabilitate an insured property or relevant portion thereof within a reasonable period of time as required in Section 10.

B. After a policy has been in effect for sixty (60) days or more, or if the policy is a renewal, it may be canceled with ten (10) days notice, for one or more of the following reasons:

(1) Nonpayment of premium;

(2) The policy was obtained because an insured concealed or misrepresented a material fact or circumstance;

(3) With regard to a policy of automobile insurance, the driver's license of any insured or any driver who lives with the insured or who customarily uses a covered vehicle has been suspended or revoked or is under a suspension or revocation for moving violations at any time during the twelve-month period immediately preceding the notice of cancellation; or

Drafting Note: States with named driver exclusion laws or provisions may wish to include a similar provision in this subsection.

(4) Fraud in the submission of a claim.

Drafting Note: If there are provisions in other statutes setting forth other prohibited reasons for cancellation and a state wishes to continue those other prohibited reasons, reference to those provisions should be made in this subsection so that cancellations based on these other prohibited reasons will be subject to the procedures of this Act.

C. In addition to the reasons stated in Sections 9B(1), (2) and (4), a property insurance policy, or a policy renewal, may be canceled with ten (10) days notice if the insured property is found to have one or more of the following conditions:

(1) Permanent repairs have not commenced within sixty (60) days after satisfactory adjustment of a loss, unless the delay is beyond the insured's control or the failure to repair does not increase the risk assumed;

(2) Buildings that have been unoccupied sixty (60) consecutive days, or vacant thirty (30) consecutive days, except buildings that have a seasonal occupancy, buildings that are actively advertised as "for rent," or buildings that are undergoing construction, repair or reconstruction, and are properly secured against unauthorized entry;

(3) Buildings on which, because of their physical condition, there is an outstanding order to vacate or an outstanding demolition order; or that have been declared unsafe in accordance with applicable law; or

(4) The risk originally accepted has increased to the degree that it would have increased the premium charged, other than an incidental amount, or affected the insurer's decision to issue the policy.

D. During the first sixty (60) days of a policy, the policy shall not be canceled for the reason that the insured has made a valid claim.

Section 10. Time for Repairs or Rehabilitation Prior to Cancellation

Notwithstanding Section 9, after a property insurance policy covering property that is capable of being repaired or rehabilitated has been in effect for sixty-one (61) days or more, except in the situation of a constructive total loss, an insurer shall not give notice of cancellation based on the condition of the property without allowing the first named insured a reasonable period of time in which to repair defects in the insured property or relevant portion of the property. The repair or rehabilitative efforts shall be in compliance with applicable local building codes. The notice of need for repair or rehabilitation shall be from the insurer and shall be itemized and specific with regard to the defect to be repaired and the time period in which to complete the repairs. The notice may be sent to the first named insured at any time during the policy term.

Section 11. Refund of Premium Upon Cancellation

A. A policy shall not be canceled on other than a pro-rata basis unless the policy form provides for another basis.

B. A producer shall not recommend, suggest or advise the insured to request cancellation of any policy, if the request will cause the policy to be canceled on other than a pro-rata basis, unless the producer first advises the insured in writing of the additional cost of the cancellation.

Section 12. Notice of Renewal or Nonrenewal

A. At least forty-five (45) days before the end of the policy term, an insurer shall mail or deliver to the last known address of the first named insured a renewal policy, an offer to renew the current policy or a notice of nonrenewal. The information in the renewal policy, the offer to renew or the notice of nonrenewal shall be mailed, delivered or transmitted electronically to the producer of record's last known address. Proof of mailing or delivery to the first named insured's last known address shall be maintained by the insurer.

(1) A notice of nonrenewal shall clearly state the specific reason or reasons for the nonrenewal.

(2) An offer to renew the policy shall state the renewal premium and the date the premium is due. The renewal premium shall be based on the known exposure as of the date of the offer to renew. The premium on the renewal policy may be subsequently amended to reflect any change in exposure not considered in the offer to renew.

(3) If the renewal premium is not received by the due date or the policy expiration date, whichever is later, the policy lapses.

B. If an insurer fails to comply with the notice requirements of this section, the policy shall be extended on the same terms and conditions for another policy term or until the effective date of similar insurance procured by the insured, whichever is earlier. The insurer may make continued coverage contingent upon the payment of premium.

C. Any policy with a policy period or term of less than six (6) months or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of six (6) months for the purpose of any nonrenewal or renewal notice required by this Act.

D. Renewal of a policy does not constitute a waiver or estoppel with respect to grounds for cancellation that existed before the effective date of the renewal.

E. A written binder of insurance issued for a term of sixty (60) days or less, which contains on its face a specific inception and expiration date and which has been furnished to the insured, shall not be subject to the nonrenewal requirements of this Act.

F. An insurer shall not fail to renew a policy that has been in effect for at least five (5) years unless:

(1) The nonrenewal is based on at least one of the reasons set forth in Section 9 of this Act; or

(2) A notice of nonrenewal is mailed or delivered to the last known address of the first named insured at least ninety (90) days before the end of the policy term, subject to all other provisions in this Section.

Section 13. Liability of Insurers or Producers Regarding Statements Made in Notices or Information

A. For a communication giving notice of or specifying the reasons for a termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a termination under this Act, there shall be no liability on the part of and no cause of action shall arise against:

(1) An insurer or its authorized representatives, producers or employees;

(2) A licensed insurance producer or broker; or

(3) A person furnishing information to an insurer as to reasons for a termination or declination.

B. Subsection A of this section shall not apply to statements not made in good faith.

Section 14. Notice to Insured as to Eligibility for Residual Market Mechanism Coverage

A. If a policy is canceled for a reason other than nonpayment of premium or is nonrenewed, and similar coverage is available through a residual market mechanism in this state, the insurer shall notify the first named insured of the insured's possible eligibility for insurance from the residual market mechanism.

B. The notice required by Subsection A of this section shall accompany or be included in the notice of cancellation or nonrenewal.

C. If the residual market mechanism limits its operations to a geographic area or areas within this state, the notice required by Subsection A of this section shall not be required if the risk is not located in the geographic area or areas served by the residual market mechanism.

Section 15. Notice; Right to Appeal

Insurers shall include a statement prominently displayed in bold-face type on all notices of termination advising the insured of the insured's right to appeal the termination to the commissioner.

Section 16. Improper Termination—Appeal

A. A policy that has been canceled for one or more of the reasons permitted by Section 9A or nonrenewed may be appealed by the named insured by giving written notice to the commissioner at least twenty-five (25) days prior to the effective date of the termination. The notice shall clearly state the reason or reasons for the appeal.

B. A policy that has been canceled for one or more of the reasons permitted by Section 9B or 9C may be appealed by the named insured by giving written notice to the commissioner prior to the effective date of the cancellation. The notice shall clearly state the reason or reasons for the appeal.

C. If a named insured timely appeals the termination of a policy, coverage under that policy shall remain in effect until the effective date specified in the order entered by the commissioner in the matter, pursuant to Section 16E or 16F. Coverage shall only remain in effect, however, so long as the named insured pays the premium due on the policy.

D. The commissioner may decide not to hold a hearing if the commissioner determines:

(1) The appeal was not made in good faith;

(2) There is no violation of the Act even if the facts alleged by the named insured to support the appeal are true; or

(3) The notice of termination, on its face, does not comply with the provisions of the Act.

E. If the commissioner does not hold a hearing, the commissioner shall issue a written order within ten (10) days after receipt of the named insured's appeal that decides the matter.

F. If the commissioner decides to hold a hearing, the hearing shall be held within twenty (20) days after receipt of the named insured's appeal. The commissioner shall give the parties at least ten (10) days notice of the hearing. Within twenty (20) days after the conclusion of the hearing, the commissioner shall issue a written order that decides the matter.

G. When the commissioner issues a written order that decides an appeal, if the commissioner finds for the named insured, the commissioner shall order the insurer to rescind its notice of termination. If the commissioner finds for the insurer, the commissioner shall order that the termination be effective:

(1) Twenty (20) days from the date of the order, when the policy was canceled for one of the reasons permitted by Section 9A or nonrenewed; or

(2) Ten (10) days from the date of the order when the policy was canceled for one of the reasons permitted by Sections 9B or 9C.

H. Costs of the hearing may be assessed against the losing party but shall not exceed $50.

Section 17. Proof of Mailing

A. Unless expressly otherwise provided, a notice of termination required to be given to a person by this Act may be given by mailing notice, postage prepaid, addressed to the person to be notified, at the person's last known address.

B. Where proof of mailing of notice to a person is required, the following constitute proof of mailing:

(1) A true copy of the notice mailed which may be a physical duplicate of the original notice reproduced through photocopy, carbon copy or generation from electronic records;

(2) A declaration made under penalty of perjury (as defined in Section [insert section] of the Code) attesting to the accuracy of the copy; and

(3) One of the following evidencing that notice was mailed:

(a) A declaration made under penalty of perjury (as defined in Section [insert section] of the Code) or an affidavit (as defined in Section [insert section] of the Code) executed by the person who deposited the notice into the mail, setting forth the date notice was mailed and the name and last known address of the person to whom notice was mailed;

(b) A document or list of mailed letters setting forth the date notice was mailed and the name and last known address of the person to whom notice was mailed, accompanied by either a declaration made under penalty of perjury (as defined in Section [insert section] of the Code) or an affidavit (as defined in Section [insert section] of the Code) executed by the person who deposited the notice into the mail, attesting to the accuracy of the document;

(c) A United States Certificate of Mailing (U. S. Post Office Form 3817 or 3877) for the notice mailed;

(d) A United States Postal Service certified mailing receipt, signed by or on behalf of the person to whom the notice is addressed; or

(e) An evidence of receipt by or on behalf of the person to whom the notice is addressed from a reputable mail delivery service.

Section 18. Improper Termination Practice—Definition; Hearing

A. It is an improper termination practice for any insurer to commit any acts in violation of this Act that are:

(1) Committed flagrantly and in conscious disregard of this Act or any rules promulgated under this Act; or

(2) Committed with such frequency as to indicate a general business practice to engage in that type of conduct.

B. Whenever the commissioner finds that an insurer doing business in this state is engaging in any improper termination practice as defined in Section 18A and that a hearing on the matter would be in the public interest, the commissioner shall issue and serve upon the insurer a notice of hearing, which shall contain a statement of charges, a location for the hearing, and a hearing date that shall be not less than ten (10) days nor more than twenty (20) days from the date of the notice.

Section 19. Improper Termination Practice—Penalty

A. If, after a hearing pursuant to Section 18 of this Act, the commissioner finds that the insurer has engaged in an improper termination practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer charged with the violation, a copy of the findings and an order requiring the insurer to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion, order one or both of the following:

(1) Payment of a civil penalty of not more than $1,000 for each violation, but not to exceed an aggregate civil penalty of $100,000, unless the violation was committed flagrantly and in conscious disregard of this Act, in which case the civil penalty shall not be more than $25,000 for each violation not to exceed an aggregate civil penalty of $250,000; or

(2) Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known that it was in violation of this Act.

Section 20. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1995 Proc. 3rd Quarter 5, 19, 143, 155-161 (adopted).

IMPROPER TERMINATION PRACTICES MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

IMPROPER TERMINATION PRACTICES MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas	NO CURRENT ACTIVITY		
California			CAL. INS. CODE § 481.5 (1976/2006).
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		

IMPROPER TERMINATION PRACTICES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana			IND. CODE §§ 27-1-31-1 to 27-1-31-3 (1987/2003).
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan			MICH. ADMIN. CODE r. 500.1514 (1981).
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey			N.J. ADMIN. CODE § 11:1-20.2 (1985/2006); §§ 11:2-29.1 to 11:2-29.9 (1991/2005); § 11:1-20.7 (1987/2006).
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		

IMPROPER TERMINATION PRACTICES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Carolina	NO CURRENT ACTIVITY		
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon			OR. REV. STAT. § 84.070 (2001/2014) (electronic cancellations); OR. ADMIN. R. 836-085-0010 to 836-085-0045 (1985/2005).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			R.I. GEN. LAWS §§ 27-29-17 to 27-29-17.4 (2003) (commercial lines).
South Carolina			S.C. CODE ANN. §§ 38-75-1110 to 38-75-1240 (2005).
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas			TEX. INS. CODE ANN. § 551.113 (2005/2013).
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-231 (1986/20015); § 38.2-2114 (1991/2013).
Washington	NO CURRENT ACTIVITY		

IMPROPER TERMINATION PRACTICES MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

HOME SERVICE DISCLOSURE MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this model Act is to establish rules that ensure meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.

Section 2. Definitions

As used in this Act:

A. "Home service distribution system" means a system in which insurance products are marketed, sold or serviced by agents in person in the home or business of the insured, owner or premium payor in assigned territories and that may be identified as "debits," and

(1) The policies are issued on a monthly or more frequent premium payment basis; and

(2) Agents are charged with the responsibilities of servicing the debit, which may include the collection of premium payments in the home or designated location on a monthly or more frequent basis, along with other services normally rendered.

B. "Small face amount life insurance policy" means an insurance policy with a face amount of $15,000 or less.

Drafting Note: The face amount specified in Subsection B should not prohibit states from using a different monetary face amount. Each state should review and consider using a face amount that is consistent with the average face amount for policies distributed through the home service distribution system in the state.

Section 3. General Disclosure Requirements

A. In accordance with the disclosure simplification standards set forth in Section 8, at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose at the time the policy is issued:

(1) Whether the policyholder is allowed to change the method of premium payment and any conditions for that change;

(2) Whether or not at a subsequent date a policyholder may combine multiple policies from the same insurance company, its affiliates and subsidiaries into one policy in order to provide like or enhanced coverage at a comparable or reduced premium to eliminate duplicate administrative costs associated with each policy;

(a) If the option is available, whether a policyholder will be subject to underwriting when combining multiple policies into one policy; and

(b) If the option is available, whether a policyholder will be subject to a new contestable period, waiting periods, etc., when combining multiple policies into one policy.

B. In accordance with the disclosure simplification standards set forth in Section 8, an insurer issuing a small face amount life policy through the home service distribution system shall provide the disclosure included in Appendix A if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy, but may be delivered with the policy.

(1) If, for a particular policy form, the cumulative premiums may exceed the face for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

(a) Provide the disclosure only in those circumstances where the premiums may exceed the face amount; or

(b) Provide the disclosure for all demographic and benefit combinations.

(2) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

(3) If an illustration has been provided that meets the requirements of [insert reference to state equivalent to the Life Insurance Illustrations Model Regulation], the disclosure requirements of Subsection B are deemed to have been met.

C. In accordance with the policy simplification standards set forth in Section 8, at the time a fire insurance policy is issued through the home service distribution system, the insurer shall disclose:

(1) Whether the amount of insurance coverage is based on the market value of the property insured. If not, the fire insurance policy shall disclose that it may not cover the full amount of the loss;

(2) Whether the policy will pay for a loss that is not caused by fire; and

(3) Whether the policy provides any liability coverage.

Section 4. Disclosure of Payment Methods

In accordance with the disclosure simplification standards set forth in Section 8, at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

A. What premium savings may be realized by a different method or less frequent mode of premium payment;

B. That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums;

C. The mailing address for payment of premiums to the company; and

D. When premium payments are made in cash or in person, that the consumer is entitled to receive a receipt for premium payments.

Section 5. Evidence of Payment

For every premium collected on a policy of property, casualty, life or disability insurance marketed, sold or serviced through the home service distribution system in this state, the agent, solicitor or broker, or any employee acting on the agent, solicitor or broker's behalf, collecting or receiving the premium in person shall:

A. Maintain and furnish to the policyholder a receipt indicating payment of premiums, which shall provide the payer with clearly understandable, written evidence of payment at the time the premium is collected. At a minimum it shall clearly show:

(1) The name of the payer;

(2) The name of insured under each policy covered by the premium;

(3) Amount paid;

(4) The date paid;

(5) The date paid-to-status of the policy;

(6) The policy number;

(7) The face amount and type of policy for which the payment will be credited;

(8) The signature of the agent;

(9) The agent's printed name and unique identification number; and

(10) The name, complete address and phone number of the insurer; and

B. Remit to the insurer's home office, applicable district office, or deposit in a fiduciary account the premium collected on behalf of the policyholder within ten (10) days of receipt from the premium payer or policy owner. In the event that the insurer utilizes an accounting system based on a monthly list bill, all premiums collected shall be credited from the date of collection. The premium shall be fully applied to that particular account.

Section 6. Proof of Policy Delivery

If an insurance policy marketed, sold or serviced through the home service distribution system is delivered by an agent, solicitor or broker, or an employee acting on the agent, solicitor or broker's behalf, a receipt shall be signed by the purchaser and the agent acknowledging delivery to the purchaser of the policy or contract and the disclosures required by this Act. The receipt shall contain the name of the purchaser, the policy or contract number, the amount of the initial premium payment and the date the delivery was completed. A policy shall be deemed to have been received six (6) months after the date of issuance if the insured has paid premiums pursuant to the contract. All delivery receipts required by this section shall be retained by the company for not less than three (3) years following delivery and shall be available for inspection upon request of the commissioner.

Section 7. Company Duties

Each insurer engaged in the home service distribution system in this state shall make available to the insurance commissioner for review:

A. Established written procedures to audit agencies engaged in the home service system of distribution of policies in this state; and

B. Proof of audits conducted periodically that reasonably ensure that the premium payer's premium recording item or records accurately reflect the premium due date and premium paid-to-status of the policy or policies purchased.

Section 8. Minimum Disclosure Language Simplification Standards

A. All policy forms shall be approved by the insurance commissioner before they are delivered or issued for delivery in this state.

B. All disclosure forms shall comply with state readability standards. It is presumed the disclosure form of Appendix A complies with the state readability standards.

Drafting Note: If a state does not have readability standards, a state may want to consider using the Flesch "reading ease" test (Rudolph Flesch, the *Art of Readable Writing* 1949, as revised 1974). While the Flesch reading ease test is the basic test set forth in this drafting note, it is recognized that other tests are also in wide use and should be permitted to be used. Two sources in particular can provide guidance in this area. The first is the National Literacy Secretariat of Canada and the second is Plain Language Action Network (PLAN). Both of these sources can be accessed through a U.S. government website: http://www.plainlanguage.gov

The National Literacy Secretariat provides direction on modern plain language ideas for the presentation of content that include, for instance, the following:

- Use simple, familiar, everyday words;
- Avoid unnecessary words (e.g., use "about" rather than "with regard to");
- Avoid using jargon;
- Avoid or explain technical words;
- Don't change verbs into nouns;
- Avoid chains of nouns;
- Be consistent in your choice of words;
- Use acronyms carefully;
- Write in clear and simple sentences;
- Don't overload sentences;
- Use active sentences;
- Keep sentences short;
- Keep sentences simple;
- Avoid ambiguity in your sentences;
- Avoid double negatives;
- Divide material into short sections; and
- Limit each paragraph to one topic.

The Plain Language Action Network was formed following the issuance of a June 1, 1998 "Presidential Memorandum on Plain Language." It is intended to provide assistance to writers in government about communications with the public. In addition to content advice, the PLAN website contains specific guidelines regarding layout and typography that comply with commonly understood plain language principles. For instance, PLAN provides guidelines for the margin, spacing, and heading parameters and for the use of upper and lower case, fonts, shading, and bullets.

C. A document will comply with the Flesch reading ease test if:

(1) The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in Subsection D of this section;

(2) It is printed in not less than ten-point type, one-point leaded; and

Drafting Note: This paragraph is not intended to include minor instructions concerning the preparation of a disclosure.

(3) The style, arrangement and overall appearance of the disclosure form give no undue prominence to any portion of the text of the disclosure form.

D. For the purposes of this Act, a Flesch reading ease test score shall be measured by the following method:

(1) For disclosure forms containing 10,000 words or less of text, the entire form shall be analyzed. For disclosure forms containing more than 10,000 words, the readability of two 200 word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(2) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(3) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(4) The sum of the figures computed under (2) and (3) subtracted from 206.835 equals the Flesch reading ease score for the policy form.

(5) For purposes of Paragraph (2), (3), and (4) of this subsection, the following procedures shall be used:

(a) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;

(b) A unit of words ending with a period, semicolon or colon, but excluding headings and captions, shall be counted as a sentence; and

(c) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

E. Filings subject to this Act shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question. The certificate does not need to be signed for the disclosure form of Appendix A or accompany the disclosure form of Appendix A. It is presumed the disclosure form of Appendix A complies with the state readability standards.

Section 9. Separability

If any provision of this Act or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the Act and its application to other persons or circumstances shall not be affected.

Section 10. Effective Date

This Act shall become effective [insert appropriate date] and shall apply to insurance policies distributed through the home service distribution system on or after the effective date.

Appendix A

Important Information About Your Policy

The premiums you'll pay for your policy may be more than the amount of your coverage (the face amount). You can find both the face amount and the annual premium in your policy. Look for the page labeled [use the label the company uses for that information, such as "Statement of Policy Cost and Benefit Information"].

- Usually, you can figure out how many years it will take until the premiums paid will be greater than the face amount. For an estimate, divide the face amount by the annual premium. Several factors may affect how many years this might take for *your* policy. These include not paying premiums when due, taking out a policy loan, surrendering your policy for cash, policy riders, payment of dividends, if any, and changes in the face amount.

- Many factors will affect how much your life insurance costs. Some are your age and health, the face amount of the policy, and the cost of a policy rider. You may be able to pay less for your insurance if you answer health questions. You may also pay less if you pay your premiums less often.

Ask your insurance agent or your insurance company if you have any questions about your premiums, your coverage, or anything else about your policy.

If You Change Your Mind ...

- You can get a full refund of premiums you've paid if you return your policy and cancel your coverage. You *must* do this within the number of days stated on your policy's front page. To return the policy for a full refund, send it back to the agent or the company.

- If you stop paying premiums or cancel your policy *after* the time that a full refund is available, you have specific rights. Ask your insurance agent or your insurance company about your rights.

Contact Information

If you have questions about your insurance policy, ask your agent or your company. If your agent isn't available, contact your insurance company at [provide telephone number (including toll-free number if available), address and website (if available)].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC

2001 Proc. 4th Quarter 162-164, 181-185, 186 (model adopted later printed here).
2002 Proc. 1st Quarter 13, 14, 394 (adopted).

HOME SERVICE DISCLOSURE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

HOME SERVICE DISCLOSURE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. §§ 23-66-401 to 23-66-408 (1993/1997) (home service standards).
California	NO CURRENT ACTIVITY		
Colorado	NO CURRENT ACTIVITY		
Connecticut	NO CURRENT ACTIVITY		
Delaware	NO CURRENT ACTIVITY		
District of Columbia	NO CURRENT ACTIVITY		
Florida	NO CURRENT ACTIVITY		
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		

HOME SERVICE DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Hawaii	NO CURRENT ACTIVITY		
Idaho	NO CURRENT ACTIVITY		
Illinois	NO CURRENT ACTIVITY		
Indiana	NO CURRENT ACTIVITY		
Iowa	NO CURRENT ACTIVITY		
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana			LA. REV. STAT. ANN. § 51:3144 (2009).
Maine	NO CURRENT ACTIVITY		
Maryland	NO CURRENT ACTIVITY		
Massachusetts	NO CURRENT ACTIVITY		
Michigan	NO CURRENT ACTIVITY		
Minnesota	NO CURRENT ACTIVITY		
Mississippi	NO CURRENT ACTIVITY		
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire	NO CURRENT ACTIVITY		
New Jersey	NO CURRENT ACTIVITY		
New Mexico	NO CURRENT ACTIVITY		
New York	NO CURRENT ACTIVITY		
North Carolina	NO CURRENT ACTIVITY		

HOME SERVICE DISCLOSURE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
North Dakota	NO CURRENT ACTIVITY		
Northern Marianas	NO CURRENT ACTIVITY		
Ohio	NO CURRENT ACTIVITY		
Oklahoma	NO CURRENT ACTIVITY		
Oregon	NO CURRENT ACTIVITY		
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island	NO CURRENT ACTIVITY		
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah	NO CURRENT ACTIVITY		
Vermont	NO CURRENT ACTIVITY		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-1805 (1986/2001) (home service standards).
Washington	NO CURRENT ACTIVITY		
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2002

HOME SERVICE DISCLOSURE MODEL ACT (#920)

1. Project Description

The Home Service Disclosure Model Act provides recommendations for disclosures that should be made to applicants when soliciting insurance through a home service distribution system The recommendation to develop a model for disclosures was made as a result of a review of the NAIC white paper titled, "The Sales and Marketing Practices, Auditing and Accounting Procedures and Products of the Insurers Utilizing the Home Service System."

2. Group Responsible for Drafting Model and States Participating

The Home Service Working Group of the Market Conduct and Consumer Affairs (D) Committee was responsible for drafting the model. Alabama and Kentucky co-chaired the working group. The following states were members of the working group: Delaware, District of Columbia, Florida, Louisiana, and Missouri. The Small Face Amount Working Group made some amendments the model. The members of that working group are, South Carolina, Chair, Arkansas, Co-Chair, Alabama, California, Delaware, District of Columbia, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New York, North Carolina, Ohio, Oklahoma, Texas, Utah, and Virginia.

The Small Face Amount Working Group of the Life Insurance & Annuities (A) Committee reviewed the model act to make sure the disclosure provisions of the model were compatible with the disclosures developed for small face amount policies contained in the Disclosure for Small Face Amount life Insurance Polices Model Act. The following states were members of the Small Face Amount Working Group: South Carolina, Chair, Arkansas, Co-Chair, Alabama, California, Delaware, District of Columbia, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New York, North Carolina, Ohio, Oklahoma, Texas, Utah, and Virginia.

3. Charge Authorizing Project

The charge of the Home Service (D) Working Group was, "to finalize the review of existing state laws that contain disclosure requirements for products distributed through the Home Service system and, based on this review and in consideration of the prior recommendations set forth in the NAIC White Paper "The Sales and Marketing Practices, Auditing and Accounting Procedures and Products of the Insurers Utilizing the Home Service System," to develop a model act which would provide meaningful information to the purchasers of products distributed through the Home Service system."

After the model was completed, the NAIC Executive Committee forwarded the model to the Small Face Amount Working Group of the A Committee to make sure the disclosure provisions of the model were compatible with the disclosures being developed for small face amount policies.

4. General Description of Drafting Process

The Home Service Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group also solicited key concerns from interested parties and collected information from states that have enacted statutes, rules, or regulations requiring disclosures in the home service distribution system. The working group received and reviewed numerous comments from interested parties.

The Small Face Amount Working Group modified the Home Service Disclosure Model Act make the disclosure provisions of the model compatible with the disclosures contained in the Disclosure for Small Face Amount life Insurance Polices Model Act. The Small Face Amount Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group received and reviewed numerous comments from interested parties on each draft of the model, which was posted on the NAIC website and attached to the minutes of the meetings.

5. Significant Issues Raised by the Home Service Working Group

The most significant issues raised and discussed by the Home Service Working Group and interested parties include: (1) the definition of home service; and (2); the definition of small amount life insurance policy. The positions of industry representatives, consumer representatives and regulators were considered while developing the model act. In addition, there were lengthy discussions about the dollar amount used in the definition of small amount life insurance policy. The working group originally included $25,000 in the definition and later reduced this amount to $15,000. The interested parties raised no objections to including the same disclosure document for home service policies as used for small face amount policies. Consumer representatives saw this as a great improvement to simply requiring a disclosure.

6. Significant Issues Raised by the Small Face Amount Working Group

The Home Service Model Act adopted by the D Committee required insurers to specify a date certain/expected date when the total premium paid on an insurance policy would exceed the death benefit. The Small Face Amount Working Group deleted this requirement to make the Home Service Model Act consistent with the Disclosure for Small Face Amount life Insurance Polices Model Act. While the Disclosure for Small Face Amount Life Insurance Polices Model Act requires the insurer to disclose that premiums paid on a policy may exceed the death benefit of the policy the model act does not require the insurer to specify a date certain/expected date when the total premium paid will exceed the death benefit. Interested parties indicated that requiring the disclosure of a date certain/expected date would require extensive computer programming.

Section 8 of the Home Service Disclosure Model Act specifies minimum disclosure simplification standards with which all disclosure forms used by insurers must comply. The Small Face Amount Working Group added the disclosure form developed for small face amount life insurance policies to the Home Service Disclosure Model Act. Section 8 of the Home Service Disclosure Model Act was modified to include a presumption that the disclosure form complies with the minimum disclosure simplification standards of Section 8.

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Drafting Note: States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the references to "small" employers and the "small" group market.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

E. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XXVII of the Public Health Service Act, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E of this Act.

H. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection H accordingly.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this state;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

M. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in HHS Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act). States with different legal standards for counting employer size should review their definitions for consistency with federal law and substitute their existing definitions when appropriate. States should also consider the adverse selection issues that arise if different definitions of "small employer" are used within the Exchange and outside the Exchange.

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act relating to governance and operations, including sections that set out:

- The appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act;
- Authority and procedures for hiring staff and procurement resources; and
- Responsibilities of State agencies coordinating activities with the Exchange.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

Drafting Note: States should be aware that the Federal Act does not refer to "affiliate" as referenced in subsection C above. Section 1311(f)(3)(B) of the Federal Act, as related to a health insurance issuer, defines "eligible entity" as a person: 1) incorporated under, and subject to the laws of, one or more States; 2) has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and 3) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. The NAIC, through the Exchanges (B) Subgroup, intends to develop an issues paper on the topic to assist States in evaluating options in this area.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for individual coverage, but only if the Exchange has adequate resources to assist these individuals and employers. States that do so will need to reconcile the eligibility rules for participation, which are currently based on residence for individual coverage and based on employment for coverage through the SHOP Exchange.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations; and

R. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submits to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and

(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

Drafting Note: States should consider revising the language above to ensure that the commissioner, consistent with the provisions of the State insurance code and regulations, is given specific authority to investigate the affairs of the Exchange, examine the properties and records of the Exchange and require the Exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the Exchange under this Act, as may be appropriate given the structure and governance of the Exchange.

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:

(a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) The premium rates and contract language have been approved by the commissioner;

Drafting Note: States should modify the language in paragraph (2) above for consistency with their State law and regulations governing rate and form review and approval.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this state;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

Drafting Note: States whose licensing laws do not use the term "producer" should substitute the appropriate terminology.

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

Drafting Note: As states consider certification standards, they should consider factors such as consumer choice and additional costs, in light of the value to enrollees provided by the proposed standards, when evaluating whether or not to include requirements above the minimum standards under section 1311(c)(1).

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this state.

Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function to the commissioner pursuant to the commissioner's rate and form review responsibilities.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

Drafting Note: States that do not provide for a limited scope license should review the language above and either not include it or modify it for consistency with applicable State law and regulations.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and

(4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Section 8. Funding; Publication of Costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Drafting Note: As provided in section 1311(d)(5)(A) of the Federal Act, in establishing an Exchange under this Act, the State must ensure that the Exchange is self-sustaining by January 1, 2015.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance with in this state. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Drafting Note: States should be aware that section 1311(d)(3)(A) of the Federal Act states that the Exchange "may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act," unless the State elects, pursuant to Section 1311(d)(3)(B) of the Federal Act, to require additional benefits and to make payments to or on behalf of enrollees to defray the cost of the additional benefits. Thus, if a State has benefit mandates that exceed the federal essential health benefit requirements, States may choose either to: 1) establish a mechanism under which qualified health plans may lawfully be offered through the Exchange without being required to provide benefits in addition to the federally designated essential benefits; or 2) establish a mechanism for evaluating and defraying the costs of the additional benefits. For States choosing to require additional benefits and defray the cost, it is recommended that the costs of the additional benefits be measured on a "net cost" basis to the extent permitted by federal law or regulations or guidance, considering both the costs of the service and any associated savings, based on an evidence-based methodology to determine the net cost, if any, of each additional benefit, and the value of the benefit to the State's residents. States also should be aware of the potential conflicts and opportunities for adverse selection created by having inconsistent benefits inside an Exchange and outside an Exchange.

Section 11. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2010 Proc. 3rd Quarter, Vol. I, 130-132, 605-606, 727-739 (adopted).

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

STATE PAGE KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

PREVIOUS VERSION: States that have citations identified in this column (and nothing listed in the Model Adoption column) have enacted an older version of the model but have **not** adopted the most recent version of the NAIC model.

RELATED ACTIVITY: Examples of Related Activity include but are not limited to statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY		
Alaska	NO CURRENT ACTIVITY		
American Samoa	NO CURRENT ACTIVITY		
Arizona	NO CURRENT ACTIVITY		
Arkansas			ARK. CODE ANN. § 23-79-156 (2013); (2013).
California			CAL. CODE REGS. tit. 10, §§ 6408 to 6718 (2013/2016).
Colorado			COLO. REV. STAT. §§ 10-22-101 to 10-22-115 (2013/2014); BULLETIN B-4.48 (2015).
Connecticut	CONN. GEN. STAT. §§ 38A-1080 to 38A-1093 (2011/2013) (portions of model).		

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Delaware	NO CURRENT ACTIVITY		
District of Columbia			D.C. CODE §§ 31-3171.01 to 31-3171.17 (2012/2014).
Florida			FLA. STAT. § 627.64995 (2011).
Georgia	NO CURRENT ACTIVITY		
Guam	NO CURRENT ACTIVITY		
Hawaii	NO CURRENT ACTIVITY		
Idaho			IDAHO CODE ANN. §§ 41-6101 to 41-6109 (2013/2014).
Illinois			215 ILL. COMP. STAT. 122/5-1 to 122/99 (2011).
Indiana			IND. CODE §§ 27-19-1-1 to 27-19-4-14 (2013).
Iowa			IOWA CODE §§ 249N.1 to 249N.8 (2013).
Kansas	NO CURRENT ACTIVITY		
Kentucky	NO CURRENT ACTIVITY		
Louisiana	NO CURRENT ACTIVITY		
Maine			ME. REV. STAT. tit. 22, § 1711-C (1999/2014).
Maryland			MD. CODE ANN., INS. §§ 15-1201 to 15-1225 (2014).

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Massachusetts			MASS. GEN. LAWS ch. 176Q, §§ 1 to 16 (2006/2014).
Michigan			BULLETIN 2013-07 (2013).
Minnesota			MINN. STAT. §§ 62v.01 to 62v.11 (2013).
Mississippi			BULLETIN 2014-6 (2014); BULLETIN 2011-9 (2011).
Missouri	NO CURRENT ACTIVITY		
Montana	NO CURRENT ACTIVITY		
Nebraska	NO CURRENT ACTIVITY		
Nevada	NO CURRENT ACTIVITY		
New Hampshire			N.H. REV. STAT. ANN. §§ 420-N:1 to 420-N:9 (2012).
New Jersey	NO CURRENT ACTIVITY		
New Mexico			N.M. STAT. §§ 59a-23f-1 to 59a-23f-12 (2013).
New York			N.Y. COMP. CODES R. & REGS, tit. 9, § 8.42 (2012).
North Carolina			N.C. GEN. STAT. § 143B-24 (2013).
North Dakota			N.D. CENT. CODE § 26.1-54-01 (2011).
Northern Marianas	NO CURRENT ACTIVITY		
Ohio			OHIO REV. CODE ANN. §§ 3905.47 to 3905.474 (2013).
Oklahoma	NO CURRENT ACTIVITY		

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

NAIC MEMBER	MODEL ADOPTION	PREVIOUS VERSION	RELATED ACTIVITY
Oregon	OR. REV. STAT. §§ 741.001 to 741.900 (2012/2015) (portions of model).		OR. ADMIN. R. 945-020-0020 to 945-040-0160 (2012/2014).
Pennsylvania	NO CURRENT ACTIVITY		
Puerto Rico	NO CURRENT ACTIVITY		
Rhode Island			220 R.I. CODE R. 90-00-1.1 to 90-00-2.9 (2019).
South Carolina	NO CURRENT ACTIVITY		
South Dakota	NO CURRENT ACTIVITY		
Tennessee	NO CURRENT ACTIVITY		
Texas	NO CURRENT ACTIVITY		
Utah			BULLETIN 2011-3 (2011).
Vermont	33 VT. STAT. ANN. §§ 1801 to 1814 (2011/2014).		
Virgin Islands	NO CURRENT ACTIVITY		
Virginia			VA. CODE ANN. § 38.2-3430 (2011).
Washington			WASH. REV. CODE 43.71.005 to 43.71.901 (2014).
West Virginia	NO CURRENT ACTIVITY		
Wisconsin	NO CURRENT ACTIVITY		
Wyoming	NO CURRENT ACTIVITY		

PROJECT HISTORY - 2010

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT (#929)

1. Description of the Project, Issues Addressed, etc.

In March, following the NAIC Spring National Meeting, the NAIC established the Exchanges Subgroup under the Health Insurance and Managed Care Committee in light of the provisions of section 1321 of the Patient Protection and Affordable Care Act (PPACA). Section 1321 of PPACA provides that the Secretary of the U.S. Department of Health and Human Services, in consultation with the NAIC and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties, issue regulations setting standards for: 1) the establishment and operation of Exchanges, including SHOP Exchanges; 2) the offering of qualified health plan through the Exchanges; 3) the establishment of the reinsurance and risk adjustment program; and 4) such other requirements as the Secretary determines appropriate.

As provided in section 1311(b) of PPACA, if a state elects to establish an exchange, the exchange must be established and operational no later than Jan. 1, 2014. Section 1321 of PPACA requires the Secretary of the U.S. Department of Health and Human Services to make a determination on or before Jan. 1, 2013, on whether any state that elects to establish an exchange has taken the actions the Secretary considers necessary to have the exchange operational by Jan. 1, 2014.

At the NAIC Summer National Meeting, in August, to assist those states electing to establish an exchange, the Exchanges Subgroup decided to develop a model act that would reflect the minimum essential provisions of PPACA for establishing an exchange. The model act was adopted by the Exchanges Subgroup and the Health Insurance and Managed Care Committee in mid-November. It outlines the essential duties and functions of an exchange as provided in section 1311 of PPACA. The model act does not include provisions where PPACA provides state flexibility, such as in the structure and operation of an exchange. The Exchanges Subgroup anticipates developing issue briefs for some of those possible provisions, including governance, funding, role of navigators/insurance producers, regional exchanges, and eligibility and enrollment. The issue briefs would highlight issues that states should consider, but not make any specific recommendations.

Major provisions in the model act include:

- Placeholder language for establishing the exchange as a governmental agency, nonprofit entity or a combination of both (Section 4).
- Language that reflects the minimum duties of an exchange as outlined in section 1311 of PPACA, such as implementing procedures for certifying, recertifying and decertifying heath benefit plans as qualified health plans, establishing a SHOP exchange and selecting entities qualified to serve as Navigators (Section 6).
- Provisions for certifying a health benefit plan as a qualified health plan and provisions for qualified dental plans (Section 7).
- Provisions for funding the exchange after Jan. 1, 2015 (Section 8).
- Provisions providing rule-making authority for the exchange (Section 9)
- Provisions related to other laws, particularly as related to section 1311(d)(3) of PPACA related to the exchange making available qualified health plans notwithstanding any of provision of law that may require benefits other than essential health benefits unless the state elects to require additional benefits and to make payments to or on behalf of enrollees to defray the cost of the additional benefits (Section 10).

2. Name of Group Responsible for Drafting the Model and States Participating

The Exchanges Subgroup drafted the model act. The members of the Subgroup are: Kansas, Co-Lead Regulator and Illinois, Co-Lead Regulator, Alaska, California, District of Columbia, Florida, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Mexico, North Dakota, Oklahoma, Pennsylvania, South Dakota, Utah, Washington and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The Exchanges Subgroup of the Health Insurance and Managed Care Committee was established by the NAIC and the Health Insurance and Managed Care Committee as a result of section 1321 of PPACA. Section 1321 of the PPACA provides that the Secretary of the U.S. Department of Health and Human Services, in consultation with the NAIC and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties, issue regulations setting standards for: 1) the establishment and

operation of Exchanges, including SHOP Exchanges; 2) the offering of qualified health plan through the Exchanges; 3) the establishment of the reinsurance and risk adjustment program; and 4) such other requirements as the Secretary determines appropriate. At the Summer National Meeting, the Exchanges Subgroup decided to develop a model act that would reflect the minimum essential provisions of PPACA for establishing an exchange.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model act was drafted by the Exchanges Subgroup. The Subgroup held face to face meetings at the Summer National Meeting and the Fall National Meeting and conference calls Nov. 9 and 15 to discuss each draft and the comments received. All drafts and comments were posted on the Subgroup's page on the NAIC internet website.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Exchanges Subgroup held face to face meetings at the Summer National Meeting and the Fall National Meeting and conference calls Nov. 9 and 15 to discuss each draft and the comments received. All drafts and comments were posted on the Subgroup's page on the NAIC internet website.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There were no significant issues or items of controversy. However, many of the interested parties, who commented on each draft, and some regulators wanted the Subgroup to go beyond having the model act reflect the basic essential requirements in PPACA for establishing an exchange. They wanted the Subgroup to develop for inclusion in the model act provisions for those areas where PPACA provides states with flexibility, such as governance. Given the varying state health insurance market conditions and policy concerns, the Subgroup decided that it would be more appropriate to develop issue briefs on these topics.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

PART A SUGGESTED REGULATION ON REPORTING REQUIREMENTS

Table of Contents

Section 1. Statement of Purpose

This regulation establishes detailed reporting requirements that are consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 2. Definitions

As used in this regulation:

A. "Claim" means the same as in subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*.

B. "Claim identifier" means the unique alphanumeric sequence assigned to a claim by the reporting entity as required by subsection 5A(1) of the *Medical Professional Liability Closed Claim Reporting Model Law*.

C. "Claimant" means the same as in subsection 2B of the *Medical Professional Liability Closed Claim Reporting Model Law*.

D. "Closed claim" means the same as in subsection 2C of the *Medical Professional Liability Closed Claim Reporting Model Law*.

E. "Commissioner" means the same as in subsection 2D of the *Medical Professional Liability Closed Claim Reporting Model Law*.

F. "Companion claims" means the same as in subsection 2E of the *Medical Professional Liability Closed Claim Reporting Model Law*.

G. "Defense and cost containment expenses" means expenses paid or incurred for defense, litigation and cost containment services. The amounts reported for an insuring entity's or self-insurer's employees should include overhead, just as an outside firm's charges would include.

(1) Defense and cost containment expenses include:

(a) Surveillance expenses;

(b) Fixed amounts for cost containment expenses;

(c) Litigation management expenses;

(d) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;

(e) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and

(f) The cost of engaging experts.

(2) Defense and cost containment expenses do not include:

(a) Fees of adjusters and settling agents (but not if engaged in a contentious defense);

(b) Attorney fees incurred in the determination of coverage, including litigation between the insuring entity and the policyholder; and

(c) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster.

H. "Economic damages" means the same as in subsection 2F of the *Medical Professional Liability Closed Claim Reporting Model Law*.

I. "Excess insuring entity" means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.

J. "Facility" means the same as in subsection 2G of the *Medical Professional Liability Closed Claim Reporting Model Law*.

K. "Incident" means an alleged medical error or omission or a series of related errors or omissions leading to allegations of harm. A single incident may span multiple years and involve numerous named defendants.

L. "Incident identifier" means the unique alphanumeric sequence assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of medical malpractice, as required by subsection 5A(2) of the *Medical Professional Liability Closed Claim Reporting Model Law*.

M. "Insuring entity" means the same as in subsection 2I of the *Medical Professional Liability Closed Claim Reporting Model Law*.

N. "Medical malpractice" means the same as in subsection 2J of the *Medical Professional Liability Closed Claim Reporting Model Law*.

O. "Noneconomic damages" means the same as in subsection 2K of the *Medical Professional Liability Closed Claim Reporting Model Law*.

P. "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage. A self-insurer is not considered to be a primary insuring entity.

Q. "Provider" means the same as in subsection 2H of the *Medical Professional Liability Closed Claim Reporting Model Law*.

R. "Reporting entity" means any person or entity required to report data under Section 4 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

S. "Self-insurer" means the same as in subsection 2L of the *Medical Professional Liability Closed Claim Reporting Model Law*.

T. "User ID" is a permanent alphanumeric sequence assigned by the commissioner to each insuring entity, self-insurer, facility or provider that reports data.

Section 3. Applicability and Scope

This regulation is intended to implement this state's medical professional liability closed claim reporting requirements in a manner that is consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*. It applies to all reporting entities as defined in subsection 2R of this regulation.

Section 4. Claims Required to Be Reported

A. The types of closed medical professional liability claims that must be reported to the commissioner include:

(1) Claims closed with an indemnity payment;

(2) Claims closed with paid defense and cost containment expenses; and

(3) Claims closed with both indemnity payments and paid defense and cost containment expenses.

B. If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*. Reporting entities are not required to report these types of accommodations to the commissioner.

C. A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

(1) Issues the final payment to the claimant in the form of a check, draft, or electronic funds transfer;

(2) Pays all outstanding bills for defense and cost containment expenses; and

(3) If applicable, receives all indemnity and defense and cost containment expense payment data needed for reporting from a facility, provider or excess insuring entity.

D. If a closed claim is reopened to update data, the reporting entity must report the updated data to the commissioner after it updates and closes the claim file.

Section 5. Assignment of Claim and Incident Identifiers

A. The reporting entity must assign a different claim identifier to each closed claim report.

(1) The commissioner will combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(2) The commissioner may use the record identifier to trace the claim for auditing purposes.

B. If a claimant makes claims against more than one facility or provider insured by an insuring entity or self-insurer, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

Section 6. Responsibility for Reporting Data

A. Except as provided by subsections B through F of this section, primary insuring entities are principally responsible for reporting closed claim data required under the *Medical Professional Liability Closed Claim Reporting Model Law*.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any indemnity or defense and cost containment expense payments made by:

(a) An insured facility or provider;

(b) An excess insuring entity; or

(c) Any other person or entity on behalf of the facility or provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

(a) The primary insuring entity must report all paid indemnity and defense and cost containment expenses; and

(b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

B. If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs defense and cost containment expenses, the excess insuring entity is principally responsible to report the required closed claim data.

(1) Self-insurers must report all claim payments and defense and cost containment expenses to the excess insuring entity for reporting purposes; and

(2) The excess insuring entity must report data on behalf of itself and the self-insurer.

(3) An excess insuring entity is not responsible to report closed claim data reported by a primary insuring entity under subsection 6A of this Guideline.

C. If a closed claim payment falls wholly within its self-insured retention, the self-insurer must report the required closed claim data.

D. A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insuring entity. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report the required closed claim data on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with the requirements of subsection 4A of the *Medical Professional Liability Closed Claim Reporting Model Law*.

E. A facility or provider is responsible to report the required closed claim data if:

(1) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay the claim; or

(2) The insuring entity or self-insurer fails to report the required closed claim data.

F. An insuring entity or self-insurer may designate a third party to report closed claim data. In this case the insuring entity or self-insurer must:

(1) Obtain a user ID from the commissioner;

(2) Designate the third party as the entity that will report closed claim data on its behalf;

(3) Manage the activities of the third party with respect to the insuring entity's or self-insurer's closed claim data; and

(4) Retain responsibility for all closed claim data submitted by the third party.

Section 7. Reporting of Specific Data Elements

A. Policy limits—When reporting the policy limits of the medical professional liability insurance policy covering the claim, reporting entities must report the following, if applicable:

(1) Primary policy limit, per occurrence (a self-insured retention is not a primary policy limit);

(2) Annual limit of primary policy;

(3) Excess policy limit, per occurrence;

(4) Annual limit of excess policy;

(5) Available primary policy limit; and

(6) Available excess policy limit.

B. Medical specialty—When reporting medical specialties, reporting entities must use the *Field of Licensure Codes* and *Medical Specialty Codes* published by the National Practitioner Data Bank.

C. Type of health care facility—When reporting the type of health care facility, the reporting entity must use the *Type of Organization Codes* published by the National Practitioner Data Bank (NPDB). Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

D. Primary location within a facility—When reporting the primary location within a facility where the incident occurred, the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

(1) Catheterization lab;

(2) Critical care unit;

(3) Dispensary;

(4) Emergency department;

(5) Labor and delivery room;

(6) Laboratory;

(7) Nursery;

(8) Operating room;

(9) Outpatient department;

(10) Patient room;

(11) Pharmacy;

(12) Physical therapy department;

(13) Radiation therapy department;

(14) Radiology department;

(15) Recovery room;

(16) Rehabilitation center;

(17) Special procedure room;

(18) Location other than an inpatient facility:

(a) Clinical support center, such as a laboratory or radiology center;

(b) Office;

(c) Walk-in clinic; or

(d) Other;

(19) Other department in hospital;

(20) Unknown; and

(21) Other.

E. County—When reporting the county in which the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one alleged medical error led to the claim, the reporting entity must choose the location where the alleged medical error leading most directly to the injury occurred. In the event that an alleged medical error occurs outside this state, but the claim is made in this state, a closed claim report must be filed in this state and the county shown as "Location out of state."

F. Severity of injury—when reporting the severity of injury, the reporting entity must use the National Practitioner Data Bank severity scale. This scale shows the medical outcome for temporary and permanent injuries.

(1) Temporary injuries include:

(a) Emotional injury only, such as fright, where no physical damage occurred;

(b) Insignificant injury, such as lacerations, contusions, minor scars or rash, where no delay in recovery occurs;

(c) Minor injury, such as infection, fracture set improperly or a fall in the hospital, where recovery is complete but delayed; and

(d) Major injury, such as burns, surgical material left, drug side effect or brain damage, where recovery is complete but delayed.

(2) Permanent injuries include:

(a) Minor injury, such as loss of fingers or loss or damage to organs, where the injury is not disabling;

(b) Significant injury, such as deafness, loss of limb, loss of eye or loss of one kidney or lung;

(c) Major injury, such as paraplegia, blindness, loss of two limbs or brain damage;

(d) Grave injury, such as quadriplegia, severe brain damage, life-long care or fatal prognosis; and

(e) Death.

(3) If several injuries are involved, the reporting entity should report the most severe injury.

G. Dates—All dates required by subsection 5I of the *Medical Professional Liability Closed Claim Reporting Model Law* must be reported. When reporting the date of notice to the insuring entity, self-insurer, facility or provider, the reporting entity must report the date on which:

(1) The insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

(2) The claimant notifies the facility or provider of a claim if insurance coverage is not available.

H. Claim disposition—when reporting the method of claim disposition, the reporting entity must describe the method of claim disposition using one of the following descriptions:

(1) Claim is abandoned by the claimant.

(2) Claim is settled by the parties.

(3) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for the plaintiff;

(b) Directed verdict for the defendant;

(c) Judgment notwithstanding verdict for the plaintiff (judgment for the defendant);

(d) Judgment notwithstanding verdict for the defendant (judgment for the plaintiff);

(e) Involuntary dismissal;

(f) Judgment for the plaintiff;

(g) Judgment for the defendant;

(h) Judgment for the plaintiff after appeal; or

(i) Judgment for the defendant after appeal.

(4) Claim is settled by an alternative dispute resolution process, whether resolved by:

(a) Arbitration;

(b) Mediation;

(c) Private judging or private trial; or

(d) Other type of alternative dispute resolution process.

I. Timing of disposition—when reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:

(1) Before requesting arbitration, mediation, or private trial;

(2) Before trial, arbitration or mediation;

(3) During trial, arbitration or mediation;

(4) After trial or hearing, but before judgment or award;

(5) After judgment or decision, but before appeal;

(6) During an appeal;

(7) After an appeal; or

(8) During review panel or non-binding arbitration.

J. Indemnity payments and defense and cost containment expenses:

(1) When reporting indemnity payments, the reporting entity must report payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:

(a) Reimbursement by the insured for a deductible;

(b) Reimbursement by a reinsurer or excess insuring entity; or

(c) Anticipated subrogation recoveries.

(2) When indemnity payments exceed the facility's or provider's policy limits, the reporting entity must report the total amount paid by all parties on behalf of the insured, including:

(a) The amount paid by all the insuring entities. The actual amount paid may be higher or lower than the policy limit, depending on the settlement agreement.

(b) Additional payments in excess of policy limits made by the insured facility or provider to the claimant.

(3) Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any defense and cost containment expenses paid to obtain those proceeds. If necessary, the reporting entity may reopen the claim to report this information.

(4) Structured settlements:

(a) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.

(b) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.

(5) If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claim payments in this manner:

(a) Indemnity payments and defense and cost containment expenses paid to defend and settle each claim must be reported separately for each facility or provider.

(b) If indemnity payments are based on a trial verdict, the reporting entity must use the apportionment resulting from the verdict.

(c) If indemnity payments are not based on a trial verdict, the reporting entity must allocate indemnity payments among facilities and providers based on an assessment of comparative fault.

(d) The reporting entity must allocate defense and cost containment expense payments based on the extent to which each facility or provider benefited from the defense services.

(e) The reporting entity is responsible for assigning incident identifiers only for its own claims.

(6) When reporting defense and cost containment expenses, the reporting entity must report:

(a) Defense and cost containment expenses paid for defense counsel, including both in-house and outside counsel;

(b) Defense and cost containment expenses paid for experts, including both in-house and outside experts;

(c) All other defense and cost containment expenses; and

(d) Total defense and cost containment expenses.

(7) When an insuring entity or self-insurer uses company employees, including professional medical staff and in-house legal counsel, to defend claims, the reporting entity:

(a) Must include in defense and cost containment expenses the salary, benefits and an allocation of overhead for those employees; and

(b) May use average salaries and the results of time studies when calculating these defense and cost containment expenses.

K. Estimation of economic and noneconomic damages:

(1) If indemnity payments are the amounts awarded by a court for economic and noneconomic damages, respectively, the reporting entity must report those amounts.

(2) Otherwise, if a reporting entity makes indemnity payments to a claimant, the reporting entity must report the portion of the indemnity payments related to economic damages and the portion of the indemnity payments related to noneconomic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine these amounts using a fixed formula, such as fifty percent of total paid indemnity.

(3) The total indemnity payments must be equal to the sum of the reporting entity's best estimate of indemnity payments related to economic damages and the reporting entity's best estimate of indemnity payments related to noneconomic damages, and neither estimate may exceed the total indemnity payment.

L. Trials—Information about defendants other than the insured should be to the best of the reporting entity's knowledge at the time the claim was closed:

(1) If a trial was started, the reporting entity must report:

(a) Whether the trial was by a judge alone or by a judge and jury; and

(b) The total number of defendants, including those it insures and any other defendants.

(2) If the trial resulted in a verdict, the reporting entity must report the total number of defendants found liable.

(3) If there was a verdict and at least one defendant was found liable, the reporting entity must report:

(a) The total verdict against all defendants (this amount should reflect the award without applying any damages caps, remittiturs, additurs, interest, or other adjustments);

(b) The percentage of fault, if any, assigned to the plaintiff;

(c) The percentage of fault assigned to the reporting entity's insured;

(d) Whether liability was joint and several, or separate;

(e) A breakdown of the total verdict into the following damages categories: economic compensatory damages, noneconomic compensatory damages, and punitive damages;

(f) The amount, if any, of pre-judgment interest awarded by the court;

(g) The amount, if any, by which the court reduced the verdict as a result of caps on damages or interest; and remittitur, or any other reason;

(h) The amount, if any, by which the court increased the verdict as a result of additur; and

(i) The total judgment awarded by the court.

Drafting Note: A state's decision to include or exclude some or all of the data elements listed in Subsection 7L may be affected by the state's Freedom of Information Act or by the confidentiality provisions used in the state's enactment of the *Medical Professional Liability Closed Claim Reporting Model Law*.

PART B
MECHANISM FOR REPORTING AND COLLECTION OF DATA

If it is feasible, the commissioner will establish a web-based reporting site to be used by reporting entities to report the required closed claim data.

The state's data reporting and collection system should include controls that prevent the entry of data that are invalid or internally inconsistent. The system should be designed to meet the needs of various types of reporting entities, many of which have not been accustomed to reporting any kind of information to the commissioner.

The commissioner should also consider the feasibility of providing for electronic transfer of batch data from reporting entities that report a substantial number of claims each year, provided that these reporting entities can incorporate into their data collection and reporting processes business rules that ensure the accuracy of the reported data.

To promote efficiency of reporting and quality of data, the commissioner will, to the extent that it is feasible, make the operation and format of the state's data reporting and collection system consistent with those of other states. In order to facilitate uniformity among states, the commissioner is encouraged to share with other states any information that can be made available regarding the design and operation of the state's system.

PART C
INSURANCE DEPARTMENT OUTREACH EFFORTS

The commissioner is responsible for collecting data from entities that are not traditionally regulated by insurance departments. To ensure timely compliance with the reporting law, the commissioner should engage in outreach and training initiatives. These are some of the groups that typically must be contacted during the outreach effort.

Sector Lobbyists
State medical associations
State hospital associations
Health care organizations, such as health maintenance organizations
Medical professional liability insurers
Nursing home associations
Surplus lines association
Risk retention group associations

Other State Agencies
Risk management agencies
University and college medical centers that provide medical services
Correctional agencies that provide medical services to inmates
Health agencies that provide public health services

Local Government
Some cities and counties provide medical services to the public or inmates residing in local correctional facilities.

Risk Management Associations
Some states have risk management associations related to health care risk management issues.

The organizations listed above can help the commissioner make reporting entities aware of the state's closed claim reporting requirements. Training programs presented by insurance department staff and accessible to members of these organizations are likely to improve the timeliness and quality of the closed claim data submitted by reporting entities.

PART D
COMPILING, VERIFYING, AND RELEASING DATA

Part D of this guideline is intended to assist state regulators in compiling claims data pursuant to the *Medical Professional Liability Closed Claim Reporting Model Law*. It is designed to promote uniformity and to ensure that data can be seamlessly aggregated across states.

The commissioner has a responsibility to ensure that the data collected are complete and accurate, to analyze the data using sound statistical methods, and to provide summary reports and data analyses for the legislature and the public.

Before data are summarized and analyzed, the commissioner should check the reasonableness of the data collected and work with reporting entities to ensure that any needed corrections are made.

As early as practical each year, the commissioner should:

(a) Summarize and analyze the data submitted on claims closed in preceding years, using sound statistical methods; and

(b) Issue a report including the data, the analysis, and any conclusions that are drawn. This report should be made available to the public on the commissioner's website.

To the extent that data are confidential, the commissioner must protect the data in a manner consistent with provisions used in the state's adoption of Section 6 of the *Medical Professional Liability Closed Claim Reporting Model Law*. If the data are not confidential, the commissioner should make the data publicly available on a website in a standard format, within a reasonable period (not to exceed one year) after the year to which the claim report relates. In addition, it is recommended that each state develop formal data verification procedures to ensure that data are as accurate and complete as possible. Data verification methods are discussed below. Lastly, for states that desire to make data available to researchers or other interested parties, methods of minimizing the risk of disclosure of confidential or sensitive information are presented.

I. Data verification

In recent years, data verification processes have evolved into highly sophisticated, rigorous, and organized systems for ensuring the integrity and accuracy of data. A variety of data problems can introduce serious statistical biases and distortions into any subsequent analysis. All states should develop formal processes to ensure that data are as accurate and complete as possible. Some of the following material is taken from the NAIC's *Market Regulation Handbook*, which provides a good overview of data verification issues.

The most frequently used data verification procedures are related to completeness, validity, internal consistency, missing records, and reasonability. If a data problem cannot be remedied, procedures should be adopted to minimize the risk of statistical bias.

Completeness

Data should be as complete as possible. Underreporting can introduce significant biases into an analysis of claims data, particularly if a state lacks corresponding exposure and premium data. Without procedures to ensure completeness, it may be difficult to differentiate between meaningful patterns and reporting errors.

To ensure completeness of the data reported by insurers, medical professional liability claims should be reconciled with control totals, if available. All states can obtain statewide data from the "state page" of the financial annual statement, including aggregate annual premiums written and earned, losses paid and incurred, and additional expense items. In addition, insurers report the number of paid claims on Supplement A to Schedule T. Unfortunately, due to different accounting standards, amounts reported on the financial annual statement may not closely reconcile with the individual-level claims data. For example, the number of paid claims on the annual statement may include payments made on claims closed on prior years. However, very large discrepancies between amounts should be noted, and states should contact insurers to provide a satisfactory explanation for such discrepancies. In at least some instances, underreporting can be detected, even though the method is imperfect.

Attached to this guideline as Appendix 1 is a reconciliation form that could be used to reconcile closed claim data to Schedule T. It is suggested that the form be completed in its entirety by the insurer and reviewed by the state insurance department, which would follow up as needed.

Analogous data for some reporting entities do not exist in most states. For example, most state insurance departments will have only limited information about self-insured entities. States should carefully review their surveillance and enforcement authority with respect to all relevant entities to ensure full compliance with reporting requirements.

Validity

Data fields should be systematically checked to determine that all values are valid and that all codes used correspond to the reporting specifications. To the extent that it's possible, the state's mechanism for collecting closed claim data should be designed to prevent the entry of invalid data. Validity is generally determined in a prima facie sense: values are wrong "on their face" in that the true value cannot logically be as reported. For example, if codes are used, data that include codes that are not specified on the reporting protocols are simply "wrong," and must be recoded. Other examples include reported policy limits below legally required minimums, or payments for non-economic damages that exceed statutory caps.

Internal consistency

States should identify ways to ensure that each data record is internally consistent, such that values reported in different data fields are not logically contradictory. To the extent that it's possible, the state's mechanism for collecting closed claim data should be designed to prevent the entry of data that are internally inconsistent. Similar to validity, inconsistency is determined on a prima facie basis: a data record is internally inconsistent when two or more values cannot logically be simultaneously correct. For example, if in a data record the reporting entity's best estimate of indemnity payments related to economic damages exceeds the total indemnity payments, the necessary conclusion is that one or both of these values are incorrect.

Missing Data Elements (including values coded as "unknown")

Missing data elements can potentially cause analyses to be biased. Bias will occur if the relevant characteristics of the subset of items for which the information is missing differ on average from the overall population. Since both the likelihood and degree of such potential differences are generally unknown, potential bias cannot be ruled out in a non-arbitrary way.

Ideally, no relevant data elements should be missing, though some small amount is often tolerated in many data quality control systems. States should develop procedures that specify the tolerable percentage of missing data.

Reasonability

Reasonability standards are relatively subjective compared to the other verification standards identified in this section. Reasonability checks identify anomalous data values that deviate significantly from averages, or "what one would expect to see." Reasonability checks can be performed by examining the upper and lower extreme values for each data element, and comparing these values to the average value for the entire dataset. In addition, values within a single record should be compared to identify anomalous relationships. Values that appear unreasonable should be investigated to determine that they are correct. For example, a claim payment of $5,000,000 on an injury with a severity level of 1 (emotional only) ought to be verified. While not strictly invalid, such a discrepancy is anomalous to such an extent as to merit further investigation.

II. Confidentiality

The *Medical Professional Liability Closed Claim Reporting Model Law* affords states significant flexibility with respect to whether, and in what form, data may be made available to the public. Closed claim databases have proven to be an important resource for legislators, insurance commissioners, and others who seek to understand the dynamics of medical professional liability insurance markets and related public policy issues. In deciding what information to make available, each state must abide by any constraints imposed by its own laws, including its Freedom of Information Act and the confidentiality provisions used in the state's enactment of the *Medical Professional Liability Closed Claim Reporting Model Law*. Each state must also balance the potential benefits of making data available against the confidentiality interests of individual claimants, providers, and facilities.

There is a continuum of disclosure options, ranging from full public disclosure of all collected information to the disclosure of only aggregate information. Full disclosure of all information (including individual identifiers) maximizes the availability of information to the public but does not protect the confidentiality interests of claimants, providers, and facilities. The disclosure of only aggregate information maximizes the protection of the privacy interests of claimants, providers, and facilities but limits the utility of the collected data because it precludes analysis by the public. Intermediate solutions balance

these interests against one another by releasing enough information to allow the data to be used effectively but not releasing so much as to create an undue risk to claimant, provider, and facility confidentiality.

States that have already created closed claim databases have opted for a range of disclosure strategies. Texas makes claim-level information available on a website in electronic format but redacts certain information, such as patient and provider names. Florida provides physician names and specialties, so that one can determine whether a particular provider has been subject to claims. Texas provides information on jury verdicts and payouts; Florida provides information only on payouts. Missouri makes available to the public individual claims data scrubbed of direct identifiers. In addition, the public data must conform to federal statistical standards that minimize disclosure risk, or the risk that identities could be inferred either directly or in conjunction with other publicly available information. Massachusetts provides information on a public website on malpractice payouts involving particular named physicians during the previous decade but does not identify claimants. Other states, including Ohio, Oklahoma, and Washington, make available only aggregate data. (The states mentioned in this paragraph are only examples; there are other states with medical professional liability closed claim databases.)

The federal government maintains a National Practitioner Data Bank ("NPDB") that contains information on closed claims and disciplinary sanctions against physicians. The NPDB makes public detailed claim-level information in electronic format but redacts patient and provider names. Hospitals, professional societies, and state medical disciplinary boards can obtain provider-specific information. The NPDB does not collect information regarding jury verdicts.

To assist individual states, this section provides three broad options designed to produce data that are analytically useful while at the same time minimizing the probability that sensitive information will be disclosed. Of greatest concern to most states is what statisticians call "disclosure risk," or the risk that the data released could enable end-users to identify individuals or entities involved in a malpractice action. These privacy concerns should be weighed against potential benefits of public data, such as enabling independent analyses or replicating results – two hallmarks of the scientific method.

The alternatives presented here are:

1. Release of individual-level "anonymized" data, in which certain characteristics associated with particular individuals or entities are either scrubbed from the data or released in more general form.

2. Release of individual-level data for limited use, subject to a confidentiality agreement.

3. Release of the data at levels of aggregation that minimize disclosure risk. This third alternative conforms to guidelines governing most federal agencies in possession of sensitive data.

Option 1: Release of individual-level records

Individual-level records can be released in a way that makes it unlikely, if not impossible, that individual identities can be inferred. In general, demographic characteristics, such as age, should be released in general categories. (For medical malpractice it is important to be able to identify baby cases and also to link the data to other data sources, for which common age cutoffs are 18 and 65. So the categories might be <1, 1-5, 6-10, 11-17, 18-24, 25-29, 30-34, . . ., 60-64, 65-69, etc.) In addition, care should be taken to ensure that no data records correspond too closely to unique circumstances of a case, whereby an individual could combine the data with other publicly available information in such a way as to ascertain an identity with some degree of certainty. For example, a dataset containing only a single claim against a neurosurgeon for an injury occurring on a given date within a specified geographic location may allow one to easily identify the practitioner. The following guidelines are intended as suggestions for states that wish to preserve anonymity while releasing data in its most usable form.

a. References to small geographic units should be suppressed, though such data may be released in aggregate form as described on option 3. For individual claims records, geographic units may be denoted with a more general identifier. For example, the county of injury might be replaced with a new field that represents regions in a state composed of multiple counties.

b. Injury, lawsuit, settlement or trial dates might be disclosed by providing only the month and year rather than the exact day. Alternatively, the timing of events can be disclosed using "number of days from injury to report" and "number of days from report to close" in conjunction with the incident year, notice year, suit year, final indemnity payment year and close year.

c. The specific identify of the reporting entity may be kept confidential in individual records. However, variables describing the type of reporting entity (such as insurer, self-insured, etc.) may be released without significant disclosure risk if there are a sufficient number of such entities providing medical professional liability coverage in a state.

d. Data records that specify fairly unique characteristics of events or individuals should be suppressed, or aggregated into broader categories. For example, states might want to consider suppression of records that identify a particular medical specialty unless there are a minimum of four additional claims during an annual period against practitioners of the same medical specialty for each identifiable unit of geography. For cases failing to meet this rule, specialties may be aggregated into a new, more general specialty code to attain the minimum five records.

e. It is preferable to aggregate information – as in the county or specialty examples above – or to suppress particular fields, such as a county or specialist field, than to suppress all of the information about a particular claim. Suppressing claims entirely will distort the whole dataset, even for research for which the county or specialty was not relevant or was of secondary importance.

Option 2: Release of individual-level data, subject to a confidentiality agreement

For data fields that could result in inadvertent release of confidential information about individual claimants, providers, or facilities, additional detail could be provided only to reputable persons who sign a confidentiality agreement. This option could provide a compromise between those who favor broader public access to information, those who recognize the value of providing data for research purposes, and those who are concerned with inadvertent release of data that could be traced back to a particular claimant, provider, or facility.

Attached to this guideline as Appendix 2 is a sample confidentiality form that could be used. This form is derived from the one used by the state of Florida for access to patient-level data on hospital admissions and outcomes. The agreement has a defined term (currently one year), but Florida generally grants extensions to allow for research that exceeds this period.

Option 3: Release of aggregate data

The Federal Committee on Statistical Methodology, under the authority of the Office of Management and Budget, has developed general guidelines to preserve the confidentiality of information collected by numerous federal agencies. These rules govern the properties that publicly released data must possess to minimize the possibility that a user could, either directly or indirectly in conjunction with other public information:

1. Discover the identity of individuals or entities;

2. Infer with some precision the value of some attribute (for example, a person's income).

The standards can be found in Federal Committee on Statistical Methodology, Office of Management and Budget, *Statistical Policy Working Paper 22 (Revised 2005) – Report on Statistical Disclosure Limitation Methodology*. As of August 2008, this paper is available on the internet at:

http://www.fcsm.gov/working-papers/spwp22.html

The most common rule type governs the statistical properties of data cells in aggregate data. The most straightforward guideline is the **threshold rule**, which is simply the requirement that a minimum number of observations appear within a data cell. Obviously, a cell count of 1 possesses a high disclosure risk. For example, assume the release of a record in which exactly one medical malpractice payment was made in 2007 on behalf of a neurosurgeon practicing in a sparsely populated county. Very likely, the individual could be identified from other publicly available information, since only a single neurosurgeon may practice in a given county.

A data cell consisting of only two observations would also pose a high risk of revealing private information. Assume that two payments were made on behalf of two physicians by two different insurers, and the data are released in aggregate. In this instance, each insurer could identify the payment amount of the other insurer simply by subtracting their payment from the total.

Obviously, the more individuals that make up the aggregate figure, the safer are the identities and of each. It is not uncommon for federal agencies to release data cells consisting of as few as three observations. A threshold of five or more may be used if the data are particularly sensitive. The threshold rule is usually supplemented by additional rules that afford greater privacy protections.

For data consisting of magnitudes (income, malpractice payments, etc.), it is likely that some cells will be highly skewed toward high-end values (incomes or malpractice payments greater than $1 million, say). Highly skewed distributions pose a high risk that an individual could identify the highest values with a reasonable degree of certainty. A cell consisting of the sum of one very large payment and several much smaller payments would itself constitute a reasonable high-end estimate of the largest value. Knowledge of the highest value case could also permit an identification of the individual associated with the case. For example, one could search court records within a county for all cases with payouts of between $1 million and $2 million. As such, the Committee on Statistical Methodology has urged government agencies to adopt at least some following "sensitivity rules" *in addition to any threshold criterion.*

(n,k) rule (also called the "dominance rule") – this rule is designed to limit access to data cells in which one or two high value observations contribute a substantial portion to the overall cell total, as in the example above. The rule is violated if some number of observations (*n*) exceeds (*k*) percent of the cell total. Commonly, *n* is assigned a value of one or two.

P-Percent Rule (or the "p-percent estimation equivocation level") – This rule contemplates a "coalition" of individuals (c) pooling knowledge to estimate the largest contributor to a cell total.[1] Such individuals could be physicians represented in a cell, their insurers, or plaintiff attorneys that have knowledge of cases represented in a cell. For example, if a single law firm represented two of three cases that comprise a cell total, the firm could easily identify the value of the third contributor by simply subtracting their two cases from the total.

The rule makes the rather generous assumption that, based solely on general knowledge, estimates can be made to within 100% of the true value of each observation that comprises a cell total. In cases where "general knowledge" is less reliable, the rule will afford significantly *greater* confidentiality protections.

To limit the ability of coalitions to pool information to reliably estimate the value of subcomponents of a total, the p-percent rule constrains the percent distribution across cases that make up the total.
Specifically, the rule states that any estimates derived from the data should be imprecise (or not come within *p* percent of the actual value). The limiting case is where the second and third largest contributors to a cell pool knowledge to estimate the largest contributor.

While the mathematical derivation and proofs of the rule are somewhat complex, the rule itself is not. It simply specifies that the sum of the remaining contributors to a cell total (everyone but the three largest contributors) must be larger than *p* percent of the largest observation:

$$\sum_{i=c+2}^{N} x_i \geq \frac{p}{100} \times x_1$$

Where

c+2 represents all observations but the largest three;

N is the total number of observations in a data cell;

X_i = the value being tested, such as claim payment amounts; and

p represents a percentage less than 100 to be determined by the commissioner.

In practice, the rule means that anyone with knowledge of the second and third largest observations will be able to estimate the highest value only with *p*-percent accuracy.

[1] It has been shown mathematically that if the value of the largest contributor cannot be estimated with accuracy, then no other subcomponent of a total can be estimated.

pq rule – This rule is derived from the p-percent rule, but assumes that a potential "coalition" could have greater knowledge than assumed in the p-percent rule. That is, the pq rule assumes that estimates of true values could be made that are much more precise than "within 100% of the true value." This rule is not in general use, nor is it recommended by the Committee on Statistical Methodology. As such, it is not further discussed here. More information can be obtained from the working paper cited above.

The parameters in each of the above rules (*c, p, n,* etc) are specified by each agency on a case-by-case basis. **Importantly, the committee recommends that the values that an agency adopts *not* be made public, since knowledge of the parameters can aid end-users in making various estimates.**

Cells that fail a test can be collapsed into other observations. For example, data at the county level can be combined with other counties or aggregated at some other higher level of geography.

The following table is derived from the *Statistical Working Paper 22*, and describes the practices of various federal agencies with respect to the public release of sensitive information.

Agency	**Threshold – minimum number for each data cell**	**Other threshold rules**
Department of Agriculture – Economic Research Service	3	**(n,k) rule –**No single observation can represent more than 60% of a given cell total (see explanation of the (n,k) rule above. In this case, (n,k) = (1,0.6)
Department of Agriculture – National Agricultural Statistics Service	3	**(n,k) rule,** the parameter values are administratively determined and vary
Department of Commerce – Bureau of Economic Analysis	N/A	**p-percent rule**, value of *p* is administratively determined and varies across datasets
Bureau of the Census	Threshold varies, though the most common rule is that a cell must represent a minimum of 3 individuals from separate households	**p-percent rule**; value of p is not published Some (sampled or micro-) data is not released on a geographic unit with a population of less than 100,000; and the most detailed micro-data are released only if sampled from a population of at least 250,000

Agency	**Threshold – minimum number for each data cell**	**Other threshold rules**
Department of Education: National Center for Education Statistics (NCES)	3	Data is matched with all publicly available data sources. If potential matches can be narrowed down to as few as two institutions, data is not disclosed Values are coded in ranges (for example, income between $50,000 – $75,000) Values are top- and bottom- coded to prevent identification of outliers
Department of Energy	N/A - cells with too few observations are suppressed for accuracy reasons rather than for confidentiality (suppressed when standard error > 50%)	**pq rule** – values of *p* and *q* are not published
National Center for Health Statistics	n=5	**(n,k) rule**, parameters aren't published
Department of Justice: Bureau of Justice Statistics (BJS)	n=10	The BJS does not use any of the additional rules specified above. They do take additional measures to enhance the anonymity of the data, such as publishing values in ranges
Department of Labor: Bureau of Labor Statistics	Value of *n* is not released to the public	**(n,k) rule**, parameters not published
Department of Transportation: Bureau of Transportation Statistics	No agency-wide rule; established on a case-by-case basis	No agency-wide rule; established on a case-by-case basis
Department of the Treasury: IRS, Statistics of Income Division	n=3 for data aggregated at the state level or larger geography; n=10 for data aggregated at sub-state levels	N/A
National Science Foundation	Does not generally rely on a threshold rule	Either **(n,k) rule** or the **p-percent rule**
Social Security Administration	n=3 at state level, n=10 at county level	

III. Internal Policies and Procedures

If data are confidential, each department should adopt reasonable policies and procedures to limit unauthorized access to files. Most agencies with sensitive files limit access to departmental employees who have a reasonable business- or job-related purpose to do so.

IV. Sharing data with other state insurance departments

Confidentiality concerns should not deter interstate data sharing. All states are signatories to the NAIC's global confidentiality agreement. This agreement ensures that a recipient state will treat data according to the originating state's legal standards and rules. In essence, the legal disclosure provisions of the originating state "travel with the data."

PART E
CODEBOOK

Each claim represents each named individual or entity alleged to have contributed to an injury, and from whom compensation was sought. **All data elements for each claim pertain to the named individual or entity on whose behalf the claim is filed**. For example, the injury date should reflect the date that the individual or entity is alleged to have contributed to an injury, regardless of whether other parties are alleged to have also contributed to the injury at different times and places. Close dates should reflect the date on which a claim was closed for the individual or entity, regardless of whether other parties negotiate independent settlements at different times.

Coding of data may not be necessary or appropriate at every step of the process. For example, if a state uses a web-based reporting site, drop-down boxes may be more user-friendly than a requirement that the reporting entity convert the data to codes before entering it. (Caution: the default value for any drop-down box should be "not reported" rather than a reportable value.) On the other hand, if a state is receiving batch data transferred electronically from reporting entities, the codes in this guideline provide an appropriate format for data reporting. For sharing raw data with other state insurance departments, coding is necessary in order to provide data that can be aggregated across states.

Reporting Universe

As used in the *Medical Professional Liability Closed Claim Reporting Model Law,* a claim consists of a demand for payment to compensate injuries sustained during the course of medical treatment. As defined in the model law, a claim generally consists of a single claimant seeking compensation from a single provider or facility. Allegations against additional providers or facilities with respect to the same injury or injuries should be reported as separate companion claims and assigned the same *incident identifier*.

General guidelines are:

- Do not report a "medical misadventure" or poor clinical outcome unless an injured party has made a demand for payment or has made specific allegations against a particular provider or facility.
- All medical treatment associated with single provider or facility that is related to single injury or set of related injuries should be treated as a single claim. The same plaintiff could be associated with multiple claims in instances where the injuries are associated with unrelated medical conditions and treatments.
- Each defendant or insured should be treated as a separate (but related) claim.
- Multiple claimants pursuing compensation for the same series of injuries should be treated as a single claim. For example, if both a mother and father file for damages on behalf of an injured child, all defense costs and indemnity payments should be combined and filed as a single claim.
- Multiple injured parties involved in single incident or series of incidents should be treated as a single claim, as in instances where both mother and child are injured during childbirth. However, multiple injuries sustained by unrelated individuals, as is the case with most class-action lawsuits, should be treated as separate claims.
- Claims involving cases of mistaken identity, such as allegations against a provider or facility that had no relationship to an injured party, should not be reported.

Table of Data Fields

Item #	Data Field	Description	Format
1	Ins_Code	Unique identifier assigned by the commissioner for each reporting entity.	Alphanumeric
2	Entity Name	Name of reporting entity	Alpha
3	ClaimID	Unique identifier for each claim	Alphanumeric
4	IncID	Unique identifier for each incident	Alphanumeric
5	PolLim_Occ_prim	Policy limits, primary coverage, per occurrence	Numeric
6	PolLim_Ann_prim	Annual policy limits, primary coverage	Numeric
7	PolLim_Occ_Ex	Policy limits, all excess coverage, per occurrence (stacked if more than one applicable coverage—see below)	Numeric
8	PolLim_ann_ex	Annual policy limits, all excess coverage (stacked if more than one applicable coverage – see below).	Numeric
9	PolLim_avail_prim	Available policy limits for this event, primary coverage.	Numeric
10	PolLim_avail_ex	Available policy limits for this event, excess coverage.	Numeric
11	Lic_code	NPDB field of licensure code.	Text, Left Zero Filled
12	Spec_code	NPDB medical specialty code.	Text, Left Zero Filled
13	Facility	Code for type of facility where incident occurred.	Text
14	Location	Code for the location within facility where incident occurred.	Alphanumeric
15	Allegation_group	NPDB general allegation code	Text, Left Zero Filled
16	Allegation_code	NPDB specific allegation code	Text
17	City	City in which injury occurred	Text
18	County	County in which injury occurred	Text
19	State and County FIPS Code	5-digit county Federal Information Processing Standard Code, 2-digit state code + 3 digit county code.	Text, Left Zero Filled
20	Inj_gender	Gender of injured party (M, F)	Alpha – M or F
21	Inj_Age	Age of injured party	Numeric
22	Severity	Injury severity code.	Numeric
23	Inj_date	Earliest date of act or omission that was the proximate cause of the claim.	MM/DD/YYYY
24	Rept_date	Date claim reported to insurer	MM/DD/YYYY
25	Suit_date	Date suit was filed, if applicable	MM/DD/YYYY

Item #	Data Field	Description	Format
26	Close_date	Date claim was closed	MM/DD/YYYY
27	Date_Payment	Date of final indemnity payment, if applicable.	MM/DD/YYYY
28	Disposition	Manner in which a claim is resolved.	Alphanumeric
29	Disp_time	Timing of disposition of claim.	Text
30	Indemnity	Total indemnity paid or incurred by this entity on behalf of a single medical provider.	Numeric
31	Econ_ind	Amount of total indemnity attributable to economic damages.	Numeric
32	Nonecon_ind	Amount of total indemnity attributable to non-economic damages.	Numeric
33	Defense_Costs_Counsel	Defense and costs containment expenses for legal counsel.	Numeric
34	Defense_costs_experts	Defense and cost containment expenses for experts.	Numeric
35	Defense_costs_other	Defense and cost containment expenses for other than legal counsel or experts.	Numeric
36	Defense_costs_total	Total defense and cost containment expenses.	Numeric
37	Trial_Type	If a trial was started, indicate bench or jury trial.	Text
38	Def_no	If verdict, total number of defendants found liable.	Numeric
Items 39 – 49 should be completed only if there was a verdict and at least one defendant was found liable			
39	Total_verdict	Total verdict for all defendants, prior to any adjustments due to damage caps, remittiturs, additurs, interest, or other adjustments.	Numeric
40	Fault_plaintiff	Percentage of fault assigned to plaintiff.	Percent
41	Fault_insured	Percentage of fault assigned to reporting entity's insured.	Percent
42	Liability_doctrine	Whether liability joint and several, or separate.	Text
43	Econ_verdict	Amount of verdict awarded to compensate economic damages.	Numeric
44	Nonecon_verdict	Amount of verdict awarded to compensate non-economic damages.	Numeric
45	Punitive_verdict	Amount of verdict for punitive damages.	Numeric
46	Interest	Amount of pre-judgment interest awarded.	Numeric

Item #	Data Field	Description	Format
47	Amt_reduced	Amount the verdict was reduced because of damage caps, remittitur, or any other reason.	Numeric
48	Additur	Amount the verdict was increased as a result of additur.	Numeric
49	Total	Total judgment awarded by court.	Numeric

Item Descriptions and Tables of Codes

Item 1: Entity ID Code

A unique identifier assigned by the commissioner for each reporting entity. Where applicable, a reporting entity's five-digit NAIC code may be used as a component of the identifier.

Item 2: Entity Name

Full legal name of the insuring or reporting entity.

Item 3: Claim Identifier

Each reporting entity should assign a unique identifier for each claim. This identifier should consist of a unique sequence of letters and / or numbers. Once an identifier has been assigned, it should not be repeated for any future claim. One claim record should be reported for each name individual or entity formally alleged to have contributed to an injury or grievance, and from whom a malpractice payment is being sought. Note that the claim identifier need not be the company's internal claim identifier.

Item 4: Incident Identifier

Each reporting entity should assign a unique numeric identifier for each incident or occurrence. An occurrence is an event or series of events leading to an allegation of malpractice, and which may involve allegations against multiple individuals and entities. An occurrence is defined causally, and may or may not be constrained in time. For example, multiple failures to diagnose a given illness may occur over a period of years. Such a series of events would be considered a single occurrence. Each claim submitted for providers involved in a single occurrence should be assigned the same incident identifier.

Item 5: Per occurrence policy limits, primary coverage

The maximum amount a primary insurer will pay for a single malpractice claim under the terms of the policy.

Item 6: Annual policy limits, primary coverage

The maximum amount a primary insurer will annually pay under the terms of a policy for one or more malpractice claims. The reported policy limit should reflect all policies in effect for a given claim (see above).

Item 7: Per occurrence policy limits, all excess coverage combined

The combined maximum amount all excess insurers will pay for a single malpractice claim under the terms of the policy. Policy limits should reflect the cumulative limits of all policies other than the primary coverage in effect for a given claim. For example, if a policy was issued with a $1 million limit, and an additional excess policy had a $5 million limit, a total limit of $6 million should be reported.

Item 8: Annual policy limits, all excess coverage combined

The combined maximum amount all excess insurers will annually pay under the terms of their respective policies or contracts. The reported policy limit should reflect all excess policies in effect for a given claim (see above).

Item 9: Policy limits available, primary coverage.

Policy limits available for the claim being reported under the insured's primary coverage.

Item 10: Policy limits available, excess coverage.

Policy limits available for the claim being reported under the insured's excess coverage.

Item 11: NPDB Occupation / Field of Licensure Code

Enter the field of licensure code from the following table for individuals named in a malpractice action. If an institution is named in the claim, enter 999.

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
	Chiropractor
603	Chiropractor
	Counselor
621	Counselor-Mental Health
651	Professional counselor
654	Professional counselor-alcohol
657	Professional counselor-family/marriage
660	Professional counselor-substance abuse
661	Marriage and family therapist
	Dental Service Provider
030	Dentist
035	Dentist/Resident
606	Dental assistant
609	Dental hygienist
612	Denturist
	Dietician/Nutritionist
200	Dietician
210	Nutritionist
	Emergency Med Tech (EMT)
250	EMT, Basic
260	EMT, Cardiac, critical care
270	EMT, Intermediate
280	EMT, Paramedic
	Eye and Vision Service Provider
630	Ocularist
633	Optician
636	Optometrist
	Nurse
100	Registered
110	Nurse anesthetist
120	Nurse midwife
130	Nurse practitioner

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
140	Licensed practical
141	Clinical nurse specialist
	Nurse aides, Home health aide, and other aide
148	Certified nurse aide/assistant
150	Nurses aide
160	Home health aide
165	Health care aide/direct care worker
175	Certified or qualified medication aide
	Pharmacy Service Provider
050	Pharmacist
055	Pharmacy intern
060	Pharmacist, nuclear
070	Pharmacy assistant
075	Pharmacy technician
	Physician
010	Physician (MD)
015	Physician inter/resident (MD)
020	Osteopathic Physician (DO)
025	Osteopathic Physician Intern/Resident (DO)
	Physician Assistant
642	Physician assistant, allopathic
645	Physician assistant, osteopathic
	Podiatric Service Provider
350	Podiatrist
648	Podiatric assistant
	Psychologist/Psychological Asst.
371	Psychologist
372	School psychologist
373	Psychological assistant, associate, examiner
	Rehabilitative, respiratory, and restorative service provider
402	Art/Recreation therapist
405	Massage therapist
410	Occupation therapist
420	Occupational therapy assistant
430	Physical therapist
440	Physical therapy assistant
450	Rehabilitation therapist
663	Respiratory therapist
666	Respiratory therapy technician
	Social worker
300	Social worker
	Speech, language, and hearing service provider
400	Audiologist
460	Speech/language pathologist
470	Hearing aid/hearing instrument specialist
	Technologist
500	Medical technologist
505	Cytotechnologist

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
510	Nuclear medicine technologist
520	Radiation therapy technologist
530	Radiologist technologist
	Other Health Care Practitioner
600	Acupuncturist
601	Athletic trainer
615	Homeopath
618	Medical assistant
624	Midwife, Lay (non-nurse)
627	Naturopath
639	Orthotics/ Prosthetics Fitter
170	Psychiatric Technician
699	Other health care practitioner-not classified
	Health Care Facility Administrator
752	Adult care facility administrator
755	Hospital administrator
758	Long-term care administrator
999	Not an individual defendant.

Item 12: NPDB Medical Specialty Codes

Select the most relevant specialty code from the following table.

NPDB Specialty Codes	
Code	**Description**
	Physician Specialties
01	Allergy and immunology
03	Aerospace medicine
05	Anesthesiology
10	Cardiovascular diseases
13	Child Psychiatry
20	Dermatology
23	Diagnostic Radiology
25	Emergency medicine
29	Forensic pathology
30	Gastroenterology
33	General / Family Practice
35	General preventive medicine
37	Hospitalist
39	Internal medicine
40	Neurology
43	Neurology, clinical neurophysiology
45	Nuclear medicine
50	Obstetrics & Gynecology
53	Occupational medicine
55	Ophthalmology
59	Otolaryngology
60	Pediatrics

NPDB Specialty Codes	
Code	**Description**
63	Psychiatry
65	Public health
67	Clinical pharmacology
69	Physical medicine & rehabilitation
70	Pulmonary diseases
73	Anatomic/clinical pathology
75	Radiology
76	Radiation oncology
80	Colon and rectal surgery
81	General surgery
82	Neurological surgery
83	Orthopedic surgery
84	Plastic surgery
85	Thoracic surgery
86	Urological surgery
98	Other specialty-not classified
99	Unspecified
	Dental specialties
D1	General dentistry (no specialty)
D2	Dental: Public Health
D3	Endodontics
D4	Oral and maxillofacial surgery
D5	Oral and maxillofacial pathology
D6	Orthodontics and dentofacial Orthopedics
D7	Pediatric Dentistry
D8	Periodontics
D9	Prosthodontics
DA	Oral and maxillofacial radiology
DB	Unknown

Item 13: Type of facility Code

Code	Description
	Group or Practice
361	Chiropractic Group / Practice
362	Dental Group / Practice
363	Optician / Optometric Group / Practice
364	Podiatric Group / Practice
365	Medical Group / Practice
366	Mental health / Substance Abuse Group / Practice
393	**Home health Agency / Organization**
383	**Hospice / Hospice Care Provider**

Hospital	
301	General/Acute Care Hospital
302	Psychiatric hospital
303	Rehabilitation Hospital
304	Federal Hospital
Hospital Unit	
307	Psychiatric Unit
308	Rehabilitation Unit
310	**Laboratory/CLIA Laboratory**
389	**Nursing Facility/Skilled Nursing Facility**
370	**Research Center/Facility**
Other Health Care Facility	
381	Adult Day Care Facility
383	Intermediate Care Facility for Mentally Retarded/Substance Abuse
386	Residential Treatment Facility/Program
388	Outpatient Rehabilitation Center/Comprehensive Outpatient Rehabilitation Center
391	Ambulatory Surgical Center
392	Ambulatory Clinic/Center
394	Health Center/Federally Qualified Health Center/Community Health Center
395	Mental Health Center/Community Mental Health Center
396	Rural Health Clinic
397	Mammography Service Provider
398	End Stage Renal Disease Facility
399	Radiology/Imaging Center
Managed Care Organization	
331	Health Maintenance Organization
335	Preferred Provider Organization
336	Provider Sponsored Organization
338	Religious, Fraternal Benefit Society Plan
320	**Health Insurance Company/Provider**

Health Care Supplier/Manufacturer	
342	Blood Bank
343	Durable medical Equipment Supplier
344	Eyewear Equipment Supplier
345	Pharmacy
346	Pharmaceutical Manufacturer
347	Biological Products manufacturer
348	Organ Procurement Organization
349	Portable X-Ray Supplier
351	Fiscal/Billing/Management Agency
352	Purchasing Service
353	Nursing/Health Care Staffing Service
390	**Ambulance Service/Transportation Company**
999	**Other not specified**

Item 14: Location within facility where incident occurred

Code	Description
Inpatient Facilities	
1	Catheterization lab
2	Critical care unit
3	Dispensary
4	Emergency department
5	Labor and delivery room
6	Laboratory
7	Nursery
8	Operating room
9	Outpatient department
10	Patient room
11	Pharmacy
12	Physical therapy department
13	Radiation therapy department
14	Radiology department
15	Recovery room
16	Rehabilitation center
17	Special procedure room
Location other than inpatient facility	
18a	Clinical support center, such as a laboratory or radiology center
18b	Office
18c	Walk-in clinic
18d	Other
Other and Unknown	
19	Other department in hospital
20	Unknown
21	Other

Item 15: Allegation Group

001 = Diagnosis related
010 = Anesthesia related
020 = Surgery Related
030 = Medication Related
040 = IV & Blood Products Related
050 = Obstetrics related
060 = Treatment related
070 = Monitoring related
080 = Equipment / Product Related
090 = Other / Miscellaneous
100 = Behavioral Health

Item 16: NPDB Allegation Code

Instructions

1. Select the code that is *most descriptive* of the alleged error or omission.

Example 1: Select "wrong dosage administered" (324) for dosage errors rather than the more generic "improper performance" (306).

Example 2: Select "delay in treatment of identified fetal distress" (203) if appropriate, rather than "delay in performance" (201).

More generic categories should be used only when a specific category that adequately describes the allegation does not exist.

2. This is taxonomy of *allegations* made by the claimants. If the claimant alleges that an infection is the result of a surgery, select the code *failure to use aseptic technique,* even if there is no specific known, proven, or identified performance failure.

3. Identify the *most accurate* code.

Example 1: Do not conflate codes such as a failure to treat fetal distress (104) with a failure to identify fetal distress (103) with delay in treatment of fetal distress (203).

Example 2: Do not conflate a failure to order appropriate medication (107) with instances in which the wrong medication is ordered (329).

4. Select the *most causally relevant* code. If numerous errors are alleged to have contributed to an injury, identify the first error that was necessary to occur to have produced the sequence of actions ultimately leading to an adverse outcome. For example, if an illness is misdiagnosed, and the misdiagnosis leads to the prescription of improper medication, the "cause" of the injury is the initial misdiagnosis. The initial action is the first "necessary" but not necessarily "sufficient" condition that ultimately led to harm. In the absence of this initial event (misdiagnosis), the most proximate cause of harm (improper prescription) would not have occurred.

NPDB Allegation Codes	
Failure to Take Appropriate Action	
100	Failure to use aseptic technique
101	Failure to diagnose ***Excludes* misdiagnoses (323), and delay in diagnosis (200). Use code only to indicate instances of a conclusion that no condition worthy of follow-up or treatment existed, when it in fact did exist.**
102	Failure to delay case when indicated
103	Failure to identify fetal distress
104	Failure to treat fetal distress
105	Failure to medicate
106	Failure to monitor
107	Failure to order appropriate medication
108	Failure to order appropriate test
109	Failure to perform preoperative evaluation
110	Failure to perform procedure
111	Failure to perform resuscitation
112	Failure to recognize a complication
113	Failure to treat
Delay in Performance	
200	Delay in diagnosis
201	Delay in performance
202	Delay in treatment
203	Delay in treatment of identified fetal distress
Error / Improper Performance	
300	Administration of blood or fluid problems
301	Agent use or selection error
302	Complimentary or alternative medication problem
303	Equipment utilization problem
304	Improper choice of delivery method
305	Improper management
306	Improper performance
307	Improperly performed C-Section
308	Improperly performed vaginal delivery
309	Improperly performed resuscitation
310	Improperly performed test
311	Improper technique
312	Intubation problem
313	Lab error
314	Pathology error
315	Medication administered via the wrong route
316	Patient history
317	Problems with patient monitoring in recovery
318	Patient monitoring problem

NPDB Allegation Codes	
319	Patient position problem
320	Problem with appliance
321	Radiology or imaging error
322	Surgical or other foreign body retained
323	Wrong diagnosis or misdiagnosis
324	Wrong dosage administered
325	Wrong dosage dispensed
326	Wrong dosage ordered of correct medication
327	Wrong medication administered
328	Wrong medication dispensed
329	Wrong medication ordered
330	Wrong body part
331	Wrong blood type
332	Wrong equipment
333	Wrong patient
334	Wrong procedure or treatment
Unnecessary/Contraindicated Procedure	
400	Contraindicated procedure
401	Surgical or procedural clearance contraindicated
402	Unnecessary procedure
403	Unnecessary test
404	Unnecessary treatment
Communication/Supervision	
500	Communication problem between practitioners
501	Failure to instruct or communicate with patient of family
502	Failure to report on patient condition
503	Failure to respond to patient
504	Failure to supervise
505	Improper supervision
Continuity of Care / Management	
600	Failure/delay in admission to hospital
601	Failure/delay in referral or consultation
602	Premature discharge from institution
603	Altered, misplace, or prematurely destroyed records
Behavioral / Legal	
700	Abandonment
701	Assault and Battery
702	Breach of contract or warranty
703	Breach of patient confidentiality
704	Equipment malfunction
705	Breach of regulation
706	Failure to ensure patient safety
707	Failure to obtain consent / lack of informed consent
708	Failure to protect 3rd party
709	Failure to test equipment
710	False imprisonment
711	(Legal, ethical, or moral) improper conduct
712	Inadequate utilization review
713	Negligent credentialing
714	Practitioner with communicable disease
715	Product liability
716	Religious issues
717	Sexual misconduct
718	Third party claimant

NPDB Allegation Codes	
719	Vicarious liability
720	Wrong life/birth
899	Cannot be determined from available records.
999	Allegation not otherwise classified

Item 17: City where injury occurred

Full name of the city in which the injury is alleged to have occurred. The city should correspond to the location of the alleged error or omission identified on item 14. If the injury did not occur in a city, leave blank.

Item 18: County where injury occurred

Full name of the county in which the injury is alleged to have occurred. The county should correspond to the location of the alleged error or omission identified on item 14.

Item 19: County FIPS Code

Five-digit Federal Information Processing Standard Code (FIPS) for the county in which the injury occurred. Do not omit leading zeros (001, 023, etc.). The FIPS code consists of the two-digit state code plus the three-digit county code (i.e. 26001). If the injury occurred outside of the United States, enter '99999.'

Item 20: Gender of injured person. Use M or F.

Item 21: Age of injured person at the date of injury.

Item 22: Severity of injury code

Code	Severity Description	Examples
Temporary Injuries (Codes 1-4)		
1	Emotional injury	Fright, no physical injury
2	Insignificant	Lacerations, contusions, minor scars or rash, no delay in recovery
3	Minor	Infection, fracture set improperly, fall in hospital. Recovery is delayed but complete
4	Major	Burns, surgical material left, drug side effect or brain injury. Recover is delayed but complete
Permanent Injuries		
5	Minor	Loss of fingers, loss or damage to minor organs. Injury is not disabling
6	Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung
7	Major	Paraplegia, blindness, loss of two limbs, or brain damage
8	Grave	Quadriplegia, severe brain damage, life-long care or fatal prognosis
9	Death	

Item 23: Date of injury

Report the date of the earliest alleged error or omission that was the first necessary if not sufficient cause of the alleged medical injury. This date should correspond to the error or omission code identified on item 14.

Item 24: Date claim was reported

The date that an insurer received a formal demand for payment for injuries arising out of alleged medical negligence. If no insurance coverage is available, use the date that the medical provider or facility received such notice.

Item 25: Date of lawsuit

The date a lawsuit was filed for this claim.

Item 26: Date claim was closed

The date of final disposition or settlement of a claim. Payments for defense costs or indemnity may occur **after** the date of closure (as in a structured settlement).

Item 27: Date of final indemnity payment

The date of the final indemnity payment, if applicable. If the final payment is scheduled for a future date, provide this date as best as can be determined when the claim is closed.

Item 28: Claim Disposition Code

Claim Disposition Codes	
Code	**Description**
1	Claim is abandoned by the claimant.
2	Claim is settled by the parties.
Claims disposed of by a court	
3a	Directed verdict for the plaintiff
3b	Directed verdict for the defendant
3c	Judgment notwithstanding verdict for the plaintiff (judgment for the defendant)
3d	Judgment notwithstanding verdict for the defendant (judgment for the plaintiff)
3e	Involuntary dismissal
3f	Judgment for the plaintiff
3g	Judgment for the defendant
3h	Judgment for the plaintiff after appeal
3i	Judgment for the defendant after appeal
Claims settled by an alternative dispute resolution process	
4a	Arbitration
4b	Mediation
4c	Private judging or private trial
4d	Other type of alternative dispute resolution process

Item 29: Timing of Disposition Code

Timing of Disposition	
1	Before filing suit or requesting arbitration or a mediation hearing
2	Before trial, arbitration or mediation
3	During trial, arbitration or mediation
4	After trial or hearing, but before judgment or award
5	After judgment or decision, but before appeal
6	During an appeal
7	After an appeal; or
8	During review panel or non-binding arbitration

Item 30: Indemnity paid by reporting entity

The amount of indemnity paid by the insurer reporting the claim, exclusive of any other amounts paid by any other insurer or party.

Note on items 31 and 32: Economic and noneconomic portions of total indemnity paid by all parties.

Amounts entered into items 31 and 32 should reasonably reflect available documentation obtained during the course of adjudicating a claim regarding actual economic costs incurred by the injured party due to the alleged medical negligence. Economic damages should reflect the reporting entity's best estimate of current and future lost wages, current and future medical costs, and any other pecuniary costs arising from the alleged act of malpractice. Arbitrarily apportioning economic and non-economic damages 50%-50% or via some other heuristic rule is not acceptable.

For costs that are not documented, each reporting entity should develop a reasonable methodology for imputing values. For example, lost life-time wages of a minor who lacks any employment history may be estimated via generally accepted econometric or actuarial methods that would be accepted in a court of law.

Noneconomic damages should not exceed any tort limitations such as damage caps that exist in the relevant jurisdiction. Within such constraints, noneconomic damages should bear a reasonable relationship to the nature and severity of the injury in terms of limitations on major life activities formerly enjoyed by the injured party, physical pain and suffering, loss of consortium, psychological or mental consequences of the injury, and any other reasonable non-pecuniary losses. Reporting entities should be prepared to document and justify allocation methodologies upon request of the insurance commissioner. **If the sum of estimated economic and non-economic damages exceeds total indemnity, the amount**s of both categories of indemnity **should be reduced by a proportionate amount.**

Item 31: Economic Indemnity

Portion of total indemnity designed to compensation an injured party for pecuniary losses, such as lost wages and medical costs attributable to the iatrogenic injury.

Item 32: Non-economic indemnity

Portion of the total indemnity designed to compensate an injured party for other than pecuniary losses, such as pain and suffering, diminished quality of life, or loss of consortium.

Defense and cost containment expenses should include overhead costs allocated to each claim. Such overhead costs include salaries, benefits, and other fixed costs.

Item 33: Defense and Cost Containment Expense for Legal Counsel

The portion of defense costs associated with legal counsel, including both in-house and outside counsel.

Item 34: Defense and Cost Containment Expense for Experts

The portion of defense costs associated with experts, including both in-house and outside experts.

Item 35: Defense and Cost Containment Expense Other than Legal Counsel of Experts

The remaining portion of defense and cost containment expenses not included in items 45 and 46.

Item 36: Total Defense and Cost Containment Expense

The sum of items 33, 34, and 35.

The following items should be completed only if a claim was brought to trial.

Item 37: Trial Type

If trial was started, indicate whether it was a bench trial (B) or jury trial (J).

Item 38: Number of liable defendants

If the trial resulted in a verdict, report the number of defendants that were found liable.

Item 39: Unadjusted Verdict

The amount of the total verdict for all defendants, prior to any adjustments due to damage caps, remittiturs, additurs, interest, of other adjustments.

Item 40: Plaintiff Fault

The percentage of fault assigned to the plaintiff.

Item 41: Insured Fault

The percentage of fault assigned to the reporting entity's insured.

Item 42: Liability Doctrine

Indicate whether liability governed by the doctrine of joint and several liability (J) or whether liability was separate (S).

Item 43: Verdict for Economic Damages

The amount of the verdict that was awarded based on economic damages.

Item 44: Verdict for Non-economic Damages

The amount of the verdict that was awarded based on non-economic damages.

Item 45: Verdict for Punitive Damages

The amount of the verdict consisting of punitive damages.

Item 46: Interest

The amount of pre-judgment interest awarded.

Item 47: Verdict Reduction

The amount by which the verdict was reduced because of damage caps, remittitur, or any other reason.

Item 48: Verdict Augmentation

The amount by which the verdict was increased as a result of additur.

Item 49: Final Verdict

Total judgment award by court after all adjustments to verdict.

Appendix 1

SCHEDULE T DATA RECONCILIATION FORM

Line Number	Line	Loss paid – number of claims	Losses paid – dollar amount
1	Schedule T, Supplement A		
2	Closed claim report totals		
3	Difference (Schedule A – Closed claims)		
	Adjustments to Schedule T		
4	Sch T – payments reported in current year on claims closed in prior years		
5	Sch T – claims not reported in quarterly claims data for other reasons (claim not reportable in this state, etc. Specify in separate explanation)		
6	Correction for other discrepancies (occurrence vs. claims reporting, other accounting issues, etc. Specify in separate explanation)		
7	Adjustments to Schedule T (Line 1 – line 4 – line 5 – line 6)		
	Adjustments to Claims Data		
8	Losses to be paid in future years on claims closed in current year		
9	Losses paid in prior years on claims closed in current year [note – this was on the TX form. I would suspect this is very unusual, and may be relegated to the "other" category]		
10	Claims not reported on Schedule T for other reasons (reported for another state, etc. Specify in separate explanation)		
11	Adjustments to claims data (line 2 – line 8 – line 9 – line 10)		
	Reconciled Amounts		
12	Difference in adjusted amounts (line 7 – line 10) – this line should equal 0.		
Explanation for adjustment on line 5:			
Explanation for adjustments on line 6:			
Explanation for adjustments on line 10:			

Appendix 2

SAMPLE CONFIDENTIALITY FORM

LIMITED DATA SET DATA USE AGREEMENT

This agreement is by and between the [state insurance department], hereinafter referred to as the Commissioner, and _____, hereinafter referred to as Requester.

This agreement addresses the conditions under which the Commissioner will disclose and Requester will obtain and use the limited data set specified herein. Requester agrees to abide by the provisions of this agreement in the use of the limited data set obtained from the Commissioner.

1. Description of Data. The following limited data set may be disclosed or used pursuant to this agreement:
   _____
   _____

2. Purpose of Agreement. Requester represents and, in furnishing the limited data set specified in this agreement, the Commissioner relies upon such representation that the limited data set will be used solely for the following purpose(s):
   _____
   _____

3. Point of Contact. The Commissioner designates the following individual as the Commissioner's point of contact for this agreement:

   _____
   Name of Point of Contact

   _____
   Street address

   _____
   City/ State/ Zip code

   _____ _____
   Phone number Fax

   _____
   E-mail

   All correspondence regarding this agreement, including, but not limited to, notification of change of custodianship, uses or disclosures of the limited data set not provided for by this agreement, disposition of the limited data set, and termination of this agreement, shall be addressed to the point of contact.

4. Custodial Responsibility. Requester names the following individual custodian of the designated record set on behalf of the Requester:

_____
Name of custodian

_____
Name of company or organization

_____
Street address

_____
City/ State/ Zip code

_____ __ _____
Phone number Fax

_____
E-mail

The custodian shall be responsible for the observance of all conditions of use and for the establishment and maintenance of safeguards as specified in this agreement to prevent unauthorized use. Requester shall notify the Commissioner in writing within fifteen (15) days of any change of custodianship. Notification of change of custodianship shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

5. Permissible Uses and Disclosures. Requester shall not use or further disclose the limited data set specified in this agreement except as permitted by this agreement or as required by federal law. Requester shall establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of and to prevent unauthorized use or access to the limited data set.

Requester shall not release or allow the release of the limited data set specified in this agreement to any persons or entities other than as permitted by this agreement.

Requester shall restrict disclosure of the limited data set to the minimum number of individuals who require the information in order to perform the functions of this agreement. Requester shall instruct individuals to whom the limited data set is disclosed of all obligations under this agreement and shall require the individuals to maintain those obligations.

Requester shall secure the limited data set when the data is not under the direct and immediate control of an authorized individual performing the functions of this agreement.

Requester shall not attempt to use the limited data set to track or link an individual's data, determine real or likely identities, gain information about an individual, or contact an individual.

Requester shall make a good faith effort to identify any use or disclosure of the limited data set not provided for by this agreement. Requester shall notify the Commissioner by certified mail, return receipt requested, or in person with proof of delivery within seventy-two (72) hours of discovery of any use or disclosure of the limited data set not provided for by this agreement of which Requester is aware. If applicable, the Requester shall return any record or records that become identified to the Commissioner by certified mail, return receipt requested, or in person with proof of delivery within seventy-two (72) hours of identification. All other copies of an identified record including a modified, hybrid or merged record shall be immediately destroyed.

A violation of this section shall constitute a material breach of this agreement.

6. Disclosure to Agents. Requester shall ensure that any agents of Requester, including, but not limited to, a contractor or subcontractor, to whom Requester provides the limited data set specified in this agreement agree to the same terms, conditions, and restrictions that apply to Requester with respect to the limited data set.

7. Release of Statistical and Research Results. Subject to the conditions of this agreement, aggregated statistical tabulations and research results derived from the limited data set specified in this agreement may be released or published; however, statistical tabulations or research results that may reveal information about an individual's record or lead to the identification of individuals shall not be published or released.

8. Penalties. Requester acknowledges that failure to abide by the terms of this agreement may subject Requester to penalties for wrongful disclosure of protected health information under federal law. Requester shall inform all persons with authorized access to the limited data set specified in this agreement of the penalties for wrongful disclosure of protected health information.

9. Indemnification. Requester agrees to indemnify, defend, and hold harmless the Commissioner from any or all claims and losses accruing to any person, organization, or other legal entity as a result of violation of this agreement by Requester or agents of Requester to the extent permitted by federal and state law.

10. Disposition of Data. Requester may retain the limited data set specified in this agreement until _____, hereinafter referred to as the retention date. Unless otherwise agreed to in writing, Requester shall destroy the limited data set and any information derived from its contents, including all copies, modified data, or hybrid or merged databases containing the limited data set, upon the retention date. Requester shall provide the Commissioner with written confirmation of the destruction of the limited data set information. If both parties agree in writing to amend the retention date, Requester shall extend the protections of this agreement and maintain the confidentiality of the limited data set until the amended retention date.

11. Term of Agreement. This agreement shall be effective upon execution by both parties and shall remain in effect until _____or until terminated by one of the parties. The Commissioner may, by no less than twenty-four (24) hours written notice to Requester, terminate this agreement upon material breach of this agreement. This agreement may be terminated by either party without cause upon thirty (30) days written notice. Notice of termination shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

The terms of this agreement may not be waived, altered, modified, or amended except by written agreement of both parties.

This agreement supersedes any and all agreements between the parties with respect to the use of the limited data set specified in this agreement.

In witness whereof, the Commissioner and Requester have caused this agreement to be signed and delivered by their duly authorized representatives as of the date set forth below.

For the Requester	**For the Commissioner**
Signature:_____	Signature: _____
Print name:_____	Print name: _____
Title: _____	Title: _____
Date:_____	Date: _____

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2010 Proc. 2nd Quarter, Vol. I 130, 111, 124, 129, 317-388, 432 (adopted).

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

NAIC MEMBER	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)

(An NAIC Guideline)

This Guideline, offered in two versions, is a revision of the Third Party Administrator Statute, which was first adopted by the NAIC as a model law in 1977 and which had been most recently amended in 2001. Version 1 of the Guideline expands the scope of the prior model by adding workers' compensation and stop-loss coverages. Version 2 of the Guideline omits workers' compensation, which makes it similar in scope to the prior model, with the difference being in those states where stop-loss insurance was defined as liability insurance and not as health insurance.

A state's best use of the Guideline will depend on whether it currently has a TPA law and/or whether it wants to have a TPA law that extends to the handling of workers' compensation claims:

- For a state that wishes to enact a TPA law that extends to workers' compensation, Version 1 should be an excellent starting point. Study the language carefully to make whatever amendments may be necessary on account of state-specific issues with workers' compensation, agent licensing and adjuster licensing statutes. The adjuster licensing statutes will probably require an especially careful examination to have a good "mesh" and to avoid duplicative requirements, while workers' compensation statutes will need to be studied to determine whether the provisions of this document regarding the rights of employers to involve themselves in claims handling or disputes are in agreement. While part of a possible response to conflicts could be to change adjuster licensing or workers' compensation laws to match this document, it is not the purpose of the Guideline to call for changes to other statutes. Although drafting notes will provide assistance in this regard, one should not skim over sections without drafting notes. There are more state-to-state differences than can be easily summarized by drafting notes.

- A state that already has a TPA law, but that wants to extend it to workers' compensation, will also find Version 1 to be an excellent reference. The advice for such a state is again to review this document carefully, looking to see where it differs from the state's current law and carefully noting where the changes proposed in this document may conflict with the state's other statutes.

- A state with or without a current TPA law, that wants to have a TPA law that does not extend to workers' compensation, is advised to consider Version 2. Version 2 is essentially the same as Version 1, but with provisions and language related to workers' compensation removed. This law still includes stop-loss and other refinements made to the previous NAIC model. Admittedly, the motivation for a state to make changes to its existing laws is likely to depend on whether it has identified a reason that it needs to "fix" its current laws. Absent the identification of any practical problems, states may assign a lower priority to the improvements contained in this document.

In addition to numerous editorial changes, some of the substantive changes to what was previously in the 2001 NAIC model law are as follow:

(a) The language of the 2001 model required individuals adjusting life and health claims to be licensed as TPAs, even though it is clear that it was never the intent of the drafters or the states that adopted the model to implement a licensure requirement for employees of TPAs or insurers adjusting life and health claims. In addition, the licensing provisions in the 2001 model allowed an individual to become licensed to act as a full-fledged TPA. While the Guideline has language to allow previously licensed individuals to be "grandfathered," it provides that only business entities can be newly licensed as TPAs. As a practical matter, licensure requirements are not cleanly met by an individual.

(b) The 2001 model exempted licensed insurers operating as TPAs from all requirements of the Act. The Guidelines maintain this exemption for lines other than workers' compensation. For workers' compensation, while Version 1 exempts insurers from licensure requirements and from audit and reporting requirements when they handle workers' compensation claims for an employer that is not their policyholder, it subjects such insurer/TPAs to many other operational requirements of the Act for workers' compensation.

(c) The Guideline adds cease & desist orders to those actions available to the commissioner and also addresses concerns that the 2001 model may have been deficient with regard to due process.

(d) The Guideline extends the life & health scope of the 2001 model to so-called "stop-loss" insurance. This may be viewed a clarification in states where stop-loss is already considered to be health insurance and cannot be written as liability insurance, but it will be a modest expansion in other states.

(e) Version 1 extends the scope of the 2001 model to workers' compensation insurance. One should note, however, that various provisions of the model applying to life & health are not uniformly extended to workers' compensation. There is an extensive new section dealing with workers' compensation contracts between insurers and TPAs, and between TPAs and insured employers.

(f) Version 1 will not allow a TPA to agree with an employer to have the employer adjust its own workers' compensation claims, and an employer cannot avoid this prohibition by simply licensing an affiliated business entity as a TPA in order to handle its own workers' compensation claims.

(g) Version 1 exempts payments made by employers to TPAs for handling workers' compensation claims under a large deductible contract from premium taxes.

(h) The account-related provisions in the 2001 model were substantially revised. Most notably, the Guideline deletes the requirement that accounts administered by the TPA must be in the name of the insurance company, as long as claims trust funds held by the TPA are not commingled with premium trust funds.

THIRD PARTY ADMINISTRATOR ACT
(NAIC Guideline Version 1)

Drafting Note: This "version 1" guideline includes workers' compensation, while the "version 2" guideline excludes workers' compensation. A state that intends to adopt a TPA law should start with the version that is appropriate for its needs.

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Section 1. Definitions

For purposes of this Act:

A. "Affiliate or affiliated" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

B. "Business entity" means a corporation, association, partnership, limited liability company or other legal entity.

Drafting Note: Many laws use very broad definitions of "entity" that include individuals. Provisions of this Act referring to business entities are specifically intended to exclude individuals, as the full scope of TPA responsibilities and requirements are not well-suited to licensure of an individual. In addition, an overbroad definition of entity or "business entity" could result in individuals working for TPAs being required to be individually licensed as TPAs.

C. "Collateral" means funds, letters of credit or any item with economic value owned by the payor but held by an insurer or TPA in case it needs to be used to fulfill premium or loss reimbursement obligations in accordance with a contract between the insurer or TPA and the payor. "Collateral" shall include anticipated loss prepayments made prior to the payment of losses, pursuant to arrangements where reimbursement is not due until after losses have been paid.

D. "Commissioner" means the Commissioner of Insurance of this state.

E. "Control" (including the terms "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert appropriate reference to state law regulating holding companies] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. "GAAP" means United States generally accepted accounting principles consistently applied.

G. "Home state" means the United States jurisdiction that has adopted this Act or a substantially similar law governing TPAs and that has granted the TPA a home state TPA license.

H. "Insurer" means an entity licensed in a United States jurisdiction to provide life, annuity, health or stop-loss coverage as an insurance company, health maintenance organization, fraternal benefit society or prepaid hospital or medical care plan.

Drafting Note: States that license multiple employer welfare arrangements (MEWAs) or workers' compensation self-insurance groups, or that authorize employee leasing companies or professional employer organizations (PEOs) to provide employee welfare benefits on a self-funded basis, will want to include these entities in the list of entities that are included in the definition of insurer for purposes of this Act, but only to the extent of their license or authorization. It is not the intention of this drafting note to include employee leasing companies or PEOs authorized to self-insure workers' compensation within the definition of "insurer." Rather, this Act contemplates that such an entity, when authorized as a workers' compensation self-insurer, will be considered to be a "workers' compensation self-insurer," which is a term that is already defined under this Act.

I. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

Drafting Note: States that use different terminology such as "agent" and/or "broker" should make appropriate adjustments to this language. In states that do not license business entities as insurance producers, use the following definition:

I. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, and also includes a business entity whose primary activities are the sales, solicitation and negotiation of insurance.

J. "Master services agreement" means a written agreement between an insurer and a TPA that specifies standards for the handling of workers' compensation claims and the handling of funds belonging to the insurer or policyholder in connection therewith.

K. "Nonresident TPA" means a TPA whose home state is any jurisdiction other than this state.

L. "Payor" means an insurer, a workers' compensation self-insurer, or an employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control.

M. "Person" means an individual or a business entity.

N. "Stop-loss insurance" means insurance protecting an employer or other person responsible for an otherwise self-insured health or life benefit plan against obligations under the plan, but "stop-loss insurance" does not include reinsurance written for an insurance company.

Drafting Note: The inclusion of the stop-loss definition and the inclusion of stop-loss throughout this law are not necessary in states where stop-loss is clearly stipulated to be health insurance and cannot be interpreted to be liability insurance or some other form of insurance. In such states, references to stop-loss may be deleted or – if retained – viewed as a clarification (as stop-loss is considered to be liability insurance in some states).

O. "Third party administrator" or "TPA" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, health, stop-loss or workers' compensation coverage, except that a person shall not be considered a TPA if that person's only actions that would otherwise cause it to be considered a TPA are among the following:

(1) A person working for a TPA to the extent that the person's activities are subject to the supervision and control of the TPA;

(2) An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control, except that workers' compensation shall not be considered as an "employee benefit plan;"

(3) The administration of a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on [*an appropriate recent date should be selected*];

(4) A workers' compensation self-insurer that has been approved by [agency responsible for the approval of workers' compensation self-insurance] or an employer otherwise authorized by law to administer its workers' compensation obligations to its employees or co-employees, while administering workers' compensation benefits for its employees or co-employees;

(5) A union administering a benefit plan on behalf of its members;

(6) An insurer administering insurance coverage for its policyholders, subscribers or certificate holders, or those of an affiliated insurer under common management and control;

(7) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums from, or adjusting or settling claims for life, annuity, health or stop-loss insurance on behalf of a client that is not a policyholder, subscriber or certificate holder, and that has its United States headquarters or principal location of business in a jurisdiction in which the insurer is licensed to write that coverage;

(8) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums, or adjusting or settling claims for life, annuity, health or stop-loss insurance, provided that the insurer is licensed in this state to write that line of insurance coverage;

(9) An insurance producer selling insurance or engaged in related activities within the scope of the producer's license, except that this shall not include the adjusting or settling of workers' compensation claims;

(10) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(11) A trust and its trustees and agents acting pursuant to such trust established in conformity with 29 U.S.C. Section 186;

(12) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees acting pursuant to such trust, or a custodian and the custodian's agents acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(13) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, when collecting or remitting premiums to licensed insurance producers or to limited lines producers or authorized payors in connection with loan payments;

(14) A credit card issuing company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;

(15) An individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage;

(16) A person licensed as a managing general agent in this state when acting within the scope of that license; or

(17) A business entity licensed pursuant to [insert statutory reference] to adjust workers' compensation loss claims, but only if that entity does not receive or manage funds from employers or other persons whose workers' compensation claims are being adjusted and does not manage or control related funds of the payor that is ultimately responsible for the claims.

Drafting Note: The above exception to the definition of "third party administrator" and "TPA" should be included if the state licenses adjusting firms to handle workers' compensation or other claims that would fall under the scope of this act. The drafting shown is for a state that licenses firms to adjust workers' compensation claims, but not other types of claims subject to this act. If the state also licenses firms to adjust life, health or stop-loss claims, then this wording should be amended accordingly. If the state licenses individuals but not business entities to adjust claims, the state should consider whether to include an exemption for business entities that do not handle client funds and whose only TPA activities are claims adjustment performed by licensed adjusters.

(18) A business entity that is affiliated with a licensed insurer while acting as a TPA for the direct and assumed insurance business of an affiliated insurer;

(19) A person providing network access services or the re-pricing of charges of participating providers for medical care rendered persons covered under workers' compensation, including related case management or credentialing services, as long as such person does not manage or control related funds of the payor that is ultimately responsible for the workers' compensation claims, and as long as such person does not engage in advising or determining whether a workers' injury is eligible for workers' compensation coverage.

P. "Underwrites" or "underwriting" means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals and the overall planning and coordination of a benefits program.

Q. "Uniform Application" means the current version of the NAIC Uniform Application for Third Party Administrators.

R. "Workers' compensation" means a government-mandated or authorized system of medical and disability benefits applying to workers and their dependents or other beneficiaries, and which arise from on-the-job injuries or disease. Workers' compensation does not include indemnification of an employer under excess workers' compensation policies, when that employer has been approved by the responsible government agency to self-insure its responsibility to provide benefits.

S. "Workers' compensation self-insurer" means an employer or co-employer approved by [agency responsible for the approval of workers' compensation self-insurance] or otherwise authorized by law to assume primary financial responsibility for the payment of workers' compensation benefits to its employees or co-employees, instead of transferring this primary financial responsibility to an insurer in exchange for an insurance premium, whether the payment of such benefits is administered by the employer, co-employer or a TPA.

Section 2. Licensing Necessary

A. No person shall act as a TPA in this state unless that person is licensed as a TPA pursuant to this Act or unless the TPA is exempted from this Act's licensing requirement pursuant to subsection B of this section or subsections G or H of section 15 of this Act. This prohibition shall not apply to a person while employed by, or when operating under contract to, a TPA that is licensed pursuant to this Act, or exempted from this Act's licensing requirements pursuant to subsection B of this section or subsections G or H of section 15 of this Act. The authority granted to a TPA pursuant to this Act does not exempt its employees from the licensing requirements of [*reference to adjuster licensing act*].

Drafting Note: The last sentence of the preceding subsection should be deleted in states that do not require the licensing of adjusters for any of the lines of insurance falling within the scope of this Act.

B. An insurer that also operates as a TPA for workers' compensation in this state shall be exempt from sections 13 through 16 of this Act if it is licensed to write workers' compensation insurance in this state.

Section 3. Workers' Compensation; Agreement with an Affiliated TPA

If an agreement between a TPA and an insurer would result in the expectation that more than thirty percent of the workers' compensation claim costs to be adjusted by the TPA in this state would be for employees or co-employees of the TPA or its affiliates, then the TPA and the insurer must submit the agreement to the [*agency responsible for the approval of workers' compensation self-insurance*] for prior approval and the agreement may not take effect until it has been approved. In considering the proposed agreement for approval or disapproval, the [*agency responsible for the approval of workers' compensation self-insurance*] shall apply the same standards that are applied to consider approval of the claims-handling activities of workers' compensation self-insurers in this state. To determine the expectation of claim costs, the TPA and the insurer shall use the *[rates or loss costs]* published by the state's designated workers' compensation advisory organization.

Drafting Note: The reference in the last sentence of this paragraph should be fitted to the state's workers' compensation rate regulatory structure.

Section 4. Payment to a TPA

If an insurer utilizes the services of a TPA, any premiums or charges for insurance paid to the TPA by or on behalf of the insured party, or any collateral furnished to the TPA by or on behalf of the insured party, shall be deemed to have been received by the insurer, and the return of collateral or the payment of return premiums or claim payments forwarded by the insurer to the TPA shall not be deemed to have been paid to the insured party or claimant until the payments are received by the insured party or claimant. Nothing in this section limits any right of the insurer against the TPA resulting from the failure of the TPA to make payments to the insurer, insured parties or claimants.

Section 5. Maintenance of Information

A. A TPA shall maintain and make available to the payor complete books and records of all transactions performed on behalf of the payor. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and shall be maintained for a period of not less than five (5) years from the date of their creation.

B. The commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit and inspection. Any documents, materials or other information in the possession or control of the commissioner that are furnished by a TPA, payor, insurance producer or an employee or agent thereof acting on behalf of the TPA, payor or insurance producer, or obtained by the commissioner in an investigation shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be not subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

C. Neither the commissioner nor any person who receives documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning confidential documents, materials, or information subject to Subsection B of this section.

D. In order to assist in the performance of his or her duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) [**OPTIONAL]** May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection D(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D of this section.

F. Nothing in this Act shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

G. Notwithstanding any contractual agreements between the payor and the TPA that operate to the contrary, the TPA shall retain the right to sufficient continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the payor.

H. In the event the payor or the TPA cancel their agreement; notwithstanding the provisions of Subsection A of this section, the TPA may, by written agreement with the payor, transfer all records to a new TPA rather than retain them for five (5) years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in Subsection A of this section.

Section 6. Approval of Advertising

A TPA that advertises on behalf of its client may only use advertising that has been approved in writing by the client in advance of its use. A TPA that mentions any current or former client in its advertising must obtain the client's prior written consent.

Section 7. Responsibilities of the Payor and TPA

A. No TPA shall act as such without a written agreement between the TPA and the payor. A copy of the agreement shall be retained by the TPA for the duration of the agreement and for five (5) years thereafter. The agreement shall contain all provisions required by this section, except insofar as the TPA does not perform all of the functions referenced in this section.

B. A payor that utilizes the services of a TPA shall retain responsibility for the benefits, premium rates, collateral and reimbursement procedures, underwriting criteria and claims payment procedures applicable to the coverage and for securing reinsurance or stop-loss insurance, if any. The rules pertaining to these matters, to the extent that they are relevant to the duties of the TPA, shall be agreed to in writing by the payor and the TPA.

C. An insurer utilizing the services of a TPA is responsible for the acts of the TPA and is responsible for providing the TPA's books and records relevant to the insurer to the commissioner upon request.

D. The written agreement between the TPA and the payor shall provide that communications between the TPA and claimants shall avoid deceptive statements with regard to the responsibilities of the TPA, payor and any insurer with regard to claims or premiums.

(1) If the TPA is also an insurer, then communications with claimants shall be designed to avoid the impression that coverage provided for the claimants is pursuant to insurance written by the insurer or an affiliated insurer.

(2) For workers' compensation coverage, if the TPA is employed by an insurer or by a large deductible policyholder, then communications with claimants shall be designed to avoid the impression that coverage provided to the claimants is pursuant to self-insurance by an employer or other entity, even when the amounts payable by the employer or other entity are a function of the claims paid on its behalf.

E. In the event of a dispute between the payor and the TPA regarding which of them is to fulfill a lawful obligation with respect to a policy, certificate or claim subject to the written agreement, the payor shall fulfill such obligation.

F. For workers' compensation, the TPA shall establish and maintain means for the payor to identify a responsible person with the TPA when the payor is contacted by a claimant or a representative of a claimant, or by the insurance department or industrial commission. Upon request, the payor shall provide this information to a claimant, a representative of a claimant, or to the insurance department or industrial commission.

G. The payor has the duty to provide for competent administration of its programs administered by a TPA and within the scope of this Act.

H. When a TPA administers benefits in connection with life, annuity, health and employee benefit stop-loss coverage for more than one hundred (100) certificate holders, subscribers, claimants or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one such review shall include an on-site audit of the operations of the TPA. The cost of such reviews or audits shall be borne by the insurer and not reimbursed by the TPA. The requirements of this subsection shall not apply when the TPA and the insurer are affiliated.

Section 8. Premium Collection and Payment of Claims

A. All insurance charges, premiums, collateral and loss reimbursements collected by a TPA on behalf of or for a payor, the return of premiums or collateral received from a payor, and any funds held by the TPA for the payment of claims, shall be held by the TPA in a fiduciary capacity. Funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the TPA in a federally insured financial institution. The TPA shall render a periodic accounting to the payor detailing all transactions performed by the TPA pertaining to the business of the payor, and the written agreement between the payor and the TPA shall include the specifications of this reporting.

B. The TPA shall keep copies of all records of any fiduciary account maintained or controlled by the TPA, and, upon request of a payor, shall furnish the payor with copies of the records pertaining to the deposits and withdrawals made on behalf of the payor. If funds deposited in a fiduciary account have been collected on behalf of or for more than one payor, or for the payment of claims associated with more than one policy, the TPA shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each payor and relating to each policyholder.

C. The TPA shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges, other than collateral or loss reimbursements for workers' compensation, are deposited. Withdrawals from a fiduciary account shall be made as provided in the written agreement between the TPA and the payor, and only for the following purposes:

(1) Remittance to a payor entitled to remittance;

(2) Deposit in an account maintained in the name of the payor;

(3) Transfer to and deposit in a claims-paying account, with claims to be paid as provided in Subsection D of this section;

(4) Payment to a group policyholder for remittance to the payor entitled to such remittance;

(5) Payment to the TPA of its earned commissions, fees or charges;

(6) Remittance of return premium to the person or persons entitled to such return premium; and

(7) Payment to other service providers as authorized by the payor.

D. All claims paid by the TPA from funds collected on behalf of or for a payor shall be paid only as authorized by the payor. Payments from an account maintained or controlled by the TPA for purposes including the payment of claims may be made only for the following purposes:

(1) Payment of valid claims;

(2) Payment of expenses associated with claims handling to the TPA or to other service providers approved by the payor;

(3) Remittance to the payor, or transfer to a successor TPA as directed by the payor, for the purpose of paying claims and associated expenses; and

(4) Return of funds held as collateral or prepayment, to the person entitled to those funds, upon a determination by the payor that those funds are no longer necessary to secure or facilitate the payment of claims and associated expenses.

Section 9. Compensation to the TPA

A. A TPA shall not enter into an agreement or understanding with a payor or, with regard to workers' compensation, a payor, employer or co-employer in which the effect is to make the amount of the TPA's commissions, fees, or charges contingent upon savings effected in the payment of losses covered by the payor's obligations. This provision shall not prohibit a TPA from receiving performance-based compensation for providing hospital or other auditing services, from providing managed care or related services, or from being compensated for subrogation expenses.

B. A payor shall not enter into an agreement with a TPA in violation of this section.

C. This section shall not prevent the compensation of a TPA from being based on premiums or charges collected or the number of claims paid or processed.

Section 10. Disclosure of Charges and Fees

A. When a TPA collects funds, the reason for collection of each item shall be identified to the insured party and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been already paid for by the payor.

B. The TPA shall disclose to the payor all charges, fees and commissions that the TPA receives arising from services it provides for the payor, including any fees or commissions paid by payors providing reinsurance or stop-loss insurance.

Section 11. Workers' Compensation; Agreements and Communication between Employers, TPAs and Insurers

No TPA shall enter into any agreement with any employer or co-employer, except a workers' compensation self-insurer, for the adjustment or handling of workers' compensation claims for its employees or co-employees that are residents of this state, or accept compensation of any kind for the adjustment or handling of workers' compensation claims for employees or co-employees that are residents of this state, unless it has a master services agreement applying to such claims with the insurer responsible for the payment of claims attributable to the employer or co-employer. This section does not apply when the employer or co-employer is an insurer.

A. The following provisions apply to master services agreements:

(1) The insurer may have more than one master services agreement with a given TPA, but it must be unambiguous which master services agreement applies for a given claim.

(2) The provisions of this Act shall prevail in the case of any conflicts between it and the master services agreement.

(3) The provisions of the master services agreement shall prevail in the case of any conflicts between it and a contract or agreement between the TPA and the employer or co-employer.

(4) The provisions of this Act shall prevail in the case of any conflicts between it and the contract or agreement between the TPA and the employer or co-employer.

(5) The master services agreement shall address any conversion of collateral held by the TPA on behalf of the insurer and shall address other details of funds management.

(6) If the TPA receives funds directly from the employer or co-employer for claims or claims handling expense, then the master services agreement must provide for uninterrupted claims handling in the event that the employer or co-employer stops paying the TPA for any reason.

(7) Each insurer and TPA must maintain copies of all master services agreements to which they are a party. These agreements shall be made available for inspection by the insurance department or the industrial commission upon request, but these agreements shall be treated as proprietary and this availability shall not be used to disclose an agreement to a third party without the permission of all parties to the agreement.

(8) The insurer may terminate the obligation and the ability of the TPA to settle claims on its behalf for an employer or co-employer at any time upon advance notice to the TPA and to the employer or co-employer.

(9) The master services agreement must make provisions for statistical reporting as required by law or regulation, and must make provision for statistical reporting and records management in the event of termination of the TPA's responsibility for the handling of an employer or co-employer, or in the event of termination of the master services agreement.

B. Subject to other provisions of this Act, contracts or agreements between a TPA and an employer or co-employer relating to workers' compensation for the employer's or co-employer's employees or co-employees may have the TPA paid or paid in part by the employer or co-employer. The following provisions apply to such funds and to reimbursements made through the conversion of collateral held by an TPA relating to a employer or co-employer:

(1) When a TPA enters into a contract or agreement with an employer or co-employer relating to workers' compensation for the employer's or co-employer' employees, the TPA shall disclose to the employer or co-employer any charges, fees or commissions that it receives as compensation for such work from any insurer.

(2) The master services agreement may authorize the TPA to handle receipts and payments on behalf of the insurer relating to premium, collateral, and reimbursement for loss payments and expenses arising out of the adjusting of claims.

(3) Payments by the employer or co-employer to the TPA for its claims adjusting services under a large deductible policy, if made directly to the TPA and not by the insurer to the TPA, and if the insurer does not assume a risk that such payments may be higher than an expected amount, do not need to be reported by the insurer as premium on its Annual Statement. All other payments, other than collateral, made by the employer or co-employer to a TPA relating to coverage under a large deductible policy must be reported by the TPA to the insurer and reported by the insurer as premium on its Annual Statement. For purposes of this section, a large deductible policy is considered to be any workers' compensation deductible policy approved by the Commissioner with a per-accident deductible of no less than one hundred thousand dollars and, if applicable, an aggregate deductible of no less than two hundred fifty thousand dollars, provided that both such deductibles must be retained by the employer or co-employer and not insured or reinsured in any fashion by any insurer not affiliated with the employer or co-employer.

Drafting Note: The definition of large deductible in Subsection B(2) should be made consistent with the minimum standards for large deductible approval otherwise contemplated in state law.

(4) Any payments made by the employer or co-employer to the TPA, that are not collateral and are not reimbursement for claims or claim adjusting expenses, and are attributable to workers' compensation for employees or co-employee that are residents of this state, shall be reported by the insurer as premium on its Annual Statement. For purposes of this paragraph, conversion of collateral to satisfy an obligation of the employer or co-employer shall be considered a payment.

C. The TPA must retain copies of all contracts, agreements and amendments thereto between the TPA and an employer or co-employer relating to claims covered by the insurer under a statutory workers' compensation policy. Upon request, the TPA must promptly provide the insurer with a copy of any contract, agreement or amendment thereto between the TPA and an employer or co-employer relating to claims covered by the insurer under a statutory workers' compensation policy. The insurer and the TPA shall make all such agreements in their possession available for inspection by the insurance department or the industrial commission upon request, but these agreements shall be treated as proprietary and this availability shall not be used to disclose an agreement to a third party without the permission of all parties to the agreement.

D. If provision for such cancellation is contained in the insurance policy, an insurer may cancel the policy for nonpayment if the employer fails to pay the TPA for services relating to claims that are the ultimate responsibility of the insurer. The endorsement addressing the use of the TPA and the employer's or co-employer's obligation to pay the TPA may provide that the employer or co-employer is also obligated to pay the insurer for any amounts that the insurer pays the TPA should the employer or co-employer not pay the TPA on a timely basis.

E. No contract between an employer and a TPA may provide or allow administration of claims by the employer or co-employer unless self-administration of claims by the employer or co-employer has either been approved by the [*agency responsible for approval of workers' compensation self-insurance*] or the employer or co-employer is otherwise authorized by law to administer its own claims in this state.

F. No contract or agreement between an employer and a TPA or an insurer may give the employer the right to deny a claim. If an employer recommends that a TPA deny a claim, then the TPA may do so if such action is consistent with the claims handling standards provided by the insurer.

Drafting Note: Subsection F should be amended as necessary in those states that give the employer specific rights to dispute or deny workers' compensation claims. The section is not intended to reduce the rights of the employer to less than it would otherwise have under state law.

G. An insurer shall not permit a TPA to delegate authority to an employer or co-employer in violation of this section.

H. A contract or an agreement between an employer and a TPA may give the employer the right to have amounts paid that otherwise may be disputed by the insurer or the TPA. In the event that a contract or agreement has this provision, the insurer must be given a copy of the contract or advised of the existence of these provisions on a timely basis after the contract or agreement is entered into or amended to include a provision of this nature, except when the insurer has already given the TPA or the policyholder written permission for this arrangement. This subsection shall not be interpreted, however, to give this right to an employer absent a provision in the contract or agreement between it and the TPA, and it shall not be interpreted as meaning that the insurer that has not already given permission cannot refuse to accept such provisions within a reasonable time after their receipt by the insurer.

I. When a contract or agreement exists between the TPA and the employer, there must be an endorsement attached to each related statutory workers' compensation policy to indicate the existence of that contract or agreement. If applicable, the endorsement must recognize the obligations of the policyholder to pay the TPA. If applicable, this endorsement must recognize the obligation of the employer or co-employer to reimburse the insurer if the insurer pays the TPA to assure continued claims services in the event of the employer's or co-employer's failure to pay. In addition, the endorsement shall provide that, in the event that the insurer terminates the TPA's role in handling claims for the employer, the employer or co-employer shall have the ability to cancel the policy without a short rate penalty if it replaces its insurance with another insurer, but using the same TPA.

Section 12. Delivery of Materials to Covered Individuals

Any policies, certificates, booklets, termination notices or other written communications delivered by the payor to the TPA for delivery to insured parties or covered individuals shall be delivered by the TPA promptly after receipt of instructions from the payor to deliver them.

Section 13. Home State TPA License

A. If a TPA is incorporated in this state or this state is its principal place of business within the United States, then the TPA may designate this state as its home state and apply to this state for licensure as a TPA. If neither the state in which a TPA is incorporated nor the state that is its principal place of business have adopted this Act or a substantially similar law governing TPAs, and if the TPA has not designated any other state that has adopted this Act or a substantially similar law governing TPAs as its home state, then the TPA may apply for licensure to this state as its home state.

B. A TPA applying to this state as its home state shall apply for licensure using the Uniform Application and designate an individual as the TPA's contact person for department communications.

Drafting Note: The contact person requirement in subsection B and the related part of the notification requirement in subsection J are recommended options for those states with computer systems or licensing and filing procedures for which the designation of a "responsible person" is necessary.

C. If a TPA designates this state as its home state because neither its state of incorporation nor the state that is its principal place of business within the United States have adopted this Act or a substantially similar law governing TPAs, but if one or both of these other jurisdictions have licensed the TPA, then the commissioner may consult with that state or states and may give due consideration to any relevant findings made by that state or states in order to avoid an unnecessarily duplicative review of the application.

D. The Uniform Application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;

(2) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(3) NAIC Biographical Affidavit for the individuals who are responsible for the conduct of affairs of the applicant; including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant;

(4) Audited annual financial statements or reports for the two (2) most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The applicant shall also include such other information as the commissioner may require to review the current financial condition of the applicant.

(5) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting; and

(6) Such other pertinent information as may be required by the commissioner.

E. A TPA licensed or applying for licensure under this section shall make available for inspection by the commissioner copies of all contracts with payors or other persons utilizing the services of the TPA.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. The commissioner may refuse to issue a license if the commissioner determines that the TPA or any individual responsible for the conduct of affairs of the TPA is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction, or if the commissioner determines that any of the grounds set forth in Section 15 of this Act exists with respect to the TPA.

H. A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in compliance with this Act.

I. An individual may not qualify for licensure under this section, except that an individual previously licensed as a TPA with this state as its home state shall retain that license, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in substantial compliance with this Act.

Drafting Note: The "grandfather" provision in Subsection I addresses situations where states amending their TPA Act may already have individuals licensed under their current TPA law. The old TPA model allowed (and ostensibly required) individuals fulfilling TPA functions to be licensed as TPAs. It was never the intent of the previous drafting to require that every individual employed by a TPA to be individually licensed, although it arguably may have been intended that an individual could form a TPA without incorporating and get a license for that operation. This subsection can be removed in states that have an existing TPA law, but where all current licensees qualify as "business entities." States that are newly adopting a TPA law can also delete this subsection, as no entity could have previously held a license as a TPA.

J. A TPA licensed or applying for licensure under this section shall notify the commissioner within thirty days of any material change in its ownership, control, contact person for the TPA or other fact or circumstance affecting its qualification for a license in this state. The commissioner shall report any such changes to (insert name of the appropriate electronic database).

K. A TPA licensed or applying for a license under this section that administers or will administer governmental or church self-insured plans in this state or any other state shall maintain a surety bond for the use and benefit of the commissioner and the insurance regulatory authority of any additional state in which the TPA is authorized to conduct business and cover individuals and persons who have remitted premiums or insurance charges or other monies to the TPA in the course of the TPA's business in the greater of the following amounts:

(1) $100,000; or

(2) Ten percent (10%) of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in this state and all additional states in which the TPA is authorized to conduct business.

Section 14. Registration Requirement

A person who is not required to be licensed as a TPA under this Act and who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, only in connection with life, annuity or health coverage provided by a self-funded plan other than a governmental or church plan, shall register with the commissioner annually, verifying its status as herein described. This section shall not apply to an insurer or to an individual performing these actions as an employee of an insurer. This section shall also not apply to a person performing these actions under contract to or as an employee of a TPA.

Section 15. Nonresident TPA License

A. Unless a TPA has obtained a license in this state under Section 13, any TPA who performs TPA duties in this state shall obtain a nonresident TPA license in accordance with this section by filing with the commissioner the Uniform Application, accompanied by a letter of certification. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the commissioner may verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

B. A TPA shall not be eligible for a nonresident TPA license under this section if it does not hold a home state certificate of authority or license in a state that has adopted this Act or that applies substantially similar provisions as are contained in this Act to that TPA. If the Act in the TPA's home state does not extend to stop-loss and workers' compensation insurance, but if the home state otherwise applies substantially similar provisions as are contained in this Act to that TPA, then that omission shall not operate to disqualify the TPA from receiving a Nonresident TPA license in this state.

C. Except as provided in Subsection B of this section and in section 17, the commissioner shall issue a nonresident TPA license to the TPA promptly upon receipt of a complete application.

D. Unless notified by the commissioner that the commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, each nonresident TPA shall annually file a statement that its home state TPA certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year.

E. At the time of filing the statement required under Subsection D of this section or, if the commissioner has notified the nonresident TPA that the commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database, on an annual date determined by the commissioner, the nonresident TPA shall pay a filing fee as required by the commissioner.

Drafting Note: The filing of the statement or time set for payment of the fee should be after September 1 so that it follows the nonresident TPA's annual renewal of its home state certificate of authority or license.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA's duties in this state are limited to the administration of group policies or plans of insurance and no more than one hundred (100) certificate holders for all such plans reside in this state.

H. A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA's duties in this state are limited to the administration of workers' compensation claims and the TPA administers less than twenty-five workers' compensation claims per calendar year in this state. This exemption shall continue to apply to a nonresident TPA exempted by this subsection until ninety days after the date that it has had twenty-five claims reported to it during a calendar year by employees whose claimed injury or disease arose from employment in this state. A TPA with a current nonresident TPA license shall be eligible for this exemption at its next renewal date following a calendar year in which it has had less than twenty-five claims reported to it during that calendar year by employees whose claimed injury or disease arose from employment in this state. The exemption described in this subsection shall not apply, however, to a TPA with a client that is an employer principally based in this state, or that has a professional employer organization as a client that is responsible for the workers' compensation obligations of a client that is principally located in this state.

Section 16. Annual Report and Filing Fee

A. Each TPA licensed under Section 13 shall file an annual report for the preceding calendar year with the commissioner on or before July 1 of each year, or within such extension of time as the commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two (2) officers of the TPA.

B. The annual report shall include the complete names and addresses of all payors with which the TPA had agreements during the preceding fiscal year.

C. At the time of filing its annual report, the TPA shall pay a filing fee as required by the commissioner.

D. The commissioner shall review the most recently filed annual report of each TPA on or before September 1 of each year. Upon completion of its review, the commissioner shall either:

(1) Issue a certification to the TPA that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in that annual report and financial statements; or

(2) Update any electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicating that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and complies with existing law, or noting any deficiencies found in the annual report.

Section 17. Grounds for Denial, Suspension or Revocation of Licensure

A. The commissioner shall, deny, suspend or revoke the license of a TPA, or shall issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

(1) Is in an unsound financial condition;

(2) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or

(3) Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.

B. The commissioner may deny, suspend or revoke the license of a TPA, or may issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

(1) Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state;

(2) Has refused to be examined or to produce its accounts, records and files for examination, or if any individual responsible for the conduct of affairs of the TPA, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the TPA; and any other person who exercises control or influence over the affairs of the TPA; has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination, when required by the commissioner;

(3) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA or a payor which it represents to secure full payment or settlement of such claims;

(4) Is required pursuant to this Act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the commissioner, unless the commissioner issued a license with knowledge of the ground for disqualification and had the authority to waive it;

(5) If any of the individuals responsible for the conduct of its affairs, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of its voting stock, voting securities or voting interest; and any other person who exercises control or influence over its affairs; has been convicted of, or has entered a plea of guilty or *nolo contendere* to, a felony without regard to whether adjudication was withheld;

(6) Is under suspension or revocation in another state; or

(7) Has failed to file a timely annual report pursuant to Section 16, if a resident TPA, or a timely statement and filing fee, as applicable, pursuant to Sections 15D and E, if a nonresident TPA. This requirement does not apply to a TPA that is an insurer exempted pursuant to Section 2B.

C. (1) The commissioner, in his or her discretion, without advance notice, and before a hearing, may issue an order immediately suspending the license of a TPA, or may issue a cease and desist order should the TPA not have a license, if the commissioner finds that one or more of the following circumstances exist:

(a) The TPA is insolvent or impaired;

(b) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the TPA has been commenced in any state; or

(c) The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(2) At the time an order has been issued by the commissioner in accordance with Paragraph (1) of this subsection, the commissioner shall serve notice to the TPA that the TPA may request a hearing within ten business days after the receipt of the order. If a hearing is requested, the commissioner shall schedule a hearing within ten business days after receipt of the request. If a hearing is not requested and the commissioner orders none, the order shall remain in effect until modified or vacated by the commissioner.

D. If the commissioner finds that one or more grounds exist for the suspension or revocation of a license issued under this part, or for a cease and desist order, the commissioner may, in lieu of or in addition to the suspension, revocation or cease and desist order, impose a fine upon the TPA.

Drafting Note: States with disciplinary provisions of general applicability for regulated insurance entities may wish to incorporate such provisions by reference and should revise the provisions of this section to the extent inconsistent with the state's general statutory scheme.

Section 18. Effective Date

Drafting Note: If a TPA act was already in effect, but is now being amended to include workers' compensation and stop-loss insurance, it will be necessary to include a prospective effective date for this extension that does not affect the applicability of the Act to other types of coverage.

THIRD PARTY ADMINISTRATOR ACT
(NAIC Guideline Version 2)

Drafting Note: This "version 2" guideline excludes workers' compensation, while the "version 1" guideline includes workers' compensation. A state that intends to adopt a TPA law should start with the version that is appropriate for its needs.

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Section 1. Definitions

For purposes of this Act:

A. "Affiliate or affiliated" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

B. "Business entity" means a corporation, association, partnership, limited liability company or other legal entity.

Drafting Note: Many laws use very broad definitions of "entity" that include individuals. Provisions of this Act referring to business entities are specifically intended to exclude individuals, as the full scope of TPA responsibilities and requirements are not well-suited to licensure of an individual. In addition, an overbroad definition of entity or "business entity" could result in individuals working for TPAs being required to be individually licensed as TPAs.

C. "Collateral" means funds, letters of credit or any item with economic value owned by the payor but held by an insurer or TPA in case it needs to be used to fulfill premium or loss reimbursement obligations in accordance with a contract between the insurer or TPA and the payor. "Collateral" shall include anticipated loss prepayments made prior to the payment of losses, pursuant to arrangements where reimbursement is not due until after losses have been paid.

D. "Commissioner" means the Commissioner of Insurance of this state.

E. "Control" (including the terms "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert appropriate reference to state law regulating holding companies] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

F. "GAAP" means United States generally accepted accounting principles consistently applied.

G. "Home state" means the United States jurisdiction that has adopted this Act or a substantially similar law governing TPAs and that has granted the TPA a home state TPA license.

H. "Insurer" means an entity licensed in a United States jurisdiction to provide life, annuity, health or stop-loss coverage as an insurance company, health maintenance organization, fraternal benefit society or prepaid hospital or medical care plan.

Drafting Note: States that license multiple employer welfare arrangements (MEWAs) or that authorize employee leasing companies or professional employer organizations (PEOs) to provide employee welfare benefits on a self-funded basis, will want to include these entities in the list of entities that are included in the definition of insurer for purposes of this Act, but only to the extent of their license or authorization.

I. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

Drafting Note: States that use different terminology such as "agent" and/or "broker" should make appropriate adjustments to this language. In states that do not license business entities as insurance producers, use the following definition:

[I. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, and also includes a business entity whose primary activities are the sales, solicitation and negotiation of insurance.]

J. "Nonresident TPA" means a TPA whose home state is any jurisdiction other than this state.

K. "Payor" means an insurer or an employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control.

L. "Person" means an individual or a business entity.

M. "Stop-loss insurance" means insurance protecting an employer or other person responsible for an otherwise self-insured health or life benefit plan against obligations under the plan, but "stop-loss insurance" does not include reinsurance written for an insurance company.

Drafting Note: The inclusion of the stop-loss definition and the inclusion of stop-loss throughout this law are not necessary in states where stop-loss is clearly stipulated to be health insurance and cannot be interpreted to be liability insurance or some other form of insurance. In such states, references to stop-loss may be deleted or – if retained – viewed as a clarification (as stop-loss is considered to be liability insurance in some states).

N. "Third party administrator" or "TPA" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, health or stop-loss coverage, except that a person shall not be considered a TPA if that person's only actions that would otherwise cause it to be considered a TPA are among the following:

(1) A person working for a TPA to the extent that the person's activities are subject to the supervision and control of the TPA;

(2) An employer administering its employee benefit plan or the employee benefit plan of an affiliated employer under common management and control;

(3) The administration of a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on [*an appropriate recent date should be selected*];

(4) A union administering a benefit plan on behalf of its members;

(5) An insurer administering insurance coverage for its policyholders, subscribers or certificate holders, or those of an affiliated insurer under common management and control;

(6) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums from, or adjusting or settling claims on behalf of a client that is not a policyholder, subscriber or certificate holder, and that has its United States headquarters or principal location of business in a jurisdiction in which the insurer is licensed to write that coverage;

(7) An insurer directly or indirectly underwriting, collecting charges, collateral or premiums, or adjusting or settling claims, provided that the insurer is licensed in this state to write that line of insurance coverage;

(8) An insurance producer selling insurance or engaged in related activities within the scope of the producer's license;

(9) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(10) A trust and its trustees and agents acting pursuant to such trust established in conformity with 29 U.S.C. Section 186;

(11) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees acting pursuant to such trust, or a custodian and the custodian's agents acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(12) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, when collecting or remitting premiums to licensed insurance producers or to limited lines producers or authorized payors in connection with loan payments;

(13) A credit card issuing company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;

(14) An individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage;

(15) A person licensed as a managing general agent in this state when acting within the scope of that license; or

(16) A business entity that is affiliated with a licensed insurer while acting as a TPA for the direct and assumed insurance business of an affiliated insurer;

O. "Underwrites" or "underwriting" means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals and the overall planning and coordination of a benefits program.

P. "Uniform Application" means the current version of the NAIC Uniform Application for Third Party Administrators.

Section 2. Licensing Necessary

No person shall act as a TPA in this state unless that person is licensed as a TPA pursuant to this Act or unless the TPA is exempted from this Act's licensing requirement pursuant to subsection G of section 13 of this Act. This prohibition shall not apply to a person while employed by, or when operating under contract to, a TPA that is licensed pursuant to this Act, or exempted from this Act's licensing requirements pursuant to subsection G of section 13 of this Act.

Section 3. Payment to a TPA

If an insurer utilizes the services of a TPA, any premiums or charges for insurance paid to the TPA by or on behalf of the insured party, or any collateral furnished to the TPA by or on behalf of the insured party, shall be deemed to have been received by the insurer, and the return of collateral or the payment of return premiums or claim payments forwarded by the insurer to the TPA shall not be deemed to have been paid to the insured party or claimant until the payments are received by the insured party or claimant. Nothing in this section limits any right of the insurer against the TPA resulting from the failure of the TPA to make payments to the insurer, insured parties or claimants.

Section 4. Maintenance of Information

A. A TPA shall maintain and make available to the payor complete books and records of all transactions performed on behalf of the payor. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and shall be maintained for a period of not less than five (5) years from the date of their creation.

B. The commissioner shall have access to books and records maintained by a TPA for the purposes of examination, audit and inspection. Any documents, materials or other information in the possession or control of the commissioner that are furnished by a TPA, payor, insurance producer or an employee or agent thereof acting on behalf of the TPA, payor or insurance producer, or obtained by the commissioner in an investigation shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be not subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

C. Neither the commissioner nor any person who receives documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning confidential documents, materials, or information subject to Subsection B of this section.

D. In order to assist in the performance of his or her duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection B of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) **[OPTIONAL]** May enter into agreements governing sharing and use of information consistent with this subsection.

Drafting Note: The language in Subsection D(1) assumes the recipient has the authority to protect the applicable confidentiality or privilege, but does not address the verification of that authority, which would presumably occur in the context of a broader information sharing agreement.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection D of this section.

F. Nothing in this Act shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to [insert appropriate reference to state law] to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

G. Notwithstanding any contractual agreements between the payor and the TPA that operate to the contrary, the TPA shall retain the right to sufficient continuing access to books and records to permit the TPA to fulfill all of its contractual obligations to insured parties, claimants, and the payor.

H. In the event the payor or the TPA cancel their agreement; notwithstanding the provisions of Subsection A of this section, the TPA may, by written agreement with the payor, transfer all records to a new TPA rather than retain them for five (5) years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA as required in Subsection A of this section.

Section 5. Approval of Advertising

A TPA that advertises on behalf of its client may only use advertising that has been approved in writing by the client in advance of its use. A TPA that mentions any current or former client in its advertising must obtain the client's prior written consent.

Section 6. Responsibilities of the Payor and TPA

A. No TPA shall act as such without a written agreement between the TPA and the payor. A copy of the agreement shall be retained by the TPA for the duration of the agreement and for five (5) years thereafter. The agreement shall contain all provisions required by this section, except insofar as the TPA does not perform all of the functions referenced in this section.

B. A payor that utilizes the services of a TPA shall retain responsibility for the benefits, premium rates, collateral and reimbursement procedures, underwriting criteria and claims payment procedures applicable to the coverage and for securing reinsurance or stop-loss insurance, if any. The rules pertaining to these matters, to the extent that they are relevant to the duties of the TPA, shall be agreed to in writing by the payor and the TPA.

C. An insurer utilizing the services of a TPA is responsible for the acts of the TPA and is responsible for providing the TPA's books and records relevant to the insurer to the commissioner upon request.

D. The written agreement between the TPA and the payor shall provide that communications between the TPA and claimants shall avoid deceptive statements with regard to the responsibilities of the TPA, payor and any insurer with regard to claims or premiums.

E. In the event of a dispute between the payor and the TPA regarding which of them is to fulfill a lawful obligation with respect to a policy, certificate or claim subject to the written agreement, the payor shall fulfill such obligation.

F. The payor has the duty to provide for competent administration of its programs administered by a TPA and within the scope of this Act.

G. When a TPA administers benefits in connection with life, annuity, health and employee benefit stop-loss coverage for more than one hundred (100) certificate holders, subscribers, claimants or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one such review shall include an on-site audit of the operations of the TPA. The cost of such reviews or audits shall be borne by the insurer and not reimbursed by the TPA. The requirements of this subsection shall not apply when the TPA and the insurer are affiliated.

Section 7. Premium Collection and Payment of Claims

A. All insurance charges, premiums, collateral and loss reimbursements collected by a TPA on behalf of or for a payor, the return of premiums or collateral received from a payor, and any funds held by the TPA for the payment of claims, shall be held by the TPA in a fiduciary capacity. Funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the TPA in a federally insured financial institution. The TPA shall render a periodic accounting to the payor detailing all transactions performed by the TPA pertaining to the business of the payor, and the written agreement between the payor and the TPA shall include the specifications of this reporting.

B. The TPA shall keep copies of all records of any fiduciary account maintained or controlled by the TPA, and, upon request of a payor, shall furnish the payor with copies of the records pertaining to the deposits and withdrawals made on behalf of the payor. If funds deposited in a fiduciary account have been collected on behalf of or for more than one payor, or for the payment of claims associated with more than one policy, the TPA shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each payor and relating to each policyholder.

C. The TPA shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from a fiduciary account shall be made as provided in the written agreement between the TPA and the payor, and only for the following purposes:

(1) Remittance to a payor entitled to remittance;

(2) Deposit in an account maintained in the name of the payor;

(3) Transfer to and deposit in a claims-paying account, with claims to be paid as provided in Subsection D of this section;

(4) Payment to a group policyholder for remittance to the payor entitled to such remittance;

(5) Payment to the TPA of its earned commissions, fees or charges;

(6) Remittance of return premium to the person or persons entitled to such return premium; and

(7) Payment to other service providers as authorized by the payor.

D. All claims paid by the TPA from funds collected on behalf of or for a payor shall be paid only as authorized by the payor. Payments from an account maintained or controlled by the TPA for purposes including the payment of claims may be made only for the following purposes:

(1) Payment of valid claims;

(2) Payment of expenses associated with claims handling to the TPA or to other service providers approved by the payor;

(3) Remittance to the payor, or transfer to a successor TPA as directed by the payor, for the purpose of paying claims and associated expenses; and

(4) Return of funds held as collateral or prepayment, to the person entitled to those funds, upon a determination by the payor that those funds are no longer necessary to secure or facilitate the payment of claims and associated expenses.

Section 8. Compensation to the TPA

A. A TPA shall not enter into an agreement or understanding with a payor in which the effect is to make the amount of the TPA's commissions, fees, or charges contingent upon savings effected in the payment of losses covered by the payor's obligations. This provision shall not prohibit a TPA from receiving performance-based compensation for providing hospital or other auditing services, from providing managed care or related services, or from being compensated for subrogation expenses.

B. A payor shall not enter into an agreement with a TPA in violation of this section.

C. This section shall not prevent the compensation of a TPA from being based on premiums or charges collected or the number of claims paid or processed.

Section 9. Disclosure of Charges and Fees

A. When a TPA collects funds, the reason for collection of each item shall be identified to the insured party and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been already paid for by the payor.

B. The TPA shall disclose to the payor all charges, fees and commissions that the TPA receives arising from services it provides for the payor, including any fees or commissions paid by payors providing reinsurance or stop-loss insurance.

Section 10. Delivery of Materials to Covered Individuals

Any policies, certificates, booklets, termination notices or other written communications delivered by the payor to the TPA for delivery to insured parties or covered individuals shall be delivered by the TPA promptly after receipt of instructions from the payor to deliver them.

Section 11. Home State TPA License

A. If a TPA is incorporated in this state or this state is its principal place of business within the United States, then the TPA may designate this state as its home state and apply to this state for licensure as a TPA. If neither the state in which a TPA is incorporated nor the state that is its principal place of business have adopted this Act or a substantially similar law governing TPAs, and if the TPA has not designated any other state that has adopted this Act or a substantially similar law governing TPAs as its home state, then the TPA may apply for licensure to this state as its home state.

B. A TPA applying to this state as its home state shall apply for licensure using the Uniform Application and designate an individual as the TPA's contact person for department communications.

Drafting Note: The contact person requirement in subsection B and the related part of the notification requirement in subsection J are recommended options for those states with computer systems or licensing and filing procedures for which the designation of a "responsible person" is necessary.

C. If a TPA designates this state as its home state because neither its state of incorporation nor the state that is its principal place of business within the United States have adopted this Act or a substantially similar law governing TPAs, but if one or both of these other jurisdictions have licensed the TPA, then the commissioner may consult with that state or states and may give due consideration to any relevant findings made by that state or states in order to avoid an unnecessarily duplicative review of the application.

D. The Uniform Application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;

(2) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(2) NAIC Biographical Affidavit for the individuals who are responsible for the conduct of affairs of the applicant; including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholders or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant; and any other person who exercises control or influence over the affairs of the applicant;

(4) Audited annual financial statements or reports for the two (2) most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the Uniform Application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with GAAP, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The applicant shall also include such other information as the commissioner may require to review the current financial condition of the applicant.

(5) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting; and

(6) Such other pertinent information as may be required by the commissioner.

E. A TPA licensed or applying for licensure under this section shall make available for inspection by the commissioner copies of all contracts with payors or other persons utilizing the services of the TPA.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. The commissioner may refuse to issue a license if the commissioner determines that the TPA or any individual responsible for the conduct of affairs of the TPA is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction, or if the commissioner determines that any of the grounds set forth in Section 15 of this Act exists with respect to the TPA.

H. A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in compliance with this Act.

I. An individual may not qualify for licensure under this section, except that an individual previously licensed as a TPA with this state as its home state shall retain that license, unless surrendered, suspended or revoked by the commissioner, for so long as the TPA continues in business in this state and remains in substantial compliance with this Act.

Drafting Note: The "grandfather" provision in Subsection I addresses situations where states amending their TPA Act may already have individuals licensed under their current TPA law. The old TPA model allowed (and ostensibly required) individuals fulfilling TPA functions to be licensed as TPAs. It was never the intent of the previous drafting to require that every individual employed by a TPA to be individually licensed, although it arguably may have been intended that an individual could form a TPA without incorporating and get a license for that operation. This subsection can be removed in states that have an existing TPA law, but where all current licensees qualify as "business entities." States that are newly adopting a TPA law can also delete this subsection, as no entity could have previously held a license as a TPA.

J. A TPA licensed or applying for licensure under this section shall notify the commissioner within thirty days of any material change in its ownership, control, contact person for the TPA or other fact or circumstance affecting its qualification for a license in this state. The commissioner shall report any such changes to (insert name of the appropriate electronic database).

K. A TPA licensed or applying for a license under this section that administers or will administer governmental or church self-insured plans in this state or any other state shall maintain a surety bond for the use and benefit of the commissioner and the insurance regulatory authority of any additional state in which the TPA is authorized to conduct business and cover individuals and persons who have remitted premiums or insurance charges or other monies to the TPA in the course of the TPA's business in the greater of the following amounts:

(1) $100,000; or

(2) Ten percent (10%) of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in this state and all additional states in which the TPA is authorized to conduct business.

Section 12. Registration Requirement

A person who is not required to be licensed as a TPA under this Act and who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, only in connection with life, annuity or health coverage provided by a self-funded plan other than a governmental or church plan, shall register with the commissioner annually, verifying its status as herein described. This section shall not apply to an insurer or to an individual performing these actions as an employee of an insurer. This section shall also not apply to a person performing these actions under contract to or as an employee of a TPA.

Section 13. Nonresident TPA License

A. Unless a TPA has obtained a license in this state under Section 11, any TPA who performs TPA duties in this state shall obtain a nonresident TPA license in accordance with this section by filing with the commissioner the Uniform Application, accompanied by a letter of certification. In lieu of requiring a TPA to file a letter of certification with the Uniform Application, the commissioner may verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

B. A TPA shall not be eligible for a nonresident TPA license under this section if it does not hold a home state certificate of authority or license in a state that has adopted this Act or that applies substantially similar provisions as are contained in this Act to that TPA. If the Act in the TPA's home state does not extend to stop-loss insurance, but if the home state otherwise applies substantially similar provisions as are contained in this Act to that TPA, then that omission shall not operate to disqualify the TPA from receiving a nonresident TPA license in this state.

C. Except as provided in Subsection B of this section and in section 15, the commissioner shall issue a nonresident TPA license to the TPA promptly upon receipt of a complete application.

D. Unless notified by the commissioner that the commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, each nonresident TPA shall annually file a statement that its home state TPA certificate of authority or license remains in force and has not been revoked or suspended by its home state during the preceding year.

E. At the time of filing the statement required under Subsection D of this section or, if the commissioner has notified the nonresident TPA that the commissioner is able to verify the nonresident TPA's home state certificate of authority or license status through an electronic database, on an annual date determined by the commissioner, the nonresident TPA shall pay a filing fee as required by the commissioner.

Drafting Note: The filing of the statement or time set for payment of the fee should be after September 1 so that it follows the nonresident TPA's annual renewal of its home state certificate of authority or license.

F. A TPA licensed or applying for licensure under this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

G. A nonresident TPA licensed in its home state is not required to hold a nonresident TPA license in this state if the TPA's duties in this state are limited to the administration of group policies or plans of insurance and no more than one hundred (100) certificate holders for all such plans reside in this state.

Section 14. Annual Report and Filing Fee

A. Each TPA licensed under Section 11 shall file an annual report for the preceding calendar year with the commissioner on or before July 1 of each year, or within such extension of time as the commissioner for good cause may grant. The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: a) amounts shown on the consolidated audited financial report shall be shown on the worksheet; b) amounts for each entity shall be stated separately, and c) explanations of consolidating and eliminating entries shall be included. The report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two (2) officers of the TPA.

B. The annual report shall include the complete names and addresses of all payors with which the TPA had agreements during the preceding fiscal year.

C. At the time of filing its annual report, the TPA shall pay a filing fee as required by the commissioner.

D. The commissioner shall review the most recently filed annual report of each TPA on or before September 1 of each year. Upon completion of its review, the commissioner shall either:

(1) Issue a certification to the TPA that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and is currently licensed and in good standing, or noting any deficiencies found in that annual report and financial statements; or

(2) Update any electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicating that the annual report shows that the TPA has a positive net worth as evidenced by audited financial statements and complies with existing law, or noting any deficiencies found in the annual report.

Section 15. Grounds for Denial, Suspension or Revocation of Licensure

A. The commissioner shall, deny, suspend or revoke the license of a TPA, or shall issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

(1) Is in an unsound financial condition;

(2) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or

(3) Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.

B. The commissioner may deny, suspend or revoke the license of a TPA, or may issue a cease and desist order should the TPA not have a license if, after notice and opportunity for hearing, the commissioner finds that the TPA:

(1) Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state;

(2) Has refused to be examined or to produce its accounts, records and files for examination, or if any individual responsible for the conduct of affairs of the TPA, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the TPA; and any other person who exercises control or influence over the affairs of the TPA; has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination, when required by the commissioner;

(3) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA or a payor which it represents to secure full payment or settlement of such claims;

(4) Is required pursuant to this Act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the commissioner, unless the commissioner issued a license with knowledge of the ground for disqualification and had the authority to waive it;

(5) If any of the individuals responsible for the conduct of its affairs, including members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company; any shareholder or member holding directly or indirectly ten percent (10%) or more of its voting stock, voting securities or voting interest; and any other person who exercises control or influence over its affairs; has been convicted of, or has entered a plea of guilty or *nolo contendere* to, a felony without regard to whether adjudication was withheld;

(6) Is under suspension or revocation in another state; or

(7) Has failed to file a timely annual report pursuant to Section 14, if a resident TPA, or a timely statement and filing fee, as applicable, pursuant to Sections 13D and E, if a nonresident TPA.

C. (1) The commissioner, in his or her discretion, without advance notice, and before a hearing, may issue an order immediately suspending the license of a TPA, or may issue a cease and desist order should the TPA not have a license, if the commissioner finds that one or more of the following circumstances exist:

(a) The TPA is insolvent or impaired;

(b) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the TPA has been commenced in any state; or

(c) The financial condition or business practices of the TPA otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(2) At the time an order has been issued by the commissioner in accordance with Paragraph (1) of this subsection, the commissioner shall serve notice to the TPA that the TPA may request a hearing within ten business days after the receipt of the order. If a hearing is requested, the commissioner shall schedule a hearing within ten business days after receipt of the request. If a hearing is not requested and the commissioner orders none, the order shall remain in effect until modified or vacated by the commissioner.

D. If the commissioner finds that one or more grounds exist for the suspension or revocation of a license issued under this part, or for a cease and desist order, the commissioner may, in lieu of or in addition to the suspension, revocation or cease and desist order, impose a fine upon the TPA.

Drafting Note: States with disciplinary provisions of general applicability for regulated insurance entities may wish to incorporate such provisions by reference and should revise the provisions of this section to the extent inconsistent with the state's general statutory scheme.

Section 16. Effective Date

Drafting Note: If a TPA act was already in effect, but is now being amended to include stop-loss insurance, it will be necessary to include a prospective effective date for this extension that does not affect the applicability of the Act to other types of coverage.

Chronological Summary of Action (all references are to the Proceeding of the NAIC)

1977 Proc. I 26, 28, 317, 319-321 (adopted).
1991 Proc. I 9, 17-18, 608, 612-613, 620-626 (amended and reprinted).
1999 Proc. 4th Quarter 15, 107, 111, 116, 119-120 (amended).
2001 Proc. 4th Quarter 6, 90, 395, 399, 400-409 (amended and reprinted).
2011 Proc. 2nd Quarter, Vol. I 122, 220-251 (converted to guideline).

REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)

(An NAIC Guideline)

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column, Previous Version column, or Related Activity column based on the definitions listed in the key below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in, and depending on which column the citation falls under, you will know whether the NAIC Legal Division has deemed a state's law to be adoption of a model or not. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)
(An NAIC Guideline)

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	ALASKA STAT. §§ 21.27.630 to 21.27.660 (1992/2009); BULLETIN 92-3 (1992); BULLETIN 97-6 (1997).
American Samoa	NO CURRENT ACTIVITY
Arizona	ARIZ. REV. STAT. ANN. §§ 20-485 to 20-485.12 (1977/2002).
Arkansas	ARK. CODE ANN. §§ 23-92-201 to 23-92-208 (1985/2015).
California	CAL. INS. CODE §§ 1759 to 1759.10 (1977/1984).
Colorado	NO CURRENT ACTIVITY
Connecticut	CONN. GEN. STAT. ANN. §§ 38a-720 to 38a-720n (2011); BULLETIN L-17 (2011).
Delaware	DEL. CODE ANN. tit. 18,§ 102 (1953/2013) (defines TPA; authority to adopt regulations); 18 DEL. CODE REGS. § 1406 (2003).
District of Columbia	NO CURRENT ACTIVITY
Florida	FLA. STAT. §§ 626.88 to 626.894 (1983/2014).
Georgia	GA. CODE ANN. §§ 33-23-100 to 33-23-105 (1991/2005); GA. COMP. R. & REGS. 120-2-49 (1993/1997).
Guam	NO CURRENT ACTIVITY
Hawaii	HAWAII STAT. 431:9J (2020).
Idaho	ADVISORY NOTICE 3-18-2010 (2010).
Illinois	215 ILL. COMP. STAT. 5/511.100 to 5/511.113 (1984/2013).
Indiana	IND. CODE §§ 27-1-25-1 to 27-1-25-16 (1980/2004).
Iowa	IOWA CODE §§ 510.11 to 510.23 (1989/1996); IOWA ADMIN. CODE r. 191-58.1 to 191-58.20 (2009) (based on proposed guideline).
Kansas	KAN. STAT. ANN. §§ 40-3801 to 40-3817 (1978/1997).
Kentucky	KY. REV. STAT. ANN. §§ 304.9-051 to 304.9-052 (2010); §§ 304.9-371 to 304.9-377 (1986).
Louisiana	LA. REV. STAT. ANN. § 22:1080 (2014) ; §§ 22:1641 to 22:1656 (1993/2004).

REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)
(An NAIC Guideline)

NAIC MEMBER	RELATED ACTIVITY
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 1901 to 1912 (1990/2000).
Maryland	MD. CODE ANN., INS. §§ 8-301 to 8-322 (1991/2009); BULLETIN 24-2009 (2009).
Massachusetts	NO CURRENT ACTIVITY
Michigan	MICH. COMP. LAWS §§ 550.901 to 550.960 (1985/2002).
Minnesota	MINN. STAT. § 60A.23 sub. 8 (1967/1999); § 79A.06 (1988/2011); MINN. R. 2767.0100 to 2767.0900 (1988/1995).
Mississippi	MISS. CODE ANN. §§ 83-18-1 to 83-18-29 (1991/1997).
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 200-9.500 to 200-9.800 (1994/1999); MO. REV. STAT. §§ 376.1075 to 376.1095 (1993/1999).
Montana	MONT. CODE ANN. §§ 33-17-602 to 33-17-618 (1979/1997).
Nebraska	NEB. REV. STAT. §§ 44-5801 to 44-5816 (1992/2003).
Nevada	NEV. ADMIN. CODE §§ 683A.100 to 683A.165 (1986/2003); NEV. REV. STAT. § 683A.025 (2011); §§ 683A.0805 to 683A.0893 (1977/2003).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 2301.01 to 2301.21 (1994/2009); N.H. REV. STAT. ANN. §§ 402-H:1 to 402-H:16 (1994/1998).
New Jersey	N.J. STAT. ANN. §§ 17B:27B-1 to 17B:27B-25 (2001); N.J. ADMIN. CODE §§ 11:23-1.1 to 11:23-5.10 (2005/2014).
New Mexico	N.M. CODE R. §§ 13.4.5.1 to 13.4.5.22 (1992/1997); N.M. STAT. ANN. §§ 59A-12A-1 to 59A-12A-17 (1989/1999).
New York	O.G.C. 11-2-2006 (#1) (2006).
North Carolina	N.C. GEN. STAT. §§ 58-47-150 to 58-47-205 (1997/2009); §§ 58-56-2 to 58-56-66 (1991/2009); 11 N.C. ADMIN. CODE 12.0332 (2010); 21.0101 to 21.0110 (1996); MEMORANDUM 6-12-2012 (2012).
North Dakota	N.D. CENT. CODE §§ 26.1-27-01 to 26.1-27-12 (1985/2005).
Northern Marianas	NO CURRENT ACTIVITY

REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs)
(An NAIC Guideline)

NAIC MEMBER	RELATED ACTIVITY
Ohio	OHIO REV. CODE ANN. §§ 3959.01 to 3959.99 (1988/1997); OHIO ADMIN. CODE § 3901-8-05 (2008).
Oklahoma	OKLA. ADMIN. CODE §§ 36:1441 to 36:1452 (1983/2008); BULLETIN 3-21-2012 (2012).
Oregon	OR. REV. STAT. §§ 744.700 to 744.740 (1991/2013); OR. ADMIN. R. 836-075-0000 to 836-075-0070 (1992/2012); 836-074-0005 to 836-074-0050 (1988/2005).
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	R.I. GEN. LAWS §§ 27-20.7-1 to 27-20.7-16 (2002).
South Carolina	S.C. CODE ANN. §§ 38-51-10 to 38-51-120 (1988/1993).
South Dakota	S.D. CODIFIED LAWS §§ 58-29D-1 to 58-29D-34 (1993/2013).
Tennessee	TENN. CODE ANN. §§ 56-6-401 to 56-6-412 (1980/1996).
Texas	TEX. INS. CODE ANN. §§ 4151.001 to 4151.309 (2005/2013).
Utah	UTAH CODE ANN. §§ 31A-25-102 to 31A-25-402 (1986/2014).
Vermont	VT. REG. I-2021-01 (2021).
Virgin Islands	V.I. CODE ANN. tit., 22 §§ 60-1520 to 60-1544 (2016).
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	W. VA. CODE §§ 33-46-1 to 33-46-20 (2003).
Wisconsin	WIS. ADMIN. CODE INS. §§ 8.20 to 8.32 (1992/1997); WIS. STAT. §§ 633.01 to 633.17 (1991/1999) (portions of model).
Wyoming	WYO. CODE R. § 044.0002.4 (1984).

PROJECT HISTORY – 2011

GUIDELINE FOR REGISTRATION AND REGULATION OF THIRD PARTY ADMINISTRATORS (TPAs) (#1090)

1. Description of the Project, Issues Addressed, etc.

The Workers' Compensation (C) Task Force was charged in 2006 with expanding the scope of the NAIC's TPA Model Act to include workers' compensation. The nearly five year drafting effort was complex and involved substantial input from regulators familiar with producer licensing concerns.

The final guideline, offered in two versions, is a revision of the Third Party Administrator Statute, which was first adopted by the NAIC as a model law in 1977 and which had been most recently amended in 2001. Version 1 of the Guideline expands the scope of the prior model by adding workers' compensation and stop-loss coverages. Version 2 of the Guideline omits workers' compensation, which makes it similar in scope to the prior model, with the difference being in those states where stop-loss insurance was defined as liability insurance and not as health insurance.

In addition to numerous editorial changes, some of the substantive changes to what was previously in the 2001 NAIC model law are as follows:

(a) The language of the 2001 model required individuals adjusting life and health claims to be licensed as TPAs, even though it is clear that it was never the intent of the drafters or the states that adopted the model to implement a licensure requirement for employees of TPAs or insurers adjusting life and health claims. In addition, the licensing provisions in the 2001 model allowed an individual to become licensed to act as a full-fledged TPA. While the Guideline has language to allow previously licensed individuals to be "grandfathered," it provides that only business entities can be newly licensed as TPAs. As a practical matter, licensure requirements are not cleanly met by an individual.

(b) The 2001 model exempted licensed insurers operating as TPAs from all requirements of the Act. The Guidelines maintain this exemption for lines other than workers' compensation. For workers' compensation, while Version 1 exempts insurers from licensure requirements and from audit and reporting requirements when they handle workers' compensation claims for an employer that is not their policyholder, it subjects such insurer/TPAs to many other operational requirements of the Act for workers' compensation.

(c) The Guideline adds cease & desist orders to those actions available to the commissioner and also addresses concerns that the 2001 model may have been deficient with regard to due process.

(d) The Guideline extends the life & health scope of the 2001 model to so-called "stop-loss" insurance. This may be viewed a clarification in states where stop-loss is already considered to be health insurance and cannot be written as liability insurance, but it will be a modest expansion in other states.

(e) Version 1 extends the scope of the 2001 model to workers' compensation insurance. One should note, however, that various provisions of the model applying to life & health are not uniformly extended to workers' compensation. There is an extensive new section dealing with workers' compensation contracts between insurers and TPAs, and between TPAs and insured employers.

(f) Version 1 will not allow a TPA to agree with an employer to have the employer adjust its own workers' compensation claims, and an employer cannot avoid this prohibition by simply licensing an affiliated business entity as a TPA in order to handle its own workers' compensation claims.

(g) Version 1 exempts payments made by employers to TPAs for handling workers' compensation claims under a large deductible contract from premium taxes.

The account-related provisions in the 2001 model were substantially revised. Most notably, the Guideline deletes the requirement that accounts administered by the TPA must be in the name of the insurance company, as long as claims trust funds held by the TPA are not commingled with premium trust funds.

A state's best use of the Guideline will depend on whether it currently has a TPA law and/or whether it wants to have a TPA law that extends to the handling of workers' compensation claims:

- For a state that wishes to enact a TPA law that extends to workers' compensation, Version 1 should be an excellent starting point. Study the language carefully to make whatever amendments may be necessary on account of state-specific issues with workers' compensation, agent licensing and adjuster licensing statutes. The adjuster licensing statutes will probably require an especially careful examination to have a good "mesh" and to avoid duplicative

requirements, while workers' compensation statutes will need to be studied to determine whether the provisions of this document regarding the rights of employers to involve themselves in claims handling or disputes are in agreement. While part of a possible response to conflicts could be to change adjuster licensing or workers' compensation laws to match this document, it is not the purpose of the Guideline to call for changes to other statutes. Although drafting notes will provide assistance in this regard, one should not skim over sections without drafting notes. There are more state-to-state differences than can be easily summarized by drafting notes.

- A state that already has a TPA law, but that wants to extend it to workers' compensation, will also find Version 1 to be an excellent reference. The advice for such a state is again to review this document carefully, looking to see where it differs from the state's current law and carefully noting where the changes proposed in this document may conflict with the state's other statutes.
- A state with or without a current TPA law, that wants to have a TPA law that does not extend to workers' compensation, is advised to consider Version 2. Version 2 is essentially the same as Version 1, but with provisions and language related to workers' compensation removed. This law still includes stop-loss and other refinements made to the previous NAIC model. Admittedly, the motivation for a state to make changes to its existing laws is likely to depend on whether it has identified a reason that it needs to "fix" its current laws. Absent the identification of any practical problems, states may assign a lower priority to the improvements contained in this document.

2. Name of Group Responsible for Drafting the Model and States Participating

The Large Deductible Study Implementation (C) Working Group of the Workers' Compensation (C) Task Force was the primary author of the draft Guidelines. After the Large Deductible (C) Working Group completed its revisions to the guidelines, it formally referred the recommended changes to the Producer Licensing (EX) Task Force for consideration. The Producer Licensing (EX) Task Force had no changes at the 2011 Spring National Meeting and has recommended adoption of the Guideline by the Property and Casualty (C) Committee and Executive Committee.

3. Project Authorized by What Charge and Date First Given to the Group

2006 CHARGES- (Adopted by Plenary on 3/5/06)

WORKERS' COMPENSATION (C) TASK FORCE

- Appoint a Large Deductible Study Implementation Working Group to assure that the NAIC charges presented in the Findings and Recommendations of the Workers' Compensation Large Deductible Study are properly completed.
- Consider amending the NAIC model law Third-Party Administrator Act to extend it to workers' compensation claims.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Large Deductible Study Implementation (C) Working Group drafted the Guideline by meeting via conference call and in person for nearly four and a half years. After the Large Deductible (C) Working Group completed its revisions to the guidelines and received feedback from the Regulatory Framework (B) Task Force, it formally referred the recommended changes to the Producer Licensing (EX) Task Force for consideration.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The drafting was complex. Not only did it require numerous amendments to an already complex statute, drafters encountered places where the original NAIC model could be improved. As a result, the changes include a number of improvements to the prior law, regardless of whether an extension to workers' compensation is desired.

The Subgroup met via conference call on nearly a monthly basis. Current revisions of the Guideline, along with appropriate supplementary materials, were kept on the Subgroup's webpage. Comments were solicited as revisions occurred and these also were posted on the webpage. All parties were invited on the monthly conference calls and kept apprised of the most recent changes to the draft Guideline. Numerous drafts of the Guideline were created until the Subgroup finalized the Guideline in March 2010.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

- ***The definition of "Home State"***-There was considerable debate over the state that would have jurisdiction over TPAs that were doing business in more than one state. Task force members sought to create a law that would ensure that only one jurisdiction would have the authority to regulate the TPA.

- ***Exemption for Business Entities Performing TPA Work for an Affiliated Insurance Com***pany. There was discussion regarding whether these types of entities should be exempted from the law because the affiliated company would already be subject to regulation. The group finally adopted wording which read: "The insurer is responsible for the acts of the administrator and is responsible for providing all the administrator's books and records to the insurance commissioner, upon a request from the insurance commissioner."

7. Any Other Important Information (e.g., amending an accreditation standard).

PROJECT HISTORY - 2001

THIRD PARTY ADMINISTRATOR STATUTE (#90)

1. Project Description

The Third Party Administrator Statue provides the basic regulatory framework for the licensing of Third Party Administrators (TPAs). The model statute was revised to create a more efficient and streamlined licensing framework. The key revisions focused on licensing reciprocity and the creation of a Uniform Application for TPAs.

2. Group Responsible for Drafting Model and States Participating

The Agent Licensing Working Group of the Market Conduct and Consumer Affairs (D) Committee was responsible for revising the model statute. Gene Reed (DE) and Sam Meyer (SD) co-chaired the working group. The following states were members of the working group: Alabama, Alaska, Arizona California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington and Wisconsin.

To help facilitate the drafting process, the Agent Licensing Working Group appointed the Third Party Administrator Statute Subgroup. Sue Stead (OH) chaired this subgroup. The initial subgroup was comprised of the District of Columbia, Kentucky and Michigan. As the drafting process proceeded all members of the Agent Licensing Working Group were invited to join the subgroup.

3. Charge Authorizing Project

The D Committee had the following charge during 2001: Appoint a working group to complete the review of the existing NAIC Managing General Agents Model Act and Third Party Administrator Statute. Consider modifications to the models to recognize that there have been and will be changes that will impact the delivery systems of insurance products and that this changing environment will require flexibility in regulating the production of insurance through various methodologies and technologies. Report by the NAIC Fall National Meeting.

4. General Description of Drafting Process

The drafting process was very open as the working group and subgroup solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The working group and subgroup also solicited key concerns from interested parties and funded consumer representatives. All of the meetings and conference calls of the working group, subgroup and the Market Conduct and Consumer Affairs (D) Committee were open to all interested parties. All revised drafts of the paper were posted on the NAIC website and circulated for public comment. The working group and subgroup received and reviewed numerous comments from interested parties.

5. Significant Issues Raised

The most significant revision was the adoption of a new section addressing non-resident licensing for TPAs and the creation of a new Uniform Application for Third Party Administrators. While a TPA must obtain a license in each state in which it operates, the model statute clarifies that the home state of TPA is principally responsible for regulating the TPA and determining the good standing of the TPA. The Uniform Application for TPAs may be used for both resident and non-resident licensing and the issuance of new and renewal licenses.

The model statute was revised to require the filing of a Biographical Affidavit and audited financial statements with the home state of the TPA. In addition, each TPA must file an annual report with its home state so the home state regulator of the TPA may make a proper determination regarding the positive net worth and good standing of the TPA.

With input from the ERISA Working Group, the Third Party Administrator Subgroup and the Agent Licensing Working Group concluded the state registration requirement for self-funded ERISA plans is a minimal requirement, is peripheral to an employee benefit plan, and would not lead to preemption of a state law because of the state law impermissibly "relating to" an ERISA plan. At the same time, additional modifications were added to the model statute to ensure a state law based upon the model statute would not impermissibly "relate to" an ERISA plan and be preempted.

There were numerous discussions regarding bond requirements for TPAs. The Third Party Administrator Subgroup and the Agent Licensing Working Group incorporated the following bond requirement for self-funded or governmental plans: "An administrator licensed or applying for a home state certificate of authority/license that administers or will administer governmental or church self-insured plans in its home state or any other state shall maintain a surety bond for the use and benefit of the home state commissioner and the insurance regulatory authority of any additional state in which the administrator is authorized to conduct business and cover individuals and persons who have remitted premiums or insurance charges or other monies to the administrator in the course of the administrator's business in the greater of the following amounts: (1) $100,000; or (2) ten percent (10%) of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in the administrator's home state and all additional states in which the administrator is authorized to conduct business."

Finally, there were significant discussions regarding an exemption from licensure for associations. An exemption for associations was not incorporated into the model statute. Interested parties with a vested interest in this issue may submit a white paper outlining the issues surrounding the association exemption. The Agent Licensing Working Group will receive the white paper as a general comment but is not currently planning to use the white paper as a basis for an official NAIC white paper on the issue.

6. Other Pertinent Information

The creation of a more efficient and reciprocal licensing framework for TPAs coincides with the broader uniform and reciprocal licensing initiatives of the NAIC.

INDEPENDENT ADJUSTER LICENSING GUIDELINE

Table of Contents

Section 1. Purpose and Scope

This Guideline governs the qualifications and procedures for licensing independent adjusters. It specifies the duties of and restrictions on independent adjusters.

Drafting Note: It is recommended that any statute or regulation inconsistent with this Guideline be repealed or amended.

Section 2. Definitions

A. "Apprentice independent adjuster" means one who is qualified in all respects as an independent adjuster except as to experience, education and/or training.

B. "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

C. "Catastrophe" means an event that results in large numbers of deaths or injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; or severely affects state, local and private sector capabilities to begin and sustain response activities. A catastrophe shall be declared by the Governor of the state, district, or territory in which the catastrophe occurred.

Drafting Note: Some states may need to expand the authority to include the insurance commissioner or other eligible governmental or regulatory body, if they are authorized to declare a catastrophe.

D. "Fingerprints" for the purposes of this Guideline, means an impression of the lines on the finger taken for purpose of identification.

Drafting Note: States that require fingerprinting would incorporate this Section, states that do not require fingerprinting need to determine if this would apply.

E. "Home state" means the District of Columbia and any state or territory of the United States in which an independent adjuster maintains his, her or its principal place of residence or business and is licensed to act as a resident independent adjuster. If the resident state does not license independent adjusters for the line of authority sought, the independent adjuster shall designate as his, her or its home state any state in which the independent adjuster is licensed and in good standing.

F. "Independent adjuster" means a person who:

(1) Is an individual, a business entity, an independent contractor, or an employee of a contractor, who contracts for compensation with insurers or self-insurers;

(2) One whom the insurer's or self-insurer's tax treatment of the individual is consistent with that of an independent contractor rather than as an employee, as defined in the Internal Revenue Code, United States Code, Title 26, Subtitle C; and

(3) Investigates, negotiates or settles property, casualty or workers' compensation claims for insurers or for self-insurers.

G. "Individual" means a natural person.

H. "Insurer" means (insert reference to appropriate section of state law).

I. "Person" means an individual or business entity.

J. "Uniform Individual Application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Individual Application for resident and nonresident individuals.

K. "Uniform Business Entity Application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities.

Drafting Note: Subsection K is optional and only applies to those states that have a business entity license requirement.

Drafting Note: If any term is similarly defined in a relevant section of the state's insurance code, do not include the definition of the term in this Guideline or, in the alternative, reference the statute: "[term] is defined in [insert appropriate reference to state law or regulation]."

Section 3. License Required

A person shall not act or hold himself out as an independent adjuster in this state unless the person is licensed as an independent adjuster in accordance with this Guideline, or is exempt from licensure as an independent adjuster under this Guideline.

Section 4. Exceptions to License Requirement

The definition of independent adjuster shall not be deemed to include, and a license as an independent adjuster shall not be required of the following:

A. Attorneys-at-law admitted to practice in this state, when acting in their professional capacity as an attorney;

B. A person employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster;

C. An individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments;

D. A person who solely performs executive, administrative, managerial or clerical duties or any combination thereof and who does not investigate, negotiate or settle claims with policyholders, claimants or their legal representative;

E. A licensed health care provider or its employee who provides managed care services so longs as the services do not include the determination of compensability;

F. A managed care organization or any of its employees or an employee of any organization providing managed care services so long as the services do not include the determination of compensability;

G. A person who settles only reinsurance or subrogation claims;

H. An officer, director, manager or employee of an authorized insurer, surplus lines insurer, a risk retention group, or an attorney-in-fact of a reciprocal insurer;

I. A U.S. Manager of the United States branch of an alien insurer;

J. A person who investigates, negotiates or settles life, accident and health, annuity, or disability insurance claims;

K. An individual employee, under a self-insured arrangement, who adjust claims on behalf of their employer;

L. A licensed insurance producer, attorney-in-fact of a reciprocal insurer or managing general agent of the insurer to whom claim authority has been granted by the insurer;

M. A person authorized to adjust workers' compensation or disability claims under the authority of a third party administrator (TPA) license pursuant to [insert applicable licensing statute].

Drafting Note: This Guideline is drafted to eliminate redundant licensure requirements with respect to the activities engaged in by a licensee. If licensed as an independent adjuster, third party administrator or similar business entity, licensees should not be required to obtain separate independent adjuster licenses, provided that the types of claims adjusted do not include life, health, annuity, or disability insurance claims.

Section 5. Temporary Licensure or Registration for Emergency Independent Adjusters

A. In the event of a declared catastrophe, an insurer shall notify the insurance commissioner via an application for temporary emergency licensure, or registration if temporary emergency licensure is not statutorily required, of each individual, not already licensed in the state where the catastrophe has been declared, that will act as an emergency independent adjuster on behalf of the insurer. The insurance commissioner shall establish standards and procedures to allow for the temporary emergency licensure or registration of an emergency independent adjuster in this state.

B. A person who is otherwise qualified to adjust claims, but not already licensed in this state where the catastrophe has been declared, may act as an emergency independent adjuster and adjust claims, if, within five days of deployment to adjust claims arising from the declared catastrophe, the insurer notifies the commissioner by providing the following information in a format prescribed by the insurance commissioner:

(1) Name of the individual;

(2) Social security number of individual;

(3) Name of insurer the independent adjuster will represent;

(4) Effective date of the contract between the insurer and independent adjuster;

(5) Catastrophe or loss control number;

(6) Catastrophe event name; and

(7) Other information the insurance commissioner deems necessary.

Drafting Note: The participating states, by rule, should clarify the state's meaning and application of "qualify" as used Section 5B.

C. An emergency independent adjuster's license or registration shall remain in force for a period not to exceed 90 days, unless extended by the insurance commissioner.

Drafting Note: The fee for emergency independent adjuster application for licensure or registration shall be in an amount determined by the insurance commissioner and shall be due and payable at the time of application for licensure or registration.

Drafting Note: The insurance commissioner may provide additional provisions that would trigger licensure or registration of an emergency independent adjuster.

Section 6. Application for License

A. An individual applying for a resident independent adjuster license shall make application to the insurance commissioner on the appropriate NAIC Uniform Individual Application in a format prescribed by the insurance commissioner and declare under penalty of suspension, revocation or refusal of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the insurance commissioner shall find that the individual:

(1) Is at least eighteen (18) years of age;

(2) Is eligible to designate this state as his or her home state;

(3) Is trustworthy, reliable and of good reputation, evidence of which shall be determined by the insurance commissioner;

(4) Has not committed any act that is a ground for probation, suspension, revocation or refusal of an independent adjuster's license as set forth in Section 12;

(5) Has completed a prelicensing course of study for the line(s) of authority for which the person has applied, where required by the insurance commissioner; and

(6) Has successfully passed the examination for the line(s) of authority for which the person has applied;

(7) Has paid the fees set forth in [insert appropriate reference to state law or regulation.

B. A business entity applying for a resident independent adjuster license shall make application to the insurance commissioner on the appropriate NAIC Uniform Business Entity Application in a format prescribed by the insurance commissioner and declare under penalty of suspension, revocation or refusal of the license that the statements made in the application are true, correct and complete to the best of the business entity's knowledge and belief. Before approving the application, the insurance commissioner shall find that the business entity:

(1) Is eligible to designate this state as its home state;

(2) Has designated a licensed independent adjuster responsible for the business entities compliance with the insurance laws, rules and regulations of this state;

(3) Has not committed an act that is a ground for probation, suspension, revocation or refusal of an independent adjuster's license as set forth in Section 12; and

(4) Has paid the fees set forth in [insert appropriate reference to state law or regulation].

Drafting Note: This Section is optional and applies only to those states that have a business entity requirement.

Drafting Note: Employee of the authoritized affiliate insurer may be considered under this exemption with the Commissioner's consent.

C. In order to make a determination of license eligibility, the insurance commissioner is authorized to require fingerprints of applicants and to submit the fingerprints and the fee required to perform the criminal history record checks to the state identification bureau (or state department of justice public state agency) and the Federal Bureau of Investigation (FBI) for state and national criminal history record checks.

Drafting Note: The FBI requires that fingerprints be submitted to the state Department of Law Enforcement, Public Safety or Criminal Justice for a check of state records before the fingerprints are submitted to the FBI for a criminal history record check. The FBI recommends all fingerprint submissions be in an electronic format. Public Law 92-544 requires specific parameters to submit fingerprints and obtain criminal history record information. The FBI has approved the language in Section 6C to authorize a state identification bureau to submit fingerprints on behalf of its applicants in conjunction with licensing and employment.

D. The insurance commissioner shall require a criminal history record check on each applicant in accordance with this Guideline. The insurance commissioner shall require each applicant to submit a full set of fingerprints (including a scanned file from a hard copy fingerprint) in order for the insurance commissioner to obtain and receive national criminal history records from the FBI Criminal Justice Information Services Division.

E. The insurance commissioner may contract for the collection and transmission of fingerprints authorized under this Guideline. If the insurance commissioner does so, the insurance commissioner may order the fee for collecting and transmitting fingerprints to be payable directly to the contractor by the applicant. The insurance commissioner may agree to a reasonable fingerprinting fee to be charged by the contractor.

F. The insurance commissioner shall treat and maintain an applicant's fingerprints and any criminal history record information obtained under this Guideline as confidential and shall apply security measures consistent with the Criminal Justice Information Services Division of the Federal Bureau of Investigation standards for the electronic storage of fingerprints and necessary identifying information and limit the use of records solely to the purposes authorized in this Guideline. The fingerprints and any criminal history record information shall not be subject to subpoena, other than one issued in a criminal action or investigation, and shall be confidential.

G. The insurance commissioner is authorized to receive criminal history record information from another government agency in lieu of the state identification bureau (or state department of justice or other public state agency) that submitted the fingerprints to the FBI.

Drafting Note: If the state has adopted fingerprint requirements for other classes of licenses, it may not necessary to adopt this language. This provision does not permit the sharing of criminal history record information with the NAIC or other insurance commissioners as such sharing of information is prohibited by 28 CFR 20.33.

H. The insurance commissioner may require any documents reasonably necessary to verify the information contained in the application.

Section 7. License

A. Unless denied licensure pursuant to Section 12, persons who have met the requirements of Sections 6 and 8 shall be issued an independent adjuster license. An independent adjuster may qualify for a license in one or more of the following lines of authority:

(1) Property and Casualty; or

(2) Workers Compensation; or

(3) Crop.

B. Any person holding a license pursuant to this provision shall not be required to hold any other independent adjuster, insurance or self-insurance administrator license in this state pursuant to [insert applicable TPA law cross reference] or any other provision, including, but not limited to, licenses by the [Workers Compensation Commissions, the Department of Labor or other applicable cross reference] provided that he, she or it does not Guideline as an independent adjuster with respect to life, health or annuity insurance, other than disability insurance.

Drafting Note: This Guideline is drafted to eliminate redundant licensure requirements with respect to the activities engaged in by the licensee. If licensed as an independent adjuster, third party administrator or similar business entity additional licenses should not be required provided that the type of claims adjusted do not include life, health, or annuity insurance claims, other than disability claims.

C. An independent adjuster license shall remain in effect unless probated, suspended, revoked or refused as long as the request for renewal and fee set forth in [insert appropriate reference to state law or regulation] is paid and all other requirements for license renewal are met by the due date, otherwise the license expires.

D. An independent adjuster whose license expires may, within twelve (12) months of the renewal date, be reissued an independent adjuster license upon receipt of the renewal request, as prescribed by the insurance commissioner. However, a penalty in the amount of double the unpaid renewal fee shall be required to reissue the expired license.

E. An independent adjuster who is unable to comply with license renewal procedures and requirements due to military service, long-term medical disability or some other extenuating circumstance may request a waiver of same and a waiver of any examination requirement, fine or other sanction imposed for failure to comply with renewal procedures.

Drafting Note: Some states may not contain expiration date or reissue a license that has been discontinued for nonrenewal.

F. An independent adjuster shall be subject to [cite state's Unfair Claims Settlement Act and state's Trade Practices and Fraud sections of the Insurance Code].

G. The independent adjuster shall inform the insurance commissioner by any means acceptable of any change in resident or business address(es) for the home state or in legal name, within thirty (30) days of the change.

H. The license shall contain the licensee's name, address, personal identification number, the date of issuance and expiration and any other information the insurance commissioner deems necessary.

I. In order to assist in the performance of the insurance commissioner's duties, the insurance commissioner may contract with non-governmental entities, including the NAIC, its affiliates or subsidiaries, to perform any ministerial functions, including the collection of fees and data, related to licensing that the insurance commissioner may deem appropriate.

Section 8. Examination

A. An individual applying for an independent adjuster license under this Guideline shall pass a written examination unless exempt pursuant to Section 9. The examination shall test the knowledge of the individual concerning, the lines of authority for which application is made, the duties and responsibilities of an independent adjuster and the insurance laws and regulations of this state. Examinations required by this Section shall be developed and conducted under rules and regulations prescribed by the insurance commissioner.

B. The insurance commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in [insert appropriate reference to state law or regulation].

C. Each individual applying for an examination shall remit a non-refundable fee as prescribed by the insurance commissioner as set forth in [insert appropriate reference to state law or regulation].

D. An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

Drafting Note: A state may wish to prescribe by regulation limitations on the frequency of application for examination in addition to other prelicensing requirements.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this section. Rather, the state may want to amend its relevant insurance producer statute to include independent adjusters.

Section 9. Exemptions from Examination

A. An individual who applies for an independent adjuster license in this state who is or was licensed in another state for the same line(s) of authority based on an independent adjuster examination shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in another state or if that state license has expired and the application is received by this state within ninety (90) days of expiration. The applicant must provide certification from the other state that the applicant's license is currently in good standing or was in good standing at the time of expiration or certification from the other state that its Producer Database records, maintained by the NAIC, its affiliates or subsidiaries, indicate that the applicant or their company is or was licensed in good standing. The certification must be of a license with the same line of authority for which the individual has applied;

B. A person licensed as an independent adjuster in another state based on an independent adjuster examination who establishes legal residency in this state shall make application within ninety (90) days to become a resident independent adjuster licensee pursuant to Section 6, with the exception that no prelicensing education or examination shall be required of this person;

C. An individual who applies for an apprentice independent adjuster license, pursuant to Section 11, and who adjust claims in that capacity, shall not be required to take and successfully complete the independent adjuster examination.

Drafting Note: If the state does not adopt Section 11, Apprentice Independent Adjuster License, then 9C should be removed as an exemption from examination.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this Section. Rather, the state may want to amend its relevant insurance producer statute to include independent adjusters.

Section 10. Nonresident License

A. Unless refused licensure pursuant to Section 12, a nonresident person shall receive a nonresident independent adjuster license if:

(1) The person is currently licensed in good standing as an independent adjuster in his, her, or its resident or home state;

(2) The person has submitted the proper request for licensure, has paid the fees required by [insert appropriate reference to state law or regulation];

(3) The person has submitted or transmitted to the insurance commissioner the appropriate completed application for licensure; and

(4) The person's designated home state awards nonresident independent adjuster licenses to persons of this state on the same basis.

B. The insurance commissioner may verify the independent adjuster's licensing status through any appropriate database, including the Producer Database maintained by the NAIC, its affiliates or subsidiaries, or may request certification of good standing as described in Section 9A of this Guideline.

C. As a condition to the continuation of a nonresident independent adjuster license, the licensee shall maintain a resident independent adjuster license in his, her or its home state. The nonresident independent adjuster license issued under this Section shall terminate and be surrendered immediately to the insurance commissioner if the resident independent adjuster license terminates for any reason, unless the termination is due to the independent adjuster being issued a new resident independent adjuster license in his, her or its new home state. The new state resident independent adjuster license must have reciprocity with the licensing nonresident state(s) otherwise the nonresident independent adjuster license(s) will terminate. Notice of resident independent adjuster license termination must be given to any state(s) that issued a nonresident independent adjuster license. Notice must be given within thirty (30) days of the termination date; if terminated for change in resident home state then the notice must include both the previous and current address. Maintaining a resident independent adjuster license is required for the nonresident independent adjuster license(s) to remain valid.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this Section. Rather, the state may want to amend its relevant insurance producer statute to include independent adjusters.

Drafting Note: In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

Section 11. Apprentice Independent Adjuster License [Optional]

A. The apprentice independent adjuster license is an optional license to facilitate the experience, education and/or training necessary to ensure reasonable competency of the responsibilities and duties of an independent adjuster as defined in this Guideline.

B. An individual applying for a resident apprentice independent adjuster license shall make application to the insurance commissioner on the appropriate NAIC Uniform Individual Application in a format prescribed by the insurance commissioner and declare under penalty of suspension, revocation or refusal of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the insurance commissioner shall find that the individual:

(1) Is at least eighteen (18) years of age;

(2) Is a resident of this state and has designated this state as his or her home state;

(3) Has a business or mailing address in this state for acceptance of service of process;

(4) Has not committed any act that is a ground for probation, suspension, revocation or denial of licensure as set forth in Section 12;

(5) Is trustworthy, reliable and of good reputation, evidence of which may be determined by the insurance commissioner;

(6) Has paid the fees set forth in [insert appropriate reference to state law or regulation].

C. The apprentice independent adjuster license shall be subject to the following terms and conditions:

(1) Accompanying the apprentice adjuster application shall be an attestation, from a licensed independent adjuster with the same line(s) of authority for which the apprentice has applied, certifying that the apprentice will be subject to training, direction and control by the licensed independent adjuster and further certifying that the licensed independent adjuster assumes responsibility for the actions of the apprentice in the apprentice's capacity as an independent adjuster;

(2) The apprentice independent adjuster is only authorized to adjust claims in the state that has issued the apprentice independent adjuster license;

(3) The apprentice licensee is restricted to participation in the investigation, settlement and negotiation of claims subject to the review and final determination of the claim by the supervising licensed independent adjuster;

(4) Compensation of an apprentice independent adjuster shall be on a salaried or hourly basis only;

(5) The apprentice independent adjuster shall not be required to take and successfully complete the independent adjuster examination pursuant to Section 8, to adjust claims as an apprentice independent adjuster. However, at any time during the apprenticeship the apprentice independent adjuster may choose to take the examination required by Section 8. If the individual takes and successfully completes the independent adjuster exam the apprentice independent adjuster license shall automatically terminate and an independent adjuster license shall be issued to that individual in place thereof;

(6) The apprentice independent adjuster license is for a period not to exceed twelve (12) months and is nonrenewable; and

(7) The licensee shall be subject to probation, suspension, revocation, or refusal pursuant to Section 12 of this Guideline.

D. The licensed independent adjuster responsible for the apprentice independent adjuster, as stated in Section 11(C)(1), shall only supervise [insert appropriate reference to state law or regulation].

Section 12. License Denial, Non-Renewal, or Revocation

A. The insurance commissioner may place on probation, suspend, revoke, or refuse to issue or renew an independent adjuster's license or may levy a civil penalty in accordance with [insert appropriate reference to state law] or any combination of the above actions for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) Violating any insurance laws, regulations, subpoena or order of the insurance commissioner or of another state's insurance commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, in the conduct of insurance business in this state or elsewhere;

(9) Having an insurance license, or its equivalent, probated, suspended, revoked or refused in any other state, province, district, or territory;

(10) Forging another's name to any document related to an insurance transaction;

(11) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license;

(12) Failing to comply with an administrative or court order imposing a child support obligation; or

(13) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax which remains unpaid.

Drafting Note: Paragraph (13) is for those states that have a state income tax.

B. In the event that the action by the insurance commissioner is to refuse application for licensure or renewal of an existing license, the insurance commissioner shall notify the applicant or licensee in writing, advising of the reason for the refusal. The applicant or licensee may make written demand upon the insurance commissioner within [insert appropriate time period from state's Administrative Procedure Act] for a hearing before the insurance commissioner to determine the reasonableness of the refusal. The hearing shall be held within [insert time period from state law] and shall be held pursuant to [insert appropriate reference to state law].

C. The license of a business entity may be probated, suspended, revoked, or refused if the insurance commissioner finds, after a hearing, that its designated individual licensee's violation occurred while acting on behalf of or representing the business entity and that the violation was known or should have been known by one or more of the business entity's partners, officers or managers and that the violation was neither reported to the insurance commissioner nor was corrective action taken.

D. In addition to or in lieu of any applicable probation, suspension, revocation or refusal, a person may, after a hearing, additionally be subject to a civil fine according to [insert appropriate reference to state law].

E. The insurance commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this Guideline and Title [insert appropriate reference to state law] against any person who is under investigation for or charged with a violation of this Guideline or Title [insert appropriate reference to state law] even if the person's license or registration has been surrendered or has expired by operation of law.

Section 13. Continuing Education

A. An individual, who holds an independent adjuster license and who is not exempt under Subsection B of this Section, shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, of which three (3) hours must be in ethics, reported to the insurance commissioner on a biennial basis in conjunction with their license renewal cycle.

B. This Section shall not apply to:

(1) Licensees not licensed for one (1) full year prior to the end of the applicable continuing education biennium; or

(2) Licensees holding nonresident independent adjuster licenses who have met the continuing education requirements of their designated home state.

Section 14. Record Retention

An independent adjuster shall maintain a copy of each contract between the independent adjuster and the insurer or self-insurer and comply with the record retention policy as agreed to in that contract.

Section 15. Standards of Conduct of Independent Adjusters [Optional]

A. An independent adjuster shall be honest and fair in all communications with the insured, the insurer and the public;

B. An independent adjuster shall give policyholders and claimants prompt, knowledgeable service and courteous, fair and objective treatment at all times;

C. An independent adjuster shall not give legal advice, and shall not deal directly with any policyholder or claimant who is represented by legal counsel without the consent of the legal counsel involved;

D. An independent adjuster shall comply with all local, state and federal privacy and information security laws, if applicable;

E. An independent adjuster shall identify himself as an independent adjuster and, if applicable, identify his employer when dealing with any policyholder or claimant; and

F. An independent adjuster shall not have any financial interest in any adjustment or acquire for himself or any person any interest or title in salvage, without first receiving written authority from the principal.

Section 16. Reporting of Actions

A. The independent adjuster shall report to the insurance commissioner any administrative action taken against the independent adjuster in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent order and any other relevant legal documents.

B. The independent adjuster shall report to the insurance commissioner any criminal action taken against the independent adjuster in this or any jurisdiction within thirty (30) days of the final disposition of the criminal matter. The report shall include a copy of the initial complaint filed, the final order issued by the court, and any other relevant legal documents.

Drafting Note: If the state has adopted the Producer Licensing Model Act, it may not be necessary to adopt this Section. Rather, the state may want to amend its relevant insurance producer statute to include independent adjusters.

Section 17. Regulations

The insurance commissioner may, in accordance with [insert appropriate reference to state law], promulgate reasonable regulations as are necessary or proper to carry out the purposes of this Guideline.

Section 18. Severability

If any provisions of this Guideline, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the Guideline, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 19. Effective Date

This Guideline shall take effect [insert date].

Note: A minimum of six months to one year implementation time for proper notice of changes, fees and procures is recommended.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2008 Proc. 3rd Quarter, Vol. I 128, 147, 167, 173, 511-523 (adopted).

INDEPENDENT ADJUSTER LICENSING GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

INDEPENDENT ADJUSTER LICENSING GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-151-.01 to 482-1-151-.16 (2012/2018) (adopted).
Alaska	ALASKA STAT. §§ 21.27.010 to 21.27.460 (1966/2014); §§ 21.27.830 to 21.27.870 (1992/2001) (adopted).
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	ARK. CODE ANN. § 23-64-209 (1959/2017).
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	FLA. ADMIN CODE r. § 69B-220.001 (1993/2010) (licensure of emergency adjusters).
Georgia	GA. CODE ANN. § 33-23-29 (1992/2019).
Guam	NO CURRENT ACTIVITY
Hawaii	HAW. REV. STAT. ANN. §§ 431:9-101 to 431:9-240 (1987).
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	IND. CODE §§ 27-1-28-1 to 27-1-28-24 (2011/2018) (adopted).
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	KY. REV. STAT. ANN. § 304.9-430 (1970/2019).
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

INDEPENDENT ADJUSTER LICENSING GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	MINN. STAT. ANN. §§ 72B.01 to 72B.136 (1971/2019) (adopted).
Mississippi	MISS. CODE. ANN. §§ 83-17-401 to 83-17-425 (1993).
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NEV. REV. STAT. ANN. §§ 684A.010 to 684A.260 (1971).
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	N.M. CODE R. § 13.4.8 (2019).
New York	N.Y. INS. LAW § 2101 (2008/2014); § 2108 (1984/2019) (adopted).
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	OKLA. STAT. tit. 36, §§ 6201 to 6222 (1973/2019) (adopted).
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	P.R. REGS. OCS REG. 8646 (2015) (adopted).
Rhode Island	R.I. GEN. LAWS §§ 27-10-1 to 27-10-14 (2014); BULLETIN 2014-8 (2014); 230 R.I. CODE R. § 20-50-4 (2015) (adopted).
South Carolina	NO CURRENT ACTIVITY

INDEPENDENT ADJUSTER LICENSING GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	UTAH CODE ANN. §§ 31A-26-201 to 31A-26-216 (1985/2019) (adopted).
Vermont	NO CURRENT ACTIVITY
Virgin Islands	V.I. CODE ANN. tit. 22, § 767 (2017).
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	W. VA. CODE ANN. §§ 33-12B-1 to 33-12B-15 (1988).
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY – 2008

INDEPENDENT ADJUSTER LICENSING GUIDELINE (#1224)

1. Description of the Project, Issues Addressed, etc.

The Independent Adjuster Licensing Guideline provides uniform resident licensing standards among the states, while allowing a properly licensed independent adjuster, through reciprocity, to become licensed in many states as dictated by insurer needs. The purpose of the Guideline is to govern the qualifications and procedures for licensing independent adjusters and to specify the duties of and restrictions on the independent adjuster. Without uniform regulation of independent adjusters among the states the insured consumer may not be sufficiently served and protected.

2. Name of Group Responsible for Drafting the Model and States Participating

The Producer Licensing Working Group of the Market Regulation and Consumer Affairs (D) Committee was responsible for drafting the Guideline. Laurie Wolf (ND) was chair of the working group until 2008. Anne Marie Narcini (NJ) became chair of the working group in 2009. Treva Wright-Donnell (KY) acted as vice-chair of the working group during the development of the guideline. The following states were members of the working group: Alaska, Alabama, Arizona Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

To help facilitate the drafting process, the Producer Licensing Working Group appointed the Independent Adjuster Licensing Guideline Subgroup. Treva Wright-Donnell (KY) chaired this subgroup, Gene Reed (DE) acted as vice-chair. The subgroup was comprised of the following states: Alaska, California, Florida, Louisiana, New Hampshire, New Jersey, New York, North Dakota, and Oklahoma.

3. Project Authorized by What Charge and Date First Given to the Group

The charge for the Producer Licensing (D) Working Group reads as follows: "Appoint a Producer Licensing Working Group to develop and implement uniform standards, interpretations and treatment of producer and adjuster licensees and licensing terminology; coordinate and consult with the National Insurance Producer Registry Board of Directors to develop and implement uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology; and monitor and respond to developments related to licensing reciprocity".

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was open to comments and participation by all interested parties. Representatives from the insurance producer industry participated fully in the process and discussion sessions. All revised drafts of the guideline were circulated for public comment. Comments were received on each draft of the guideline and considered by the subgroup in open conference calls and meetings. The subgroup received and reviewed numerous comments from interested parties. The process resulted in a total of 16 revised drafts.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Copies of every draft were posted on the NAIC website or distributed by e-mail along with the solicitation for public comment. The Producer Licensing (D) Working Group adopted this model on April 21, 2008.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

State regulators and industry representatives expressed concerns about the definition of Independent Adjuster. In response, several comments were received from states and industry to determine the best language. The final result ended as a three-part definition to cover all areas of concern.

Each draft from the initial to the final have included discussions regarding the definition of a "home state" included in Sections 2 - Definitions, Section 3 - License Required, and Section 5 - Temporary Licensure or Registration for Emergency Independent Adjusters. The discussion originated due to states that do not require an adjuster license and the inability for an applicant to designate a home state if no license is offered. A survey was conducted to determine what states license adjusters. Based on the survey responses and language provided from industry and state departments the definition of home state was modified to allow an adjuster to designate a home state.

7. Any Other Important Information (e.g., designated home state)

The American Association of Independent Claims Professionals (AAICP) brought up an issue concerning section 6 of the guideline after the guideline was adopted. According to the AAICP, the language would require an adjuster would be required to have a business or mailing address in the nonresident "designated home state." Based upon these concerns, the working group removed Section 6A(3) and Section 6B(2) and added the following drafting note: "Employee of the authorized affiliate insurer may be considered under this exemption with the commissioners consent".

NOTICE OF PROTECTION
PROVIDED BY [STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the [STATE] Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under [STATE] law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with [STATE] law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - [$___,000] in death benefits
  - [$___,000] in cash surrender and withdrawal values
- Health Insurance
  - [$___,000] for health benefit plans (see definition below)
  - [$___,000] in disability [income] insurance benefits
  - [$___,000] in long-term care insurance benefits
  - [$___,000] in other types of health insurance benefits
- Annuities
  - [$___,000] in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is [$___,000]. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in [insert citation to applicable guaranty association statute] and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under [STATE] law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, [as well as protections relating to group contracts or retirement plans,] please visit the Association's website at [www._____], or contact:

[STATE] Life and Health Insurance Guaranty Association
[ADDRESS]
[PHONE NUMBER]

[STATE] Department of Insurance
[ADDRESS]
[PHONE NUMBER]

Notice of Protection Provided by [State]
Life and Health Insurance Guaranty Association

Insurance companies and agents are not allowed by [STATE] law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and [STATE] law, then [STATE] law will control.

Chronological Summary of Action (All references are to the Proceedings of the NAIC)

2010 Proc. 1st Quarter, Vol. I 105, 129, 134, 297 (adopted).
June 18, 2015 Ex/Plenary Conference Call (technical correction)
4th Quarter 2018 (amended).

NOTICE OF PROTECTION PROVIDED BY [STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

What are the state pages?

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How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation. To perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

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NOTICE OF PROTECTION PROVIDED BY
[STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	ORDER R2018-3 (2018).
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	BULLETIN 2010-7 (2010).
Indiana	BULLETIN 249 (2019).
Iowa	BULLETIN 2012-2 (2012); BULLETIN 2012-3 (2012).
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

NOTICE OF PROTECTION PROVIDED BY
[STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

NAIC MEMBER	RELATED ACTIVITY
Maryland	MD. CODE REGS. § 31.04.14.03 (1996/2015).
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	19-24 MISS. CODE R. PT. 1, § 24.06; Appendix A (2012/2014).
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-5.600 (1988/2016).
Montana	MONT. ADMIN. R. 6.6.4603; Appendix A (2011/2019).
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	BULLETIN 2013-005 (2013).
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	N.D. ADMIN. CODE § 45-11-01, Ex A (1990/2012).
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	BULLETIN 2010-03 (#2) (2010).
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY

NOTICE OF PROTECTION PROVIDED BY
[STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

NAIC MEMBER	RELATED ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	UTAH ADMIN. CODE r. R590-155 (2010/2019).
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	ADMINISTRATIVE LETTER 2018-2 (2018).
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	44-43 WYO. CODE R. §§ 1 to 3 (2004/2016).

PROJECT HISTORY - 2018

NOTICE OF PROTECTION PROVIDED BY [STATE] LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION GUIDELINE #1525)

1. Description of the Project, Issues Addressed, etc.

The Executive (EX) Committee and Plenary adopted amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) on Dec. 21, 2017, that address assessments for long-term care insurance (LTCI) insolvencies, the addition of health maintenance organizations (HMOs) as members of the guaranty association, and certain guaranty association coverages and limitations.

On Aug. 5, 2018, the Receivership and Insolvency (E) Task Force received a request from the American Council of Life Insurers (ACLI) for proposed revisions to the *Notice of Protection Provided by [State] Life and Health Insurance Guaranty Association* (#1525) to incorporate changes that conform to the adopted revisions to Model #520. The revisions to Guideline #1525 include references to HMOs, health benefit plans and LTCI riders.

2. Name of Group Responsible for Drafting the Guideline and States Participating

The Receivership and Insolvency (E) Task Force is responsible for Guideline #1525. The 2018 members of the Task Force are: New Jersey (Chair); District of Columbia (Co-Vice Chair), Texas (Co-Vice Chair), Alaska, American Samoa, Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, Washington, Wisconsin and Wyoming.

The amendments to Guideline #1525 were drafted jointly by the ACLI, the National Organization of Life and Health Guaranty Associations (NOLHGA) and certain health insurers.

3. Project Authorized by What Charge and Date First Given to the Group

The Receivership and Insolvency (E) Task Force is charged with addressing any issues that affect receivership laws, including amendments to models and guidelines. The request to amend Guideline #1525 was first considered by the Task Force on Aug. 5, 2018.

4. A General Description of the Drafting Process and Due Process

The Receivership and Insolvency (E) Task Force discussed the proposal on Aug. 5, 2018, at the NAIC Summer National Meeting. The Task Force exposed the proposed amendments for a 30-day public comment period ending Sept. 5, 2018. No comments were received. The Task Force adopted the amendments on Oct. 1, 2018.

The Financial Condition (E) Committee adopted the amendments on October 31, 2018.

5. A Discussion of the Significant Issues

None.

6. Any Other Important Information

None.

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

Drafting Note: State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a twenty-four-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB).[1] The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a "stay" under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes. Notwithstanding NAIC's request for inclusion, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for QFCs. Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to require a stay with respect to the termination of a netting agreement or QFC of an insurer in insolvency:

Stay on Termination of Netting Agreements and Qualified Financial Contracts

A person who is a party to a netting agreement or qualified financial contract under [cite to applicable state law addressing qualified financial agreements] with an insurer that is the subject of an insolvency proceeding may not exercise any right that the person has to terminate, liquidate, accelerate or close-out the obligations with respect to the contract by reason of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding,

(1) Until 5:00 p.m. (eastern time) on the business day following the date of appointment of a receiver; or

(2) After the person has received notice that the contract has been transferred pursuant to [cite applicable state law addressing transfer of qualified financial contracts].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2013 Proc. 2nd Quarter, Vol. I 113, 127, 131-132, 537-538 (adopted).
Fall 2019 (amended).

[1] *Restrictions on Qualified Financial Contracts of Systemically Important U.S. Banking Organizations and the U.S. Operations of Systemically Important Foreign Banking Organizations*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 42882 (13 November 2017), available at https://www.federalregister.gov/d/2017-19053; *Restrictions on Qualified Financial Contracts of Certain FDIC Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 50228 (30 October 2017), available at https://www.federalregister.gov/d/2017-21951; *Restrictions on Qualified Financial Contracts of Certain FDIC-Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definition, 82 FR 61443 (28 December 2017), available at https://www.federalregister.gov/d/2017-27971; *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at https://www.federalregister.gov/d/2017-25529.

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

NAIC MEMBER	RELATED ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS

NAIC MEMBER	RELATED ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2019

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS (#1556)

1. Description of the Project, Issues Addressed, etc.

In 2017 the Board of Governors of the Federal Reserve System (the Federal Reserve), the Federal Deposit Insurance Corporation (the FDIC) and the Office of the Comptroller of the Currency (the OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB).[1] The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a "stay" under several defined resolution regimes including Title II of Dodd Frank, the FDIA, as well as comparable foreign resolution regimes.

Notwithstanding NAIC's request for inclusion through a formal comment letter and subsequent discussions, stays under the state insurance receivership regime (State Receivership Stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize State Receivership Stays, if a state implements a stay as contemplated by the *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* (Guideline #1556), insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for qualified financial contracts (QFCs).

On Dec. 2, 2017, the Receivership and Insolvency (E) Task Force received a referral from the Financial Stability (EX) Task Force that included three tasks, one of which was to "evaluate whether there are any current misalignments between federal and state laws that could be an obstacle to achieving effective and orderly recovery and resolutions for U.S. insurance groups (e.g., federal rule recognizing importance of temporary stays on the termination of master netting agreements for QFCs that does not recognize the utility and import of state-based stays in state receivership proceedings).

The RITF assigned the task of evaluating these issues to a drafting group, who evaluated the impact of the federal rule recognizing temporary stays on terminating master netting agreements for QFCs. The regulators held discussions with federal banking authorities regarding the handling of QFCs in banking resolutions to assess the utility of a stay on terminations in insurance receiverships.

To address the conflict with the federal rule, the drafting group proposed amendments to the drafting note of Guideline #1556 explaining the above issue. Therefore, if a state is considering implementation of Guideline #1556, consideration should be given to whether the rules of the Federal Reserve, FDIC and OCC have been amended to recognize State Receivership Stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize State Receivership Stays.

2. Name of Group Responsible for Drafting the Guideline and States Participating

The Receivership and Insolvency (E) Task Force is responsible for Guideline #1556. The 2019 members of the Task Force are: Texas (Chair); District of Columbia (Co-Vice Chair), Alaska, American Samoa, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, and Washington.

The amendments to Guideline #1556 were drafted by the Task Force's drafting group. The drafting group was comprised of Texas (Lead), Colorado, Connecticut, District of Columbia, Illinois, Massachusetts, Michigan, New Jersey, New Mexico, Pennsylvania. Washington, and Wisconsin.

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[1] *Restrictions on Qualified Financial Contracts of Systemically Important U.S. Banking Organizations and the U.S. Operations of Systemically Important Foreign Banking Organizations*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 42882 (13 November 2017), available at https://www.federalregister.gov/d/2017-19053; *Restrictions on Qualified Financial Contracts of Certain FDIC Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 50228 (30 October 2017), available at https://www.federalregister.gov/d/2017-21951; *Restrictions on Qualified Financial Contracts of Certain FDIC-Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definition, 82 FR 61443 (28 December 2017), available at https://www.federalregister.gov/d/2017-27971; *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at https://www.federalregister.gov/d/2017-25529.

3. Project Authorized by What Charge and Date First Given to the Group

The Receivership and Insolvency (E) Task Force is charged with addressing any issues that affect receivership laws, including amendments to models and guidelines. The request to address misalignments with federal rules was first considered by the Task Force on March 25, 2018, at the NAIC 2018 Spring National Meeting, when a work plan to address the Financial Stability (EX) Task Force's referral and formation of drafting groups were discussed.

4. A General Description of the Drafting Process and Due Process

The drafting group of the Receivership and Insolvency (E) Task Force discussed the proposed amendments on a conference call on March 14, 2019, which included twenty interested parties.

The Receivership and Insolvency (E) Task Force discussed the proposed amendments in open session on April 7, 2019, at the NAIC Spring National Meeting. The Task Force exposed the proposed amendments for a 30-day public comment period ending May 7, 2019. One comment was received supporting the need for Federal rule changes. No changes were made to the Guideline #1556.

The Receivership and Insolvency (E) Task Force adopted the amendments on Aug. 4, 2019, at the NAIC Summer National Meeting.

The Financial Condition (E) Committee adopted the amendments on October 31, 2019.

The NAIC Executive (EX) Committee and Plenary adopted the amendments on [DATE TBD].

5. A Discussion of the Significant Issues

None.

6. Any Other Important Information

None.

PROJECT HISTORY - 2013

GUIDELINE FOR STAY ON TERMINATION OF NETTING AGREEMENTS AND QUALIFIED FINANCIAL CONTRACTS (#1556)

1. Description of the Project, Issues Addressed, etc.

In 2011, the Receivership and Insolvency (E) Task Force (Task Force) recognized that the current economic environment had changed since the *Insurer Receivership Model Act* (#555) (commonly referred to as IRMA) Section 711 was revised in 2005. The Task Force began a research project to assess IRMA Section 711 with respect to the impact on receiverships of any netting agreement or qualified financial contract (QFC). The urgency of such research increased with the requirement under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) to shift standardized derivatives contracts to centralized clearinghouses. The implications of IRMA Section 711 are to: (1) allow immediate netting of offsetting positions between counterparties; and (2) immediate access to collateral pledged against the netted position. The IRMA Section 711 (E) Subgroup was formed in 2011 by the Task Force and charged to:

- Provide Task Force members with a better understanding of the purpose, operational mechanics and implications of *Insurer Receivership Model Act* (#555) (commonly referred to as IRMA) Section 711.
- Assist Task Force members in understanding any policy issues associated with IRMA Section 711 *or* with the absence of IRMA Section 711.
- Provide receivership-focused input on regulatory issues associated with qualified financial contracts.

In 2012, the Subgroup conducted its research of IRMA Section 711, which included surveys to regulators and interested parties on research topics and presentations from industry experts on: (1) the use, regulation and reporting of QFCs, such as derivatives; (2) technical interpretation of the language in IRMA Section 711; and (3) non-insurance insolvencies (i.e., banking) under Section 711-like provisions.

During the Subgroup's research, it determined that state receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration or closeout of obligations with respect to any netting agreement or QFC with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The Subgroup noted that the FDIA also provides for a 24-hour stay to allow for the transfer of QFCs by the receiver to another entity, rather than permitting the immediate termination and netting of the QFC [12 U.S.C. § 1821(e)(9)–(12)]. Currently, state laws do not include a similar 24-hour stay provision.

Included in the recommendations from the Subgroup's research was that the states that permit the termination and netting of QFCs might want to consider adopting a stay provision similar to the FDIA with respect to the termination of a netting agreement or QFC of an insurer in insolvency. The stay provision would give the receiver 24 hours to transfer a contract before termination.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force was charged by the Financial Condition (E) Committee with drafting a new model guideline. The Task Force delegated the drafting of the guideline to the IRMA Section 711 (E) Subgroup. The 2012 members of the IRMA Section 711 (E) Subgroup that drafted the model guideline were: Illinois (Chair), California, Delaware, Florida, Ohio and Texas. The Subgroup was renamed in November 2012 to the Federal Home Loan Bank Legislation (E) Subgroup. Indiana and Missouri joined the Subgroup in 2013. The eight-member Subgroup adopted the model guideline Feb. 8, 2013.

3. Project Authorized by What Charge and Date First Given to the Group

On a May 7, 2012, conference call vote, the Financial Condition (E) Committee unanimously agreed to request that the Receivership and Insolvency (E) Task Force develop a model guideline for the purpose of recommending to NAIC-member jurisdictions that the 24-hour stay provision be included when the state implements IRMA Section 711. On a May 14, 2012, e-vote, the Receivership and Insolvency (E) Task Force delegated the drafting of the model guideline to the IRMA Section 711 (E) Subgroup.

4. A General Description of the Drafting Process and Due Process

- The stay provision was discussed on open conference calls of the Subgroup held Jan. 26, 2012, and Feb. 27, 2012.
- The Subgroup made recommendations as a result of its research, including a recommendation to draft the model guideline. The recommendations were exposed for public comment from Feb. 14, 2012, until Feb. 23, 2012. One comment letter was received from the industry indicating support for the Subgroup's recommendations.
- The stay provision was discussed on an open conference call of Financial Condition (E) Committee held May 7, 2012, during which the Committee approved the recommendation to draft a model guideline.
- An open conference call of the Subgroup was held Dec. 10, 2012, to discuss the draft.
- The draft model guideline was released for public comment from Dec. 10, 2012, until Jan. 24, 2013. No comments were received.
- An open conference call of the Subgroup was held Feb. 8, 2013, where the Subgroup adopted the model guideline.
- The Receivership and Insolvency (E) Task Force and the Financial Condition (E) Committee adopted the model guideline at the Spring National Meeting during meetings held April 7, 2013, and April 8, 2013, respectively.

5. A Discussion of the Significant Issues

The following topics of the model guideline were discussed with regulators and interested parties:

Uniformity with Federal Law

The Subgroup noted that the FDIA provides for a 24-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC [12 U.S.C. § 1821(e)(9)–(12)].

6. Any Other Important Information

None.

GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES

Drafting Note: The Receivership and Insolvency (E) Task Force examined concerns for the timing and collection of reinsurance recoverables held by insurers in receivership. In 2009, a survey was conducted with receivers regarding the status of reinsurance recoverables held by insurers in receivership. The Receivership Reinsurance Recoverables (E) Working Group was given the charge to review the survey responses and recommend possible solutions that potentially address those concerns. On March 27, 2011, the Receivership and Insolvency (E) Task Force adopted the memorandum - *Draft of Solutions Identified to Address Concerns for the Timing and Collection of Reinsurance Recoverables Held by Insurers in Receivership*. The memorandum suggested a solution with respect to Interest on Overdue Payments, which is intended to bring leverage against reinsurers by requiring them to pay interest applicable to delayed payments. The Guideline is intended for use by receivers in instances where a reinsurer unjustifiably denies payment after such time as a claim under its reinsurance agreements has been shown to be properly due and owed. The following statutory language is not an amendment to the NAIC receivership models and is not intended to affect other rights and responsibilities under receivership law, but is intended as a Guideline for use by those states seeking to permit a receiver to collect the payment of interest on overdue reinsurance recoverables:

Payment of Interest on Overdue Reinsurance Recoverables

If a reinsurer does not pay the amount billed by the receiver for a valid claim within 90 days after the billing date, interest on the billed amount will begin to accrue at the statutory legal rate provided in Subsection [fill in state reference], except that all or a portion of the interest may be waived as part of an arbitration proceeding or by the receivership court.

(1) For purposes of this section, the term "valid claim" shall mean a claim that has been allowed by the liquidator, rehabilitator, receiver or conservator.

(2) If requested by the reinsurer, a hearing shall be held to determine whether a claim is a valid claim. If a court determines that the claim is a valid claim, then the reinsurer shall be liable for interest, court costs and costs of recovery for the receiver from the date that the request for payment was first made by the receiver.

(3) Interest will be payable by the reinsurer to the receiver under this section regardless of whether the reinsurance contract expressly permits payment of interest.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2014 Proc. 3rd Quarter, Vol. I 121, 135, 140, 253-255 (adopted).

GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

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GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY

GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES

NAIC MEMBER	RELATED ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2014

MODEL GUIDELINE FOR PAYMENT OF INTEREST TO RECEIVER ON OVERDUE REINSURANCE RECOVERABLES (#1600)

1. Description of the Project, Issues Addressed, etc.

During 2010 and 2011, the Receivership Reinsurance Recoverables (E) Working Group, at the direction of the Receivership and Insolvency (E) Task Force, reviewed and drafted possible solutions to address concerns for the timing and collection of reinsurance recoverables held by insurers in receivership.

The Working Group reviewed suggestions and decided on possible solutions. One of the solutions the Working Group recommended is to require interest on overdue reinsurance payments. This solution is intended to bring leverage against reinsurers by requiring them to pay interest applicable to delayed payments with uniform language across states.

On March 27, 2011, the Working Group issued a memorandum to the Receivership and Insolvency (E) Task Force, and on June 8, 2011, the Task Force sent a referral to the Reinsurance (E) Task Force recommending it consider the uniform reinsurance contract language in the *Credit for Reinsurance Model Law* (#785) to address interest on overdue payments in receivership.

On Sept. 19, 2011, the Financial Condition (E) Committee received a separate referral from the Receivership and Insolvency (E) Task Force requesting assistance with the recommended solution from the adopted March 27 memorandum regarding the enforcement of the collection of undisputed balances. The Committee requested that the Reinsurance (E) Task Force study issues regarding regulatory support for the collection of undisputed reinsurance recoverable balances held by ceding insurance companies in receivership and consider any appropriate NAIC action.

On Feb. 27, 2012, the Reinsurance (E) Task Force issued a report to the Receivership and Insolvency (E) Task Force stating it received and discussed requests from Receivership and Insolvency (E) Task Force during an interim meeting on July 11, 2011, during the process of considering revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786). With regard to the proposed reinsurance contract language to address interest on overdue payments, following discussion with regulators and interested parties, the Reinsurance (E) Task Force determined that a mandatory contract clause within the Model #785 or Model #786 would not be the appropriate mechanism to address this item. The members generally agreed with the intent of the proposed solution; however, the general consensus was that this item might be more appropriately addressed within a state's laws regarding insolvency or general civil procedure. In addition, discussion suggested that further consideration might be necessary with respect to certain aspects of this proposed solution, e.g., definition of the term "valid claim." As such, the Reinsurance (E) Task Force did not implement this clause within Model #785 or Model #786.

On March 4, 2012, the Reinsurance (E) Task Force reconstituted the Receivership Reinsurance Recoverables (E) Working Group with the charge to study and provide a recommendation for the issue of requiring interest on overdue reinsurance payments in receivership.

On Sept. 18, 2012, the Working Group held a conference call, at the conclusion of which it considered drafting a Guideline.

During 2013, NAIC staff conducted surveys of states to gather more information about existing state laws as they pertain to reinsurance payments in receivership. NAIC staff reviewed state survey results; the *Insurer Receivership Model Act* (#555), with a focus on section 504-Powers of the Liquidator, and 611-Reinsurer's Liability; and the language of the Model Acts preceding Model #555—*Insurers Rehabilitation and Liquidation Model Act* and the *Insurers Supervision, Rehabilitation and Liquidation Model Act*. Based on this review, a proposed Guideline was drafted for discussion.

2. Name of Group Responsible for Drafting the Model and States Participating

The Working Group was responsible for drafting the Guideline. The 2013-2014 members of the Working Group that drafted the Guideline were: Delaware (Chair), Illinois, Indiana, Pennsylvania, and Texas. The five-member Working Group adopted the Guideline Aug. 16, 2014.

3. Project Authorized by What Charge and Date First Given to the Group

The Working Group, at the direction of the Receivership and Insolvency (E) Task Force, was reconstituted March 4, 2012, and charged to study and provide a recommendation for the issue of requiring interest on overdue reinsurance payments in receivership.

4. A General Description of the Drafting Process and Due Process

- The Guideline was discussed at open meetings of the Working Group held Dec. 15, 2013; Mar. 29, 2014; and Aug. 16, 2014.
- The Guideline was exposed for public comment from Dec. 15, 2013– Feb. 14, 2014. The exposure was distributed to members, interested regulators and interested parties of both the Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website. Comment letters were received from California, New Jersey, the Reinsurance Association of America (RAA) and Stillman Consulting Services (SCS). The letters were discussed on Mar. 29, 2014, and the RAA was asked to draft additional revisions to the Guideline's drafting note to clarify the Guideline's intent.
- The draft Guideline was released for public comment a second time from July 1, 2014– July. 21, 2014, with the RAA's proposed edits to the drafting note. The exposure was distributed to members, interested regulators and interested parties of both the Working Group and the Receivership and Insolvency (E) Task Force, and posted to the NAIC website. Comments were received from California, Utah and Washington, and were discussed Aug. 16, 2014.
- The Working Group adopted the Guideline on Aug. 16, 2014.
- The Receivership and Insolvency (E) Task Force adopted the Guideline Aug. 17, 2014.
- The Financial Condition (E) Committee adopted the Guideline Aug. 18, 2014.

5. A Discussion of the Significant Issues

The following topics of the Guideline were discussed with regulators and interested parties:

- It was noted during drafting that the simplicity of the Guideline's language was intentional and is designed to fit into each state's existing receivership laws.
- It was also noted during discussions that each state's implementation of such a provision is important. As stated in the Guideline's drafting note, the Guideline is intended for use by receivers in instances where a reinsurer unjustifiably denies payment after such time as a claim under its reinsurance agreements has been shown to be properly due and owed. The Guideline is not an amendment to the NAIC receivership models and is not intended to affect other rights and responsibilities under receivership law, but is intended as a Guideline for use by those states seeking to permit a receiver to collect the payment of interest on overdue reinsurance recoverable. If it is used as intended, the Guideline could be helpful in cases where there is an uncooperative reinsurer.

6. Any Other Important Information

None.

FINANCIAL GUARANTY INSURANCE GUIDELINE

Table of Contents

Section 1. Definitions

A. **As used in this article:**

(1) "Financial guaranty insurance" means a surety bond, an insurance policy or, when issued by an insurer or any person doing an insurance business as defined in Section [insert section], an indemnity contract and any guaranty similar to the foregoing types, under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee or indemnitee as a result of any of the following events:

(a) Failure of any obligor on or issuer of any debt instrument or other monetary obligation (including equity securities guarantied under a surety bond, insurance policy or indemnity contract) to pay when due [to be paid by the obligor or scheduled at the time insured to be received by the holder of the obligation], principal, interest, premium, dividend or purchase price of or on, or other amounts due or payable with respect to**,** the instrument or obligation, when the failure is the result of a financial default or insolvency or, provided that such payment source is investment grade, any other failure to make payment, regardless of whether the obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted;

(b) Changes in the levels of interest rates, whether short or long term, or the differential in interest rates between various markets or products;

(c) Changes in the rate of exchange of currency;

Drafting Note: This provision was not enacted in the New York and California financial guaranty insurance laws, since such risks are viewed as political risk insurance, rather than financial guaranty insurance.

(d) Changes in the value of specific assets or commodities, financial or commodity indices, or price levels in general; or

(e) Other events which the commissioner determines are substantially similar to any of the foregoing.

(2) Notwithstanding Paragraph one (1) of this subsection, "financial guaranty insurance" shall not include:

(a) Insurance of any loss resulting from any event described in Subsection A(1) of this section, if the loss is payable only upon the occurrence of any of the following, as specified in a surety bond, insurance policy or indemnity contract:

(i) A fortuitous physical event;

(ii) A failure of or deficiency in the operation of equipment; or

(iii) An inability to extract or recover a natural resource;

(b) An individual or schedule public official bond;

(c) A contract bond, including bid, payment or maintenance bond, or a performance bond where the bond is guarantying the execution of a contract other than a contract of indebtedness or other monetary obligation;

(d) A bond required or permitted in connection with judicial, probate, bankruptcy or equity proceedings, including appeal, injunction, waiver, probate, open estate and life tenant bonds, and bonds otherwise by law allowed including bonds accepted by state or municipal authorities in lieu of deposits as security for the performance of insurance contracts;

(e) A bond running to the federal, state, county, municipal government or other political subdivision, as a condition precedent to granting of a license to engage in a particular business or of a permit to exercise a particular privilege;

(f) An indemnity bond running to a governmental unit, railroad or charitable organization, or a lost security or utility payment bond;

(g) A lease, purchase and sale or concessionaire surety bond; provided that the obligation of the insurer shall not exceed a period of five (5) years, and the bond is not issued directly or indirectly in connection with the sale of securities, a pooling of financial assets or a credit default swap as defined by Section 1(I) of this article;

(h) A bond guaranteeing the performance of a contract of indebtedness or other monetary obligation where: (i) the aggregate gross principal, interest and other monetary indebtedness or other monetary obligations of any obligor, whose obligations are guaranteed by the insurer, under all bonds issued to that obligor pursuant to this subparagraph do not exceed $10,000,000 and; (ii) the bond is not issued directly or indirectly in connection with the sale of securities, a pooling of financial assets or a credit default swap as defined in Section 1(I) of this article; and (iii) the bond by its terms terminates upon any sale or other transfer of the insured obligation in connection with the sale of securities, a pooling of financial assets or a credit default swap as defined in Section 1(I) of this article;

(i) A depository bond that insures deposits in financial institutions to the extent of the excess cover over the amount insured by the Federal Deposit Insurance Corporation;

(j) A bond, which shall not exceed a period of greater than five (5) years, that guarantees the payment of a premium, deductible, or self-insured retention to an insurer issuing a workers' compensation or liability policy;

(k) Fidelity insurance authorized by Section [insert section];

(l) Credit unemployment insurance, meaning insurance on a debtor in connection with a specific loan or other credit transaction, to provide payments to a creditor in the event of unemployment of the debtor for the installments or other periodic payments becoming due while a debtor is unemployed;

Drafting Note: Subparagraph (l) is to be used by states which do not authorize credit unemployment insurance as a separate line of business but do permit this line to be written.

(m) Credit insurance, meaning insurance indemnifying manufacturers, merchants or educational institutions extending credit against loss or damage resulting from nonpayment of debts owed to them for goods or services provided in the normal course of their business;

Drafting Note: Subparagraph (m) is to be used by states which do not authorize credit insurance as a separate line of business but do permit this line to be written**.**

(n) Guaranteed investment contracts issued by life insurance companies which provide that the life insurer itself will make specified payments in exchange for specific premiums or contributions;

(o) Residual value insurance authorized by Section [insert section];

(p) Mortgage guaranty insurance authorized by Section [insert section];

(q) Indemnity contracts or similar guarantees, to the extent that they are not otherwise limited or proscribed by this chapter,

(i) In which a life insurer or an insurer subject to Section [ ] guarantees its obligations or indebtedness or the obligations or indebtedness of a subsidiary (as defined in Section [insert section]) other than a financial guaranty insurance corporation; provided that:

(I) To the extent that any such obligations or indebtedness are backed by specific assets, the assets must at all times be owned by the insurer or the subsidiary; and

(II) In the case of the guaranty of the obligations or indebtedness of the subsidiary that are not backed by specific assets of the insurer, the guaranty terminates once the subsidiary ceases to be a subsidiary; or

(ii) In which a life insurer guarantees obligations or indebtedness (including the obligation to substitute assets where appropriate) with respect to specific assets acquired by a life insurer in the course of normal investment activities and not for the purpose of resale with credit enhancement, or guarantees obligations or indebtedness acquired by its subsidiary, provided that the assets acquired pursuant to this item (ii) have been:

(I) Acquired by a special purpose entity, whose sole purpose is to acquire specific assets of the life insurer or the subsidiary and issue securities or participation certificates backed by such assets; or

(II) Sold to an independent third party; or

(iii) In which a life insurer guarantees obligations or indebtedness of an employee or insurance agent of the life insurer;

(r) Guarantees of higher education loans, unless written by a financial guaranty insurance corporation;

(s) Guarantees of insurance contracts, except for:

(i) Guarantees of performance of a contract insuring against physical damage to property in favor of mortgagees or other loss payees named in such contract when issued by a surety insurer or an authorized reinsurer;

Drafting Note: Subparagraph (i) is to be used by states which have a provision comparable to Section 1114 of the New York Insurance Law authorizing a surety insurer to guaranty insurance contracts.

(ii) Financial guaranty insurance policies insuring guaranteed investment contracts issued by life insurers, provided that:

(I) The obligations under such contracts are not dependent on the continuance of human life;

(II) The financial guaranty insurance policies do not guaranty death benefits provided by such contracts;

(III) The obligations insured by the financial guaranty insurance policies are investment grade based on the rating of the life insurers or, in the case of separate account guaranteed investment contracts, based on the ratings of such separate accounts;

(IV) The financial guaranty insurance policies shall not condition or delay payment of a claim with respect to such contracts upon the insured or beneficiary making a claim on the contracts with any insurance guaranty fund under this chapter or of any other jurisdiction; and

(V) The financial guaranty insurance policies provide that if, prior to payment by the insurer under the financial guaranty insurance policies, the guaranty fund has paid a claim under such contracts for an amount that, when added to the amount payable under the financial guaranty insurance policies, would exceed the amount owed under such contracts. The financial guaranty insurer shall pay the portion of the amount payable in excess of the contract amounts to the guaranty fund instead of to the beneficiary under such contracts; or

(t) Any other form of insurance covering risks which the commissioner determines to be substantially similar to any of the foregoing.

B. “Affiliate” means a person which, directly or indirectly, owns at least ten (10) but less than fifty percent (50%) of the financial guaranty insurance corporation or which is at least ten percent (10%) but less than fifty percent (50%), directly or indirectly, owned by a financial guaranty insurance corporation.

C. "Aggregate net liability" means the aggregate amount of insured unpaid principal, interest and other monetary payments, if any, of guarantied obligations insured or assumed, less reinsurance ceded and less collateral.

D. "Asset-backed securities" mean:

(1) Securities or other financial obligations of an issuer provided that:

(a) The issuer is a special purpose corporation, trust or other entity, or (provided that the securities or other financial obligations constitute an insurable risk) is a bank, trust company or other financial institution, deposits in which are insured by the Bank Insurance Fund or the Savings Insurance Fund (or any successor thereto); and

(2) A pool of assets:

(a) Has been conveyed, pledged or otherwise transferred to or is otherwise owned or acquired by the issuer;

(b) That backs the securities or other financial obligations issued; and

(c) Where no asset in such pool, other than an asset directly payable by, guaranteed by, or backed by the full faith and credit of the United States government or that otherwise qualifies as collateral under Paragraph One (1) or Two (2) of subsection (F) of this section, has a value exceeding twenty percent (20%) of the pool's aggregate value; or

(3) A pool of credit default swaps or credit default swaps referencing a pool of obligations, provided that:

(a) The swap counterparty whose obligations are insured under the credit default swap is a special purpose corporation, special purpose trust or other special purpose legal entity;

(b) No reference obligation in such pool, other than an obligation directly payable by, guaranteed by or backed by the full faith and credit of the United States government or that otherwise qualifies as collateral under Paragraph Two (2) of Subsection (F) of this section, has a notional amount exceeding ten percent (10%) of the pool's aggregate notional amount; and

(c) The insurer has the benefit of a deductible or other first loss credit protection against claims under its insurance policy.

E. "Average annual debt service" means the amount of insured unpaid principal and interest on an obligation multiplied by the number of insured obligations (assuming that each obligation represents a $1,000 par value), divided by the amount equal to the aggregate life of all these obligations (assuming that each obligation represents a $1,000 par value). This definition, expressed as a formula in regard to bonds, is as follows:

$$\text{Average Annual Debt Service} = \frac{\text{Total Debt Service} \times \text{Number of Bonds}}{\text{Bond Years}}$$

$$\text{Total Debt Service} = \text{Insured Unpaid Principal} + \text{Interest}$$

$$\text{Number of Bonds} = \frac{\text{Total Insured Principal}}{\$1{,}000}$$

$$\text{Bond Years} = \text{Number of Bonds} \times \text{Term in Years}$$

Term in Years = Term to maturity based on scheduled amortization or, in the absence of a scheduled amortization in the case of asset-backed securities or other obligations lacking a scheduled amortization, expected amortization, in each case determined as of the date of issuance of the insurance policy based upon the amortization assumptions employed in pricing the insured obligations or otherwise used by the insurer to determine aggregate net liability.

F. "Collateral" means:

(1) Cash; or

(2) The cash flow from specific obligations which are not callable and scheduled to be received based on expected prepayment speed on or prior to the date of scheduled debt service (including scheduled redemptions or prepayments) on the insured obligation provided that (i) such specific obligations are directly payable by, guaranteed by, or backed by the full faith and credit of the United States government; (ii) in the case of insured obligations denominated or payable in foreign currency as permitted under Paragraph (B) of Section Four (4) of this article, such specific obligations are directly payable by, guaranteed by, or backed by the full faith and credit of such foreign government or the central bank thereof; or (iii) such specific obligations are insured by the same insurer that insures the obligations being collateralized, and the cash flows from such specific obligations are sufficient to cover the insured scheduled payments on the obligations being collateralized; or

(3) The market value of investment grade securities obligations, other than securities obligations evidencing an interest in the project or projects financed with the proceeds of the insured obligations, in an amount not to exceed the principal amount of the insured obligation.

(4) The face amount of each letter of credit that:

(a) Is irrevocable;

(b) Provides for payment under the letter of credit in lieu of or as reimbursement to the insurer for payment required under a financial guaranty insurance policy;

(c) Is issued, presentable and payable either:

(i) At an office of the letter of credit issuer in the United States; or

(ii) At an office of the letter of credit issuer located in the jurisdiction in which the trustee or paying agent for the insured obligation is located;

(d) Contains a statement that either:

(i) Identifies the insurer and any successor by operation of law, including any liquidator, rehabilitator, receiver, or conservator as the beneficiary; or

(ii) Identifies the trustee or the paying agent for the insured obligation as the beneficiary;

(e) Contains a statement to the effect that the obligation of the letter of credit issuer under the letter of credit is an individual obligation of such issuer and is in no way contingent upon reimbursement with respect thereto;

(f) Contains an issue date and a date of expiration;

(g) Either:

(i) Has a term at least as long as the shorter of the term of the insured obligation or the term of the financial guaranty policy; or

(ii) Provides that the letter of credit shall not expire without thirty (30) days prior written notice to the beneficiary and allows for drawing under the letter of credit in the event that, prior to expiration, the letter of credit is not renewed or extended or a substitute letter of credit or alternate collateral meeting the requirements of this subsection is not provided;

(h) States that it is governed by the laws of the state of [insert state] or by the 1983 or 1993 Revision of the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400 or 500) or any successor Revision if approved by the commissioner, and contains a provision for an extension of time, of not less than thirty (30) days after resumption of business, to draw against the letter of credit in the event that one or more of the occurrences described in Article 19 of Publication 400 or 500 occurs; and

(i) Is issued by a bank, trust company, or savings and loan association that:

(i) Is organized and existing under the laws of the United States or any state thereof or, in the case of a non-domestic financial institution, has a branch or agency office licensed under the laws of the United States or any state thereof and is domiciled in a member country of the Organization for Economic Co-operation and Development having a sovereign rating in one of the top two (2) generic lettered rating classifications by a securities rating agency acceptable to the commissioner;

(ii) Has (or is the principal operating subsidiary of a financial institution holding company that has) a long-term debt rating of at least investment grade; and

(iii) Is not a parent, subsidiary or affiliate of the trustee or paying agent, if any, with respect to the insured obligation if such trustee or paying agent is the named beneficiary of the letter of credit; or

(5) The amount of credit protection available to the insurer (or its nominee) under each credit default swap that:

(a) May not be amended without the consent of the insurer and may only be terminated:

(i) At the option of the insurer;

(ii) At the option of the counterparty to the insurer, or its nominee, if the credit default swap provides for the payment of a termination amount equal to the replacement cost of the terminated credit default swap determined with reference to standard documentation of the International Swap and Derivatives Association, Inc. or otherwise acceptable to the commissioner; or

(iii) At the discretion of the commissioner acting as a rehabilitator, liquidator or receiver of the insurer upon payment by or on behalf of the insurer of any termination amount due from the insurer.

(b) Provides for payment under all instances in which payment under a financial guaranty insurance policy is required, except that payment under the credit default swap may be on a first loss, excess of loss or other non-pro-rata basis and may apply on an aggregate basis to more than one policy;

(c) Is provided by:

(i) A counterparty whose obligations under the credit default swap are insured by a financial guaranty insurance corporation licensed under this article or guaranteed by a financial institution referred to in Items (ii) and (iii) of this subparagraph;

(ii) A financial institution satisfying the requirements of Items (i) through (iii) of subparagraph (i) of Paragraph Four (4) of this subsection; provided that

(I) Obligations of such financial institution on parity with its obligations under the credit default swap are investment grade and

(II) If such financial institution is not organized under, or acting through a branch or agency office licensed under, the laws of the United States or any state thereof, then such financial institution is required to collateralize the replacement cost of the credit default swap in the event that it shall fail to maintain such rating; or

(iii) Any other financial institution that the commissioner determines to be substantially similar to any of the foregoing.

Collateral must be deposited with the insurer, held in trust by a trustee or custodian acceptable to the commissioner for the benefit of the insurer, or held in trust pursuant to the bond indenture or other trust arrangement for the benefit of security holders in the form of funds for the payment of insured obligations, sinking funds or other reserves which may be used for the payment of insured obligations and trustee and other administrative fees on a first priority basis established and continually maintained pursuant to the bond indenture or other trust arrangement by a trustee acceptable to the commissioner. The commissioner may promulgate regulations to limit the amount of collateral provided by obligations, letters of credit, or credit default swaps or to limit the amount of collateral provided by any single issuer, bank, or counterparty as provided for in this section.

G. "Commercial real estate" means income producing real property other than residential property consisting of less than five (5) units.

H. “Contingency reserve” means an additional liability reserve established to protect policyholders against the effects of adverse economic cycles or other unforeseen circumstances.

I. "Credit default swap" means an agreement referencing the credit derivative definitions published from time to time by the International Swap and Derivatives Association, Inc. or otherwise acceptable to the commissioner, pursuant to which a party agrees to compensate another party in the event of a payment default by, insolvency of, or other adverse credit event in respect of an issuer of a specified security or other obligation, provided that such agreement does not constitute an insurance contract and the making of such credit default swap does not constitute the doing of an insurance business.

J. “Financial guaranty insurance corporation” or “corporation” means an insurer licensed to transact the business of financial guaranty insurance in this state.

K. “Governmental unit” means the United States of America, Canada, a member country of the Organization for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a securities rating agency acceptable to the commissioner, state, territory or possession of the United States of America, the District of Columbia, a province of Canada, a municipality, or a political subdivision of any of the foregoing, or any public agency or instrumentality thereof.

L. "Excess spread" means, with respect to any insured issue of asset-backed securities, the excess of (a) the scheduled cash flow on the underlying assets that is reasonably projected to be available, over the term of the insured securities after payment of the expenses associated with the insured issue, to make debt service payments on the insured securities over (b) the scheduled debt service requirements on the insured securities, provided that such excess is held in the same manner as collateral is required to be held under Subsection (F) of this section.

M. (1) "Consumer debt obligations" guarantees means financial guaranty insurance that indemnifies a purchaser or lender against loss or damage resulting from defaults on a pool of debts owed for extensions of credit (including in respect of installment purchase agreements and leases) to individuals, provided in the normal course of the purchaser's or lender's business, provided that

(a) Such pool meets the requirements of Paragraph Two (2) of Subsection (D) of this section; and

(b) Such pool has been determined to be investment grade.

(2) Policies providing this coverage shall contain a provision that all coverage under the policies terminates upon sale or transfer of the underlying consumer debt obligation to any transferee that is not an insured of the financial guaranty insurance corporation under a similar policy.

N. “Industrial development bond” means any security, or other instrument, other than a utility first mortgage obligation, under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a private industrial, commercial or manufacturing purpose and not payable or guarantied by a governmental unit.

O. "Insurable risk" means, with respect to asset-backed securities, as defined in Subsection (D) of this section, that such obligation on an uninsured basis has been determined to be not less than investment grade based solely on the pool of assets backing the insured obligation or securing the insurer, without consideration of the creditworthiness of the issuer.

P. “Investment grade” means that

(1) The obligation or parity obligation of the same issuer has been determined to be in one of the top four generic lettered rating classifications by a securities rating agency acceptable to the commissioner;

(2) The obligation or parity obligation of the same issuer has been identified in writing by the rating agency to be of investment grade quality; or

(3) If the obligation or parity obligation of the same issuer has not been submitted to any such rating agency, the obligation is determined to be investment grade (as indicated by a rating in Category 1 or 2) by the Securities Valuation Office of the National Association of Insurance Commissioners.

Q. "Municipal bonds" means municipal obligation bonds and special revenue bonds.

R. "Municipal obligation bond" means any security or other instrument, including a lease payable or guaranteed by the United States or another national government that qualifies as a governmental unit or any agency, department or instrumentality thereof, or by a state or an equivalent political subdivision of another national government that qualifies as a governmental unit, but not a lease of any other governmental unit, under which a payment obligation is created, issued by or on behalf of or payable or guaranteed by a governmental unit or issued by a special purpose corporation, special purpose trust or other special purpose legal entity to finance a project serving a substantial public purpose, and which is:

(1) (a) Payable from tax revenues, but not tax allocations, within the jurisdiction of such governmental unit;

(b) Payable or guaranteed by the United States or another national government that qualifies as a governmental unit, or any agency, department or instrumentality thereof, or by a housing agency of a state or an equivalent subdivision of another national government that qualifies as a governmental unit;

(c) Payable from rates or charges (but not tolls) levied or collected in respect of a non-nuclear utility project, public transportation facility (other than an airport facility) or public higher education facility; or

(d) Payable from future appropriations with respect to lease obligations.

(2) Provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity:

(a) Such obligations are investment grade at the time of issuance;

(b) Such obligations are payable from sources enumerated in subparagraph (a), (b), (c) or (d) of paragraph one (1) of this subsection; and

(c) The project being financed, or the tolls, tariffs, usage fees or other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

S. "Reinsurance" means cessions qualifying for credit under Section 6 (VI) of this Act.

T. "Special revenue bond" means any security, or other instrument under which a payment obligation is created, issued by or on behalf of, or payable or guaranteed by a governmental unit to finance a project serving a substantial public purpose and not payable from any of the sources enumerated in Subsection R of this section, or securities which are the functional equivalent of the foregoing issued by a not-for-profit corporation or a special purpose corporation, special purpose trust or other special purpose legal entity, provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity:

(1) Such obligations are investment grade at the time of issuance;

(2) Such obligations are not payable from the sources enumerated in subparagraph (a), (b), (c) or (d) of paragraph one (1) of subsection (R) of this section; and

(3) The project being financed, or the tolls, tariffs, usage fees or other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

U. "Utility first mortgage obligation" means any obligation of an issuer secured by a first priority mortgage on utility property owned by or leased to an investor-owned or cooperative-owned utility company and located in the United States, Canada, or a member country of the Organization for Economic Co-operation and Development having a sovereign rating in one of the top two (2) generic lettered rating classifications by a securities rating agency acceptable to the commissioner, provided that the utility or utility property or the usage fees or other similar utility rates or charges are subject to regulation or oversight by a governmental unit.

Section 2. Organization; Financial Requirements

A. A financial guaranty insurance corporation may be organized and licensed in the manner prescribed in Section [insert section] and a foreign insurer may be licensed in the manner prescribed in Section [insert section], except as modified by the following provisions:

(1) A corporation organized for the purpose of transacting financial guaranty insurance may, subject to all the applicable provisions of this chapter, be licensed to transact only the following additional kinds of insurance:

(a) Residual value insurance, as authorized by Section [insert section];

(b) Surety insurance, as authorized by Section [insert section]; and

(c) Credit insurance, as authorized by Section [insert section].

(2) A corporation may only assume those lines of insurance for which it is licensed to write direct business.

(3) Prior to the issuance of a license, unless a plan of operation has been previously approved by the commissioner, a corporation shall submit for the approval of the commissioner a plan of operation detailing the types and projected diversification of guarantees that will be issued, the underwriting procedures that will be followed, managerial oversight methods, investment policies and such other matters as may be prescribed by the commissioner.

(4) A financial guaranty insurance corporation's investments in any one entity insured by that corporation shall not exceed four percent (4%) of its admitted assets at last year-end, except that this limit shall not apply to investments payable or guaranteed by a United States governmental unit or [insert state] if such investments payable or guaranteed by the United States governmental unit or [insert state] shall be rated in one of the top two (2) generic lettered rating classifications by a securities rating agency acceptable to the commissioner.

(5) In addition to any transaction that an insurer [may effect and maintain under any other provision of this chapter], a financial guaranty insurance corporation may effect and maintain transactions in:

(a) Contracts for the future delivery or receipt of the currency of a foreign country;

(b) Interest rate options;

(c) Credit default swaps under which the insurer is acquiring credit protection; and

(d) Other products included in the plan referred to in Clause (vii) of this subparagraph, in each case meeting the following requirements:

(i) The transaction is used for the purpose of limiting risk of loss under financial guaranty insurance policies or reinsurance contracts covering such policies due to fluctuations in interest rates or currency exchange rates or, in the case of credit default swaps, financial default, insolvency or other credit events;

(ii) The transaction shall not exceed a duration of twelve (12) months beyond the term of such policies or reinsurance contracts;

(iii) The amount of foreign currencies to be purchased under the transaction shall not exceed the amount guaranteed under such policies or reinsurance contracts that is denominated in foreign currency;

(iv) The amount that is subject to interest rate hedging transactions does not exceed the amount guaranteed under such policies or reinsurance contracts that is subject to the risk of interest rate fluctuations;

(v) The counterparty to such transaction has, or is the principal operating subsidiary of a holding company that has, a long term unsecured debt rating or claims-paying ability rating that is at least investment grade;

(vi) The transaction is not conducted for arbitrage purposes; and

(vii) The transaction is entered into pursuant to a plan that has been approved by the board of directors of the financial guaranty insurance corporation and filed with and approved by the commissioner.

B. (1) A financial guaranty corporation shall not transact business unless it has paid-in capital of at least $2.5 million and paid-in surplus of at least $72.5 million, and shall at all times thereafter maintain a minimum surplus to policyholders of at least $65 million;

(2) An insurer transacting only financial guaranty insurance prior to the effective date of this article which has a paid-in capital of at least $2.5 million and maintains surplus to policyholders of at least $45 million shall have thirty-six (36) months from the effective date of this article to fully comply with the surplus requirements set forth in paragraph one (1) of this subsection.

Section 3. Contingency, Loss and Unearned Premium Reserves

Drafting Note: States can either adopt the following from Article 69 of the New York Insurance Law or the section that follows from the California Insurance Code. Both are shown in this guideline to provide alternatives for enactment.

A. Contingency reserves.

(1) A corporation shall establish and maintain contingency reserves for the protection of insureds and claimants against the effects of excessive losses occurring during adverse economic cycles.

(2) With respect to all financial guarantees written prior to and in force as of the first day of the next calendar quarter commencing after July 1, 1989:

(a) The insurer shall establish and maintain a contingency reserve consistent with the requirements applicable for municipal bond guarantees in effect prior to July 1, 1989 equal to fifty percent (50%) of earned premiums on such policies; and

(b) To the extent that the insurer's contingency reserves maintained as of the first day of the next calendar quarter commencing after July 1, 1989 are less than those required for municipal bond guarantees, the insurer shall have three (3) years from such date to bring its contingency reserves into compliance.

(3) With respect to financial guarantees of municipal obligation bonds, special revenue bonds, industrial development bonds and utility first mortgage obligations written on and after the first day of the next calendar quarter commencing after the date that the act enacting this article shall become law:

(a) The insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each category listed in subparagraph (b) of this paragraph;

(b) The total contingency reserve required shall be the greater of fifty percent (50%) of premiums written for each such category or the following amount prescribed for each such category:

(i) Municipal obligation bonds, 0.55 percent (55%) of principal guarantied;

(ii) Special revenue bonds, and obligations demonstrated to the satisfaction of the commissioner to be the functional equivalent thereof, 0.85 percent (.85%) of principal guarantied;

(iii) Investment grade industrial development bonds, secured by collateral or having a term of seven (7) years or less, and utility first mortgage obligations, 1.0 percent (1%) of principal guarantied;

(iv) Other investment grade industrial development bonds, 1.5 (1.5%) percent of principal guarantied; and

(v) All other industrial development bonds, 2.5 percent (2.5%) of principal guarantied; and

(c) Contributions to the contingency reserve required by this paragraph, equal to one-eightieth of the total reserve required, shall be made each quarter for twenty (20) years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in Items (i) through (v) of Subparagraph (b) of this paragraph exceeds the percentages contained in such Items (i) through (v) when applied against unpaid principal.

(4) With respect to all other financial guarantees written on or after July 1, 1989

(a) The insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each such category listed in Subparagraph (b) of this paragraph;

(b) The total contingency reserve required shall be the greater of fifty percent (50%) of premiums written for each such category or the following amount prescribed for each such category:

(i) Investment grade obligations, secured by collateral or having a term of seven (7) years or less, 1.0 percent (1%) of principal guarantied;

(ii) Other investment grade obligations, 1.5 percent (1.5%) of principal guarantied;

(iii) Non-investment grade consumer debt obligations, 2.0 percent (2%) of principal guarantied;

(iv) Non-investment grade asset-backed securities, 2.0 percent (2%) of principal guarantied;

(v) Other non-investment grade obligations, 2.5 percent (2.5%) of principal guarantied; and

(c) Contributions to the contingency reserve required by this paragraph, equal to one-sixtieth of the total reserve required, shall be made each quarter for fifteen (15) years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in Items (i) through (v) of Subparagraph (b) of this paragraph exceeds the percentages contained in such Items (i) through (v) when applied against unpaid principal.

(5) Contingency reserves required in paragraphs two, three and four of this subsection may be established and maintained net of collateral and reinsurance, provided that, in the case of reinsurance, the reinsurance agreement requires that the reinsurer shall, on or after the effective date of the reinsurance, establish and maintain a reserve in an amount equal to the amount by which the insurer reduces its contingency reserve, and contingency reserves required in paragraphs three and four of this subsection may be maintained:

(a) Net of refunds and refinancing to the extent the refunded or refinanced issue is paid off or secured by obligations which are directly payable or guarantied by the United States government and

(b) Net of insured securities in a unit investment trust or mutual fund that have been sold from the trust or fund without insurance.

(6) The contingency reserves may be released thereafter in the same manner in which they were established and withdrawals thereof, to the extent of any excess, may be made from the earliest contributions to such reserves remaining therein:

(a) With the prior written approval of the commissioner:

(i) If the actual incurred losses for the year, in the case of the categories of guarantees subject to paragraph three (3) of this subsection exceeds thirty-five percent (35%) of earned premiums, or in the case of the categories of guarantees subject to Paragraph Four (4) of this subsection exceed sixty-five percent (65%) of earned premiums; or

(ii) If the contingency reserve applicable to the categories of guarantees subject to paragraph three (3) of this subsection has been in existence for less than forty (40) quarters, or for less than thirty (30) quarters for the categories of guarantees subject to paragraph four (4) of this subsection, upon a demonstration satisfactory to the commissioner that the amount carried is excessive in relation to the insurer's outstanding obligations under its financial guarantees.

(b) As shall not otherwise be disapproved by the commissioner within thirty (30) days following receipt of written notification providing a demonstration satisfactory to the commissioner that the amount carried is excessive in relation to the insurer's outstanding obligations under its financial guarantees, provided that the contingency reserve applicable to the categories of guarantees subject to paragraph three (3) of this subsection has been in existence for forty (40) quarters, or thirty (30) quarters for categories of guarantees subject to paragraph four (4) of this subsection.

(7) An insurer providing financial guaranty insurance may invest the contingency reserve in tax and loss bonds (or similar securities) purchased pursuant to Section 832(e) of the Internal Revenue Code (or any successor provision), only to the extent of the tax savings resulting from the deduction for federal income tax purposes of a sum equal to the annual contributions to the contingency reserve. The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in [insert statutory reference to permissible investments].

End of New York Article 69.

Drafting Note: States can either adopt the following from Section 12108 of the California Insurance Code, or the previous section from the New York Insurance Law.

A. An admitted financial guaranty insurance corporation shall establish and maintain a contingency reserve.

B. With respect to all financial guarantees written prior to and in force as of July 1, 1989:

(1) The financial guaranty insurance corporation shall establish and maintain a contingency reserve consistent with the requirements applicable for municipal bond insurance policies which were in effect prior to July 1, 1989, in an amount equal to 50 percent (50%) of earned premiums on those policies.

(2) To the extent that the financial guaranty insurance corporation's contingency reserves maintained as of July 1, 1989, are less than those required for municipal bond insurance policies pursuant to paragraph one (1), the corporation shall have until January 1, 1994, to bring its reserves into compliance.

C. With respect to financial guarantees of municipal obligation bonds, special revenue bonds and investment grade industrial development bonds written after July 1, 1989:

(1) The financial guaranty insurance corporation shall establish and maintain a contingency reserve in accordance with Paragraph Three (3) of Subdivision (D) for all those insured issues in each calendar year for each category listed in paragraph two (2) of this subdivision.

(2) The total contingency reserve required shall be the greater of 50 percent (50%) of premiums written for each such category or the following amount prescribed for each such category:

(a) Municipal obligation bonds, 0.8 percent (.8%) of principal outstanding.

(b) Special revenue bonds, 1.2 percent (1.2%) of principal outstanding.

(c) Investment grade industrial development bonds secured by collateral or with a remaining term at the date of insurance of seven (7) years or less and utility first mortgage obligations, 1.4 percent (1.4%) of principal outstanding.

(d) All other investment grade industrial development bonds, 1.6 percent (1.6%) of principal outstanding.

(3) Contributions to the contingency reserve required by this paragraph, equal to one-eightieth of the total reserve required, shall be made each quarter for twenty (20) years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in Items (a) through (d) of subparagraph two (2) exceeds the percentages contained in Items (a) through (d) when applied against unpaid principal.

D. With respect to all other financial guarantees written on or after July 1, 1989:

(1) The financial guaranty insurance corporation shall establish and maintain a contingency reserve in accordance with paragraph three (3) for all those insured issues in each calendar year for each such category listed in paragraph two (2).

(2) The total contingency reserve required shall be the greater of 50 percent (50%) of premiums written for each such category or the following amount prescribed for each such category:

(a) Investment grade obligations, secured by collateral, or with a remaining term at the date of insurance of seven (7) years or less, 1.2 percent (1.2%) of principal outstanding.

(b) Other investment grade obligations, 1.7 percent (1.7%) of principal outstanding.

(c) Non-investment grade obligations secured by collateral, 2.5 percent (2.5%) of principal outstanding.

(d) Other non-investment grade obligations, 3.0 percent (3.0%) of principal outstanding.

(3) Contributions to the contingency reserve required by subparagraphs (a) and (b) of paragraph two (2), equal to one-sixtieth of the total reserve required, shall be made each quarter for fifteen (15) years, and contributions to the contingency reserve required by subparagraphs (c) and (d) of paragraph two (2), equal to one-fortieth of the total reserve required, shall be made each quarter for ten (10) years provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in subparagraphs (a) through (d) of paragraph two (2) exceeds the percentages contained in subparagraphs (a) through (d) when applied against unpaid principal.

E. Contingency reserves required in Subdivisions (B), (C), and (D) may be established and maintained net of collateral and reinsurance, provided that, in the case of reinsurance, the reinsurance agreement requires that the reinsurer shall, on or after the effective date of the reinsurance, establish and maintain a reserve in an amount equal to the amount by which the financial guaranty insurance corporation reduces its contingency reserve. In addition, contingency reserves required in Subdivisions (C) and (D) may be maintained net of refunds and refinancing to the extent the refunded or refinanced issue is paid off or secured by obligations that are directly payable or guarantied by the United States government, and net of insured securities in a unit investment trust or mutual fund that have been sold from the trust or fund without insurance.

F. The contingency reserves may be released thereafter in the same manner in which they were established and withdrawals thereof, to the extent of any excess, may be made from the earliest contributions to such reserves remaining therein:

(1) With the prior written approval of the commissioner, if the actual incurred losses for the year, in the case of the categories of guarantees subject to Subdivision (C) exceeds 35 percent (35%) of earned premiums, or in the case of the categories of guarantees subject to Subdivision (D) exceed 65 percent (65%) of earned premiums.

(2) Upon thirty (30) days prior written notice to the commissioner, provided that the contingency reserve has been in existence for forty (40) quarters, for reserves subject to Subdivision (C), and thirty (30) quarters, for reserves subject to Subdivision (D), upon demonstration that the amount carried is in excess of required amounts or excessive in relation to the financial guaranty insurance corporation's outstanding obligations.

(3) A financial guaranty insurance corporation may invest the contingency reserve in tax and loss bonds or similar securities purchased pursuant to Section 832(e) of the Internal Revenue Code (or any successor provision), only to the extent of the tax savings resulting from the deduction for federal income tax purposes of a sum equal to the annual contributions to the contingency reserve. The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in [insert applicable reserve investment statutory reference].

End of California Contingency Reserve Language.

B. Loss reserves.

(1) In addition to the contingency reserve, the case basis method or other method as may be prescribed by the commissioner shall be used to establish and maintain loss reserves, net of collateral, for claims reported and unpaid, in a manner consistent with Section [insert section], A deduction from loss reserves shall be allowed for the time value of money by application of a discount rate equal to the average rate of return on the admitted assets of the insurer as of the date of the computation of the reserve. The discount rate shall be adjusted at the end of each calendar year.

(2) If the insured principal and interest on a defaulted issue of obligations due and payable during any three (3) years following the date of default exceeds ten percent (10%) of the insurer's surplus to policyholders and contingency reserves, its reserve so established shall be supported by a report from an independent source acceptable to the commissioner.

C. Unearned premium reserve. An unearned premium reserve shall be established and maintained net of reinsurance and collateral with respect to all financial guaranty premiums. Where financial guaranty insurance premiums are paid on an installment basis, an unearned premium reserve shall be established and maintained, net of reinsurance and collateral, computed on a daily or monthly pro rata basis. All other financial guaranty insurance premiums written shall be earned in proportion with the expiration of exposure, or by such other method as may be prescribed by the commissioner.

Section 4. Limitations

A. Financial guaranty insurance may be transacted in this state only by a corporation licensed for that purpose pursuant to Section 2 (II) of this act.

B. Permissible guarantees.

(1) The commissioner shall not permit the writing of financial guaranty insurance except as defined in Subparagraph (a) of Paragraph One (1) of Subsection (A) of section one of this article, and a corporation may insure the timely payment of United States dollar debt instruments, or other monetary obligations, only in the following categories:

(a) Municipal obligation bonds;

(b) Special revenue bonds;

(c) Industrial development bonds;

(d) Obligations of the governments of a country not qualifying as a governmental unit or a municipality, a political subdivision, or any public agency or instrumentality thereof;

(e) Obligations of corporations, trusts or other similar entities established under applicable law;

(f) Partnership obligations;

(g) Asset-backed securities, trust certificates and trust obligations other than mortgage-backed securities secured by first mortgages on real property which are insurable by a mortgage guaranty insurer authorized under Section [insert section], unless:

(i) Such mortgages with loan-to-value ratios in excess of eighty percent (80%) are:

(I) In the case of mortgages on property located in the state of [insert state], insured by mortgage guaranty insurers authorized under Section [insert section];

(II) In the case of mortgages on property located in a state other than the state of [insert state], insured by mortgage guaranty insurers authorized to do business in such other state; or

(III) In an aggregate principal amount less than the single risk limits prescribed in paragraph five (5) of subsection (D) of this section; or

(ii) Additional mortgages with principal balances, other collateral with a market value, or (provided the insured risk is investment grade) excess spread in an amount, in each instance at least equal to the coverage that would otherwise be provided by such mortgage guaranty insurers in accordance with Item (i) of this subparagraph are pledged as additional security for the asset-backed securities;

(h) Installment purchase agreements executed as a condition of sale;

(i) Consumer debt obligations;

(j) Utility first mortgage obligations; and

(k) Any other debt instrument or financial obligation which the commissioner determines to be substantially similar to any of the foregoing.

(2) An insurer may insure obligations enumerated in Subparagraphs (a), (b) and (c) of Subsection B(1) that are not investment grade so long as at least ninety-five percent (95%), or such lower percentage as shall be acceptable to the commissioner of the insurer's aggregate net liability on the kinds of obligations enumerated in Subparagraphs (a), (b) and (c) of Subsection B(1) shall be investment grade. The commissioner may accept a lower percentage of the insurer's aggregate net liability to be investment grade upon determination that there is no undue risk to the insurer's policyholders associated with so doing. In making such a determination, the commissioner shall take into consideration, among other factors, the corporation's outstanding liabilities on non-investment grade instruments and obligations and in relation to the amount of its surplus to policyholders.

(3) A corporation may insure the timely payment of monetary obligations in any category designated in this subsection notwithstanding that such obligation may be insured by a financial guaranty insurance policy issued by another insurer. In the event that any obligation is insured by more than one financial guaranty insurance policy, then each such insurance policy may by its terms specify its priority of payment in the event of a default under the obligation insured or any other insurance policy, provided that an insurer shall be entitled to take into account payment under another policy insuring such obligation for purposes of (i) determining compliance with single risk limits in Subsection D of this section and (ii) establishing and maintaining loss reserves only to the extent that the policy issued by such insurer provides for payment only in the event of payment default under both such obligation and the other policy.

(4) A corporation may also write financial guaranty insurance as defined in Subparagraph (a) of Paragraph One (1) of Subsection (A) of Section One (I) of this article to insure the timely payment of non-United States dollar debt instruments or other monetary obligations denominated or payable in foreign currency, only for the categories listed in subparagraphs (a) through (k) of paragraph one (1) of this subsection, provided that:

(a) Such currency is that of an Organization for Economic Co-operation and Development country or such other country

(i) Whose sovereign rating is investment grade; or

(ii) As shall not otherwise be disapproved by the commissioner within thirty (30) days following receipt of written notification. The commissioner shall not disapprove such notification upon demonstration that there is no undue risk associated with insuring the timely payment of such instruments or obligations. In making such a determination the commissioner shall take into consideration the corporation's outstanding liabilities on non-investment grade instruments and obligations in relation to its outstanding liabilities on all instruments and obligations and in relation to the amount of its surplus to policyholders.

(b) Reserves required pursuant to Section Three of this article in regard to such obligations shall be established and adjusted quarterly based upon the then current foreign exchange rates;

(c) Such obligations shall not exceed twenty-five percent (25%) of an insurer's aggregate net liability; and

(d) The aggregate and single risk limitations prescribed by Subsections (C) and (D) of this section shall be determined by applying the then current foreign exchange rates.

C. Aggregate risk limits. The corporation must at all times maintain surplus to policyholders and contingency reserves in the aggregate no less than the sum of:

(1) (a) 0.3333 percent (.3333%) or 1/300th of the aggregate net liability under guarantees of municipal bonds including obligations demonstrated to the satisfaction of the commissioner to be the functional equivalent thereof and investment grade utility first mortgage obligations; plus

(b) 0.6666 percent (.6666%) or 1/150th of the aggregate net liability under guarantees of investment grade asset-backed securities; plus

(c) 1.0 percent (1%) or 1/100th of the aggregate net liability under guarantees, secured by collateral or having a term of seven (7) years or less, of:

(i) Investment grade industrial development bonds,

(ii) Other investment grade obligations; plus

(d) 1.5 percent (1.5%) or 1/66.67th of the aggregate net liability under guarantees of other investment grade obligations; plus

(e) 2.0 percent (2%) or 1/50th of the aggregate net liability under guarantees of:

(i) Non-investment grade consumer debt obligations, and

(ii) Non-investment grade asset-backed securities; plus

(f) 2.5 percent (2.5%) or 1/40th of the aggregate net liability under guarantees of non-investment grade obligations secured by first mortgages on commercial real estate and having loan-to-value ratios of eighty percent (80%) or less; plus

(g) 4.0 percent (4%) or 1/25th of the aggregate net liability under guarantees of other non-investment grade obligations; and

(h) If the amount of collateral required by subparagraph (c) of this paragraph is no longer maintained, that proportion of the obligation insured which is not so collateralized shall be subject to the aggregate limits specified in subparagraph (d) of this paragraph; and

(2) Surplus to policyholders determined by the commissioner to be adequate to support the writing of residual value insurance, surety insurance and credit insurance, if the corporation has elected to transact those kinds of insurance pursuant to Section 2(A) of this Act.

D. Single risk limits. A financial guaranty insurance corporation shall limit its exposure to loss, net of collateral and reinsurance, as follows:

(1) For municipal obligation bonds, special revenue bonds and obligations demonstrated to the satisfaction of the commissioner to be the functional equivalent thereof:

(a) The insured average annual debt service with respect to any one entity and backed by a single revenue source may not exceed ten percent (10%) of the aggregate of the corporation's surplus to policyholders and contingency reserve; and

(b) The insured unpaid principal issued by a single entity and backed by a single revenue source may not exceed seventy-five percent (75%) of the aggregate of the corporation's surplus to policyholders and contingency reserve;

(2) For each issue of asset-backed securities issued by a single entity and for each pool of consumer debt obligations, the lesser of:

(a) Insured average annual debt service; or

(b) Insured unpaid principal (reduced by the extent to which the unpaid principal of the supporting assets and, provided the insured risk is investment grade, excess spread exceed the insured unpaid principal) divided by nine; shall not exceed ten percent (10%) of the aggregate of the insurer's surplus to policyholders and contingency reserve, provided that no asset in the pool supporting the asset-backed securities exceeds the single risk limits prescribed in paragraph five (5) of this subsection, if directly guaranteed; and provided further that, if the issuer of such insured asset-backed securities is a special purpose corporation, trust or other entity and such issuer shall have indebtedness outstanding with respect to any other pool of assets, either such other indebtedness shall be entitled to the benefits of a financial guaranty policy of the same insurer, or such other indebtedness shall:

(i) Be fully subordinated to the insured obligation, with respect to, or be non-recourse with respect to, the pool of assets that supports the insured obligation;

(ii) Be non-recourse to the issuer other than with respect to the asset pool securing such other indebtedness and proceeds in excess of the proceeds necessary to pay the insured obligation ("excess proceeds"); and

(iii) Not constitute a claim against the issuer to the extent that the asset pool securing such other indebtedness or excess proceeds are insufficient to pay such other indebtedness.

(3) For obligations issued by a single entity and secured by commercial real estate, and not meeting the definition of asset-backed securities, the insured unpaid principal less fifty percent (50%) of the appraised value of the underlying real estate shall not exceed ten percent (10%) of the aggregate of the insurer's surplus to policyholders and contingency reserve;

(4) For utility first mortgage obligations, the insured average annual debt service shall not exceed ten percent (10%) of the aggregate of the insurer's surplus to policyholders and contingency reserve; and

(5) For all other policies providing financial guaranty insurance with respect to obligations issued by a single entity and backed by a single revenue source, the insured unpaid principal shall not exceed ten percent (10%) of the aggregate of the insurer's surplus to policyholders and contingency reserve.

E. Except as provided in Subsection (F) of this section, if an insurer at any time exceeds any limitation prescribed by Subsection (C) or (D) of this section or the last sentence of paragraph one (1) of subsection (B) of this section, the insurer shall within thirty (30) days after the limitations are breached, submit a written plan to the commissioner detailing the steps that it will take or has taken to reduce its exposure to loss to no more than the permitted amounts, and if after notice and hearing the commissioner determines that an insurer has exceeded any limitation prescribed by this section, he may order such insurer to cease transacting any new financial guaranty insurance business until its exposure to loss no longer exceeds said limitations or with respect to the limitations prescribed in the last sentence of paragraph one (1) of subsection (B) of this section, may order such insurer to limit its writing of the types of guarantees permitted under subparagraphs (a), (b) and (c) of paragraph one (1) of subsection (B) of this section to investment grade obligations until such time as it shall be in compliance with such limitations.

F. An insurer shall not be deemed in violation of any limitation prescribed by Subsection (D) of this section with respect to any financial guaranty insurance outstanding prior to the effective date of this article, if the insurer was in compliance with the applicable single risk limit in effect in this state at the time that the financial guaranty insurance policy was issued. If the insurer was not so in compliance, such financial guaranty insurance shall comply with the limitations prescribed by Subsection (D) of this section no later than three (3) years after the effective date of this article.

G. No insurer authorized to transact the business of financial guaranty insurance shall pay any commission or make any gift of money, property or other valuable thing to any employee, agent, or representative of any potential purchaser of a financial guaranty insurance policy as an inducement to the purchase of such a policy, and no such employee, agent, or representative of such potential purchaser shall receive any such payment or gift. Violation of the provisions of this section shall not, however, have the effect of rendering void the insurance policy issued by the insurer.

Section 5. Filing of Policy Forms and Rates

A. Policy forms and any amendments thereto shall be filed with the commissioner within thirty (30) days of their use by the insurer if not otherwise filed prior to the effective date of this article. Every such policy shall provide that, in the event of a payment default by or insolvency of the obligor, there shall be no acceleration of the payment required to be made under such policy unless such acceleration is at the sole option of the corporation provided that:

(1) Policies may insure amounts payable under a credit default swap or interest rate, currency, or other swap upon a credit event or termination event if the expected amount payable on an accelerated basis in respect of any individual obligation referenced by a credit default swap or in the aggregate under an interest rate, currency or other swap does not exceed the single risk limits prescribed in Paragraph Five (5) of Subsection (D) of Section Four (4) of this article; and

(2) Policies insuring credit default swaps referencing an obligation shall be treated as if the insurer had directly insured the referenced obligation for all other purposes of this article, except that the currency of amounts owed under the credit default swap, rather than the currency of the obligations referenced by the credit default swap, shall apply for purposes of determining whether the obligation is a permissible guaranty under Subsection (B) of Section Four of this article. The commissioner may prescribe minimum policy provisions determined by the commissioner to be necessary or appropriate to protect policyholders, claimants, obligees or indemnitees.

B. Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition, detrimental to the solvency of the insurer or otherwise unreasonable. In determining whether rates comply with the foregoing standards, the commissioner shall include all income earned by such insurer. Criteria and guidelines utilized by insurers in establishing rating categories and ranges of rates to be utilized shall be filed with the commissioner for information prior to their use by the insurer if not otherwise filed prior to the effective date of this article.

Drafting Note: If this standard is contained in the state's insurance law, a section reference may be substituted.

C. All filings shall be available for public inspection at the insurance department.

Section 6. Reinsurance

A. For financial guaranty insurance that takes effect on or after the effective date of this Act, a financial guaranty insurance corporation shall receive credit for reinsurance in accordance with the provisions of this chapter applicable to property and casualty insurers as an asset or as a reduction from liabilities provided that the reinsurance is subject to an agreement that for its stated term and with respect to any such reinsured financial guaranty insurance in force, the reinsurance agreement (facultative or treaty) may only be terminated or amended (i) at the option of the reinsurer or the ceding insurer, if the reinsurance agreement provides that the liability of the reinsurer with respect to policies in effect at the date of termination shall continue until the expiration or cancellation of each such policy; or (ii) with the consent of the ceding company, if the reinsurance agreement provides for a cutoff of the reinsurance in force at the date of termination; or (iii) at the discretion of the commissioner acting as rehabilitator, liquidator or receiver of the ceding or assuming insurer; and provided that such reinsurance is:

(1) Placed with another financial guaranty insurance corporation licensed under this Act or an insurer writing only financial guaranty insurance as is or would be permitted by this Act; or

(2) Placed with a property and casualty insurer or an accredited reinsurer licensed or accredited to reinsure risks of every kind or description (including municipal obligation bonds), as set forth in [insert section authorizing property and casualty reinsurance], if the reinsurance agreement with such insurer requires that such insurer:

(a) Have and maintain surplus to policyholders of at least $35 million;

(b) Establish and maintain the reserves required in Section 3 (III) of this guideline, except that if the reinsurance agreement is not pro rata the contribution to the contingency reserve shall be equal to fifty percent (50%) of the quarterly earned reinsurance premium. However, the assuming insurer need not establish and maintain such reserve to the extent that the ceding insurer has established and continues to maintain such reserve;

(c) Comply with the provisions of Subsection C of Section 4 (IV) of this act, except that its maximum total exposures reinsured net of retrocessions and collateral shall be one-half that permitted for a financial guaranty insurance corporation;

(d) If a parent of the insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer, then the aggregate of all risks assumed by such reinsurers shall not exceed ten percent (10%) of the insurer's exposures, net of retrocessions and collateral. Direct or indirect ownership interests of fifty percent (50%) or more shall be deemed a parent/subsidiary relationship;

(e) If an affiliate of the financial guaranty insurance corporation, the affiliate shall not assume a percentage of the corporation's total exposures insured net of retrocessions and collateral in excess of its percentage of equity interest in the corporation; and

(f) Assumes from the financial guaranty insurer and any affiliate, parent of the insurer, another subsidiary of the parent of the insurer, or subsidiary of the insurer that is a financial guaranty insurance corporation or an insurer writing only financial guaranty insurance as is or would be permitted by this article and such other kinds of insurance that a financial guaranty insurance corporation may write in this state, together with all other reinsurers subject to this paragraph, less than fifty percent (50%) of the total exposures insured by the financial guaranty insurer and such affiliates, parents or subsidiaries of the insurer, net of collateral, remaining after deducting any reinsurance placed with another financial guaranty insurance corporation that is not an affiliate, a parent of the financial guaranty insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer or a financial guaranty insurer writing only financial guaranty insurance as is or would be permitted by this article that is not an affiliate, a parent of the financial guaranty insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer; or

(3) If placed with an unauthorized or unaccredited reinsurer which otherwise meets the requirements of either the opening paragraph of this subsection and paragraph one (1) of this subsection, or the opening paragraph of this subsection and subparagraphs (a), (d), (e) and (f) of paragraph two (2) of this subsection, in an amount not exceeding the liabilities carried by the ceding insurer for amounts withheld under a reinsurance treaty with the reinsurer or amounts deposited by the reinsurer as security for the payment of obligations under the treaty, if the funds or deposit are held subject to withdrawal by, and under the control of the ceding insurer.

B. In determining whether the corporation meets the aggregate risk limitations, in addition to credit for other types of qualifying reinsurance, the corporation's aggregate risk may be reduced to the extent of the limit for aggregate excess reinsurance but, in no event, in an amount greater than the amount of the aggregate risk which will become due during the unexpired term of the reinsurance agreement in excess of the corporation's retention pursuant to the reinsurance agreement.

Section 7. Transition Provisions

A licensed insurer writing financial guaranty insurance prior to the effective date of this article, but which is not authorized to write financial guaranty insurance in this state, shall be subject to all the provisions of this article, except Section Two of this article, and:

A. May, unless the commissioner determines after notice and an opportunity to be heard that such activity poses a hazard to the insurer, its policyholders or to the public, continue to write financial guarantees (except guarantees of municipal bonds) of the types authorized by Subsection (B) of Section Four of this article applicable to financial guaranty insurance corporations, subject to the following conditions:

(1) For a transition period not to exceed sixty (60) months from the effective date of this article, if the insurer has and maintains surplus to policyholders of at least $75 million (for the purpose of this paragraph, if the insurer is a foreign insurer, its surplus to policyholders shall be computed as if it were a domestic insurer); provided that:

(a) During the sixty (60) month transition period, the amount of surplus to policyholders needed to meet the single and aggregate risk limitations imposed by this article must be less than four percent (4%) of the insurer's surplus to policyholders;

(b) Within nine (9) months of the effective date of this article, the insurer shall file a reasonable plan of operation, acceptable to the commissioner, which shall contain:

(i) A reasonable timetable and appropriate procedures to implement that timetable to make a determination as to whether or not the insurer will make application to organize a financial guaranty insurance corporation during the aforesaid sixty (60) month period;

(ii) The types and projected diversification of guarantees that will be issued during the transition period;

(iii) The underwriting procedures that will be followed;

(iv) Oversight methods;

(v) Investment policies; and

(vi) Such other matters as may be prescribed by the commissioner.

The plan of operation shall be deemed acceptable unless, within sixty (60) days of its filing, the commissioner notifies the insurer of any specific objections to such plan. The plan shall be updated in the event of a material change with respect to the foregoing and at least annually:

(c) If the insurer has determined that it will not organize a financial guaranty insurance corporation, within thirty (30) days after that determination it shall notify the commissioner, cease writing policies of financial guaranty insurance and comply with the provisions of paragraph four (4) of this subsection; and

(d) The insurer shall file such additional statements or reports as may be required by the commissioner.

(2) For a transition period not to exceed ninety-six (96) months from the effective date of this article, if the insurer has and maintains surplus to policyholders of at least $150 million (for the purpose of this section, surplus to policyholders means the aggregate surplus to policyholders of said insurer and other member companies of an inter-company pool, and if the insurer is a foreign insurer its surplus to policyholders shall be computed as if it were a domestic insurer) and the aggregate financial guaranty written premium of said insurer and other member companies of an inter-company pool shall have been at least $1 million in any one of the five (5) years ending December thirty-first (31) of the year prior to this article becoming law, provided that:

(a) During the first sixty (60) months of the transition period, the amount of surplus to policyholders needed to meet the aggregate risk limitations imposed by this article must be less than four percent (4%) of the insurer's surplus to policyholders. After such sixty (60) month period, provided the insurer complies with subparagraph (d) of this paragraph, the amount of surplus to policyholders needed to meet such aggregate risk limitations must be less than five percent (5%) of the insurer's surplus to policyholders for the succeeding twelve (12) month period and less than six percent (6%) for the next succeeding twenty-four (24) month period;

(b) During the transition period, the amount of surplus to policyholders needed to meet the single risk limitations imposed by Paragraphs Two through Five of Subsection (D) of Section Four of this article must be less than twenty percent (20%) of the insurer's surplus to policyholders, except that the single risk limitation with respect to investment grade obligations under such paragraph five (5) shall be the lesser of $80 million or seven percent (7%) of the insurer's surplus to policyholders;

(c) During the transition period, notwithstanding the last sentence of Paragraph One (1) of Subsection (B) of Section Four, industrial development bonds shall not be included in the investment grade requirements set forth in such sentence;

(d) During the transition period, reinsurance in the form of inter-company pooling agreements, shall not be subject to Subparagraphs (c), (d), (e) and (f) of Paragraph Two (2) of Subsection (A) of Section Six of this article, if such inter-company pooling agreements were in effect on January first (1), of the year in which this article becomes effective, and reinsurance placed with insurers which are subject to the provisions of Paragraph Two (2) of Subsection (A) of Section Six and are not members of the ceding company's inter-company pooling agreement may not exceed sixty percent (60%) of the total exposures insured net of collateral remaining after deducting any reinsurance placed with another financial guaranty insurance corporation or an insurer writing only financial guaranty insurance as is or would be permitted by this article;

(e) Within sixty (60) months of the effective date of this article, the insurer shall file a reasonable plan of operation, acceptable to the commissioner, which shall contain:

(i) A reasonable timetable and appropriate procedures to implement that timetable to make a determination as to whether or not the insurer will make application to organize a financial guaranty insurance corporation during the aforesaid ninety-six (96) month period;

(ii) The types and projected diversification of guarantees that will be issued during the transition period;

(iii) The underwriting procedures that will be followed;

(iv) Oversight methods;

(v) Investment policies; and

(vi) Such other matters as may be prescribed by the commissioner.

The plan of operation shall be deemed acceptable unless, within sixty (60) days of its filing, the commissioner notifies the insurer of any specific objections to such plan. The plan shall be updated in the event of a material change with respect to the foregoing and at least annually:

(f) If the insurer has determined that it will not organize a financial guaranty insurance corporation, within thirty (30) days after that determination it shall notify the commissioner, cease writing policies of financial guaranty insurance and comply with the provisions of paragraph four (4) of this subsection; and

(g) The insurer shall file such additional statements or reports as may be required by the commissioner.

(3) For a transition period not to exceed twelve (12) months from the effective date of this article, in the case of an insurer transacting only financial guaranty insurance prior to the effective date of this article and which qualifies for licensing as a financial guaranty insurance corporation under Section Two of this article, provided that it makes application to amend its current license to that of a financial guaranty insurance corporation licensed to transact only those kinds of insurance permitted pursuant to Section Two of this article within sixty (60) days of the effective date of this article, and provided that, for purposes of this paragraph, an insurer shall be deemed to be transacting only financial guaranty insurance prior to the effective date of this article if, with the approval of the commissioner, it has reinsured all of any other insurance liabilities with one or more authorized insurers or has otherwise made provision for such liabilities.

(4) For a transition period not to exceed nine (9) months, in the case of an insurer that does not qualify under either paragraph one (1), two (2) or three (3) of this subsection or does not file a plan of operation pursuant to paragraph one (1) or two (2) of this subsection, such insurer shall cease writing any new financial guaranty insurance business and may:

(a) Reinsure its net in force business with a licensed financial guaranty insurance corporation; or

(b) Subject to the prior approval of its domiciliary commissioner, reinsure all or part of its net in force business in accordance with the requirements of Paragraph Two (2) of Subsection (A) of Section Six of this article, except that Subparagraphs (d), (e) and (f) of Paragraph Two (2) of such subsection shall not be applicable. The assuming insurer shall maintain reserves of such reinsured business in the manner applicable to the ceding insurer under this paragraph; or

(c) Thereafter continue the risks then in force and, with thirty (30) days prior written notice to its domiciliary commissioner, issue new financial guaranty policies, provided that the issuing of such policies is reasonably prudent to mitigate either the amount of or possibility of loss in connection with business transacted prior to the effective date of this article. However, an insurer must receive the prior approval of its domiciliary commissioner before issuing any new financial guaranty insurance policies that would have the effect of increasing its risk of loss.

B. Shall, for all guarantees in force prior to the effective date of this article, including those which fall under the definition of financial guaranty insurance contained in Subsection (A) of Section One of this article, be subject to the reserve requirements in Section 3 (III) of this article. To the extent that the insurer's contingency reserves maintained as of the effective date of this article are less than those required by Section 3 (III) of this article, the insurer shall have three (3) years to bring its reserves into compliance, except that a part of the reserve may be released proportional to the reduction in aggregate net liability resulting from reinsurance, provided that the reinsurer shall, on the effective date of the reinsurance, establish a reserve in an amount equal to the amount released and, in addition, a part of the reserve may be released with the approval of the commissioner upon demonstration that the amount carried is excessive in relation to the corporation's outstanding obligations; and

C. Shall be subject to the reserve requirements specified in Section Three of this article for all policies of financial guaranty insurance issued on or after the effective date of this article.

Drafting Note: This section contains transitional provisions for those states currently without a financial guaranty insurance statute and with licensed multiline insurers currently writing financial guaranty insurance. The transition provisions permit such insurers to continue to write financial insurance for the specified time period, subject to certain conditions, while the insurer determines whether to form a monoline financial guaranty insurer to continue writing business after expiration of the transition period.

Section 8. Applicability of Other Laws

An insurer issuing policies of financial guaranty insurance shall be subject to all of the provisions of this chapter applicable to property and casualty insurers to the extent that such provisions are not inconsistent with the provisions of this article.

Section 9. Relationship to Security Fund

No insurer or agent of an insurer may deliver a policy of financial guaranty insurance unless such policy and any prospectus delivered on or after the effective date of this article with respect to the insured obligations clearly discloses that the policy is not covered by the [property and casualty insurance security fund or guaranty association] specified in Article [insert article].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2007 Proc. 4th Quarter, Vol. I 116, 137, 143, 190-194 (adopted).

FINANCIAL GUARANTY INSURANCE GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

FINANCIAL GUARANTY INSURANCE GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	ORDER No. R90-2 (1990).
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	CAL. INS. CODE §§ 12100 to 12122 (1991/2006).
Colorado	NO CURRENT ACTIVITY
Connecticut	CONN. GEN. STAT. §§ 38a-92a to 38a-92n (1993/2014).
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	FLA. STAT. §§ 627.971 to 627.975 (1988).
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	ILL. ADMIN. CODE tit. 50, §§ 205.10 to 205.90 (1987) (municipal bond insurance).
Indiana	NO CURRENT ACTIVITY
Iowa	IOWA ADMIN. CODE r. 191-22.1 to 191.22.2 (1987).
Kansas	NO CURRENT ACTIVITY

FINANCIAL GUARANTY INSURANCE GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	MD. CODE REGS. 31.05.10.01 to 31.05.10.08 (2003/2006).
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	N.J. ADMIN. CODE §§ 11:7-1.1 to 11:7-1.7 (1975/2003) (municipal bonds only).
New Mexico	NO CURRENT ACTIVITY
New York	N.Y. INS. LAW §§ 6901 to 6909 (1989/2004); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 63.0 to 63.2 (Regulation 61) (1980/1997) (municipal bonds only).
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY

FINANCIAL GUARANTY INSURANCE GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	WIS. ADMIN. CODE INS. § 3.08 (1984/1986) (municipal bonds only).
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2007

FINANCIAL GUARANTY INSURANCE GUIDELINE (#1626)

1. Description of the Project, Issues Addressed, etc.

The project began on March 1, 2007, when the Financial Guaranty Model Act Revisions (E) Working Group (the "Working Group") held its first conference call. The project included reviewing the NAIC Financial Guaranty Insurance Model Act (#626) to determine if any updates should be made to the model. The review consisted primarily of comparing the NAIC model, which had not been updated since its original adoption in 1986, with the language included in the New York and California statutes on financial guaranty insurance that had been updated several times since enactment, most recently in 2004 and 2005. The comparison to New York's statute was considered appropriate as 7 of the 19 financial guaranty insurers that file with the NAIC are domiciled in New York, with many of the other states that have monoline companies utilizing the more detailed New York statute when necessary. The comparison to California was considered appropriate because its statute is considered similar to the New York statute and California is a large market for many of the financial guaranty insurers.

Purpose of the Project

The primary purpose of updating the NAIC model act is to provide a guide for law making bodies setting requirements for monoline financial guaranty insurers. An updated NAIC model allows for consistency with the New York and California statutes, which are seen as the highest standards by the industry, thus encouraging only legislation that is consistent with the best of current practice. To the extent states consider changes to their statutes for monoline financial guaranty insurance in the future; this update does request that such states consider adopting this updated guideline.

Adopted As a Guideline

In May 2007, the NAIC developed a new process for the consideration of model laws which established specific criteria that must be met for an item to be considered an NAIC model. At the onset of this project, NAIC records indicated that only six states had adopted legislation for monoline financial guaranty insurance. Upon review of the criteria, the Working Group determined the criteria had not been met relative to this model or the proposed changes to the model. The Working Group recommends adoption as a guideline.

Significant Changes to the Guideline

Since 1986, New York and California have made significant changes to their statutes to accommodate changes in marketplace practice. The changes to this guideline include numerous changes that bring the guidance in line with the New York and California statutes. The following represents a summary of the more significant changes:

> Clarifies financial guaranty insurance definitions; allows the use of credit default swaps as collateral; strengthens the contingency reserve requirements as well as changes to the limitations; includes of transitional language for those states currently without a financial guaranty statute and for licensed multi-line insurers writing financial guaranty insurance.

2. Name of Group Responsible for Drafting the Model and States Participating

Financial Guaranty Model Act Revisions (E) Working Group

States Participating:

New York, Chair
California
New Jersey
Maryland
Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The Financial Condition (E) Committee charged the newly formed Financial Guaranty Model Act Revisions (E) Working Group at the 2006 Winter National Meeting:

> Review the Financial Guaranty Insurance Model Act and consider any changes necessary to update the model.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process began with a document prepared by the Association of Financial Guaranty Insurers ("AFGI") that showed all of the changes necessary to bring the NAIC model in line with the statutory amendments that New York and California adopted to reflect changes in best practices for monoline financial guaranty insurers. The document prepared by AFGI also explained the specific reason for each particular change.

The document was exposed for comment to interested regulators and interested parties on March 1, 2007 with a 30 day comment deadline. Limited comments were received from the industry interested parties, and those noted were accepted by the Working Group. One representative of AFGI noted on one conference call that the industry views this project as a mechanical process to simply update the model and is not opposed to the project or the changes.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group held three conference calls subsequent to the initial meeting, during which the document was revised and redistributed for further discussion after each call. As noted previously, comments from the industry were limited, thus additional exposure time was never considered necessary.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Section 3A(6)(b)-Release of Contingency Reserves
This section has specific language about the release of contingency reserves. One member of the Working Group expressed concern with this language, and requested it be modified to require satisfactory demonstration to the commissioner before the reserves are released. The language was revised and modified as requested.

Section 3B(2) — Contingency, Loss and Unearned Premium Reserves
This section requires an independent review of the claim reserves if the claims experience was unfavorable in the prior three years and exceeded ten percent of surplus. One member of the Working Group questioned how this 10% figure was established and wondered if it should be reduced. Another Working Group member noted that when this threshold was established in his state, there was no empirical evidence or statistical analysis to support the 10%; however, they thought 10% was a good measure of a material event. The Working Group did not change this provision believing that the independent auditor's separate opinion on the adequacy of the reserves provides an opportunity for the reserves to be challenged on an objective ground and at a more granular level.

Section 4B(1)(g) — Mortgage Guaranty Insurers
This section 4 provides limits on certain asset backed securities. This particular section includes some delineation between financial guaranty insurers and mortgage guaranty insurers, and one of the members questioned if the two types of entities could coexist with similar products. Another member responded that there had not been any issues raised in his state relative to this language. Ultimately the Working Group made no change to this area, with the belief that there were no concerns in this area.

Section 4B(2)-Insured Municipal Obligations
This section requires that 95% of outstanding total liabilities on municipal obligations be investment grade. One member of the Working Group requested language to be added to allow commissioner discretion in this area. A separate member supported this change. However, another member expressed concern with allowing commissioner discretion, as it could result in increased risk. It was noted that the rating agencies generally limit exposure below the level in this guideline to be considered a AAA company, but may be lower if the reporting entity was willing to operate with a lower rating. To the extent such a company existed, and did business in this state, it could either require a change in statute in that state, or some type of action by this state. Ultimately the Working Group maintained this language, although this state abstained from voting on final guideline, therefore this item was particularly controversial.

Section 5 — Filing of Policy Forms and Rates

This section sets out requirements for filing policy forms with a commissioner. One member of the Working Group expressed concern with how this section allows the product to be used immediately and differs from the more typical file-and-use statute. This same member noted that if this model were to become an accreditation standard, his state may not be willing to allow this type of filing. It was noted that this model had been around for nearly two decades, and given there hadn't previously been a push for accreditation it didn't appear that would be an issue. Ultimately the Working Group agreed to adopt the language that allows the product to be used immediately.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

2011 TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE

Contents

Part A. Introduction

The purpose of the Title Agent Statistical Data Plan (the "stat plan") is to give information that is more useful to state regulators about the business of title insurance at the agency level. In the 2007 United States Government Accountability Office (GAO) Report on Title Insurance, Actions Needed to Improve Oversight of the Title Industry and Better Protect Consumers (GAO-07-401), it was noted that "large insurers [tend] to use local or regional title agents to conduct their business." Additionally, the GAO stated "potentially understanding the relationship between costs and the amounts consumers pay could help regulators improve their ability to protect consumers." Finally, the report recommended that:

> State regulators take action to (1) improve consumers' ability to shop for title insurance and (2) improve their oversight of title agents. As part of this process, we are recommending that these regulators consider evaluating the competitive benefits of publicizing complete title insurance cost information... including the collection of data on title agents' operations...

While annual financial reporting by insurers (also called underwriters) captures the overall picture of premiums and losses, there are many factors of the business which are only experienced by the ground-level title agent, including actual operating costs and losses not typically paid by an underwriter. This lack of information about the role of agencies in providing title insurance products and related services makes the business of title insurance particularly susceptible to question about the amount of premium retained by agencies, profitability of the industry, and the value of title insurance in general.

Although the stat plan attempts to capture comprehensive information on the title agency experience, the plan in its current form does not capture all information regarding the daily experience of title agencies. In the course of searching and examining land records, title agencies fulfill their main role in the title insurance process of identifying actual and/or potential clouds or defects on the title that may lead to future losses. Agents may work to correct or eliminate the title defects that can be fixed, and inform the insured of which ones cannot be cured by the agent and will be listed as exceptions in the policy. Title agents may also cure defects at the direction of the buyer, the lending institution, or the title insurer. Depending on the state, this function may be performed by an escrow agent, a title agent, or another third party. Sometimes, an entity will spend numerous hours evaluating and eliminating risk before the premium is even paid.

This statistical plan does not differentiate between the resources spent to correct or eliminate title defects and the resources spent to identify title defects and to perform other policy acquisition activities. This is one of the fundamental differences between title insurance and casualty insurance. While technology helps to some extent, automated land records do not eliminate the cost of searching for and addressing defects in title. In most jurisdictions, automated land records are no more than automated indices and images of documents. Although these systems can reduce the time and effort necessary to search land records, the actual process is unchanged, and title insurance producers or abstractors still must search all records, find those related to a property, and manually examine each document. While some software systems collect and store information, they can be prohibitively expensive for many agencies. In an effort to keep the burden of completing the stat plan as low as possible, information on specific defects found and/or fixed in each search is not collected at this time. Therefore, the stat plan should not be viewed as a fully accurate picture of the profitability of title insurance agencies, but rather as a tool to better understand the economics of the industry.

Part B. Mechanism for Reporting and Collection of Data/Implementation

Although the actual data points collected in the stat plan are points that should be readily available to reporting entities, it is important to note that most have not been previously required to collect and report this data in the current form. Title insurance agencies will need time to develop and put in place systems for collecting and organizing the data, which may

involve purchasing new or updating existing software systems, developing tracking mechanisms, and other administrative tasks involved with the collection of requested data.

Therefore, it is suggested that state regulatory agencies provide as much notice as possible prior to the actual expected dates for collecting required data for reporting in the following year. A regulator looking to implement the stat plan should provide sufficient notice prior to January 1 of the year that collection will begin, thereby ensuring enough time for agencies to adopt and adapt their systems before having to track and collect the data. After that, title agencies will track the data points through the year, and ongoing basis, enabling them to easily compile, prepare, and submit the data plan each year to their regulatory agency. The Task Force recommends a yearly reporting date of June 1 for the previous year's data.

Prior to implementation, regulators should also examine the values, labels, and instructions in the stat plan and make any necessary modifications to conform the plan to local practices and customs. Although it is recommended that the plan remain substantially similar, it is recognized that not all terms and values in the plan will translate well from jurisdiction to jurisdiction.

If feasible, the regulator should establish a web-based reporting site for electronic collection of stat plan data, as well as to disseminate important information about the stat plan. A web-based reporting site should include anticipatory and experientially based FAQs. In the absence of a web-based reporting system, the regulator should develop a system for manually reporting data which can be used by all reporting entities, that prescribes a format and set parameters common to the industry and consistent with other data collection requirements.

The state's data reporting and collection system should include controls that prevent the entry of data that are invalid or internally inconsistent. The system should be designed to meet the needs of various types of reporting entities, many of which have not been accustomed to reporting any kind of information to the commissioner.

The regulator should strive to be as clear as possible about the requirements of reporting, including by issuing FAQs and other formal guidance for reporting agents to rely upon when reporting data under the stat plan. To promote efficiency of reporting and quality of data, regulators should make the operation and format of the stat plan's data reporting and collection system consistent with other uniform data collection conventions and those of other states. In order to facilitate uniformity among states, regulators are encouraged to share with other states any information available regarding the design and operation of each state's system.

Part C. Confidentiality of Data

Due to the sensitive nature of individual agent data, including income, expense, and loss experience, it is strongly recommended that regulators keep individual responses on the stat plan confidential. While such data may already be protected as proprietary, financial, or other sensitive information, it is highly recommended that states determine whether they can hold the stat plan information confidential, and enact any statutory or regulatory amendments necessary to do so. However, nothing herein should be construed as attempting to limit the sharing or publication of aggregate data, since such publication may in fact make important disclosures regarding the experience of title agents in a particular geographic area or business demographic (i.e. by county, state, or by agency type). Additionally, the sharing of data among regulators should be exempted from any confidential protections given to collected data.

Part D. Uses of Data

Because the data collected as part of the stat plan does not fully capture the agent experience as it pertains to items caught and corrected prior to issuance of policy, caution should be taken if regulators intend on using the stat plan to set rates or analyze entities' justifications of rates and fees. Although rate and fee setting is a conceivable use of the data collected, regulators need to be aware of the shortcomings of the plan, and willing to accept data and justifications provided beyond the scope of the stat plan.

Other uses of the data collected include:

- Fulfilling GAO recommendations of increased title agent data collection
- Comparison of relationship of costs to title agents and prices consumers pay
- Quantitative analysis of differences between title insurance and other lines of insurance (particularly in operating costs vs. loss costs)
- Comparison of FTEs in agencies vs. total licensees in a jurisdiction

- Agent premium experience
- Market share analysis
- Marketing expense ratios (compared to market share)
- Premium vs. agency claims loss experience
- Agent experience by locality (county, city, etc.)
- Develop Market Conduct Base Line Market Analyses

Part E. Insurance Department Outreach Efforts

Under the stat plan, regulators are responsible for collecting data from entities not traditionally required to provide annual data statistics to insurance departments. To ensure efficient implementation and timely compliance with annual reporting requirements, regulators should engage in outreach and training initiatives. Some of the groups to contact during outreach efforts include:

Industry Associations

- State land title associations
- National land title associations
- National Title Insurance Computer System Providers
- Title Insurance Data Collection and Consulting firms

Other Organizations

- Title insurance underwriters' state offices
- Other state departments of insurance
- National Association of Insurance Commissioners

The organizations listed above can help regulators make reporting entities aware of the state's annual title agency statistical reporting requirements. Training programs conducted by regulators and accessibility to members of these organizations will improve the timeliness and quality of data submitted by reporting entities.

Part F. Suggested Statute Language

Title Agent Statistical Data Plan.

(1) Every title agency doing business in this state, on or before the last day of May in each year, shall submit to the commissioner a report, signed and certified by an owner, officer, partner, or director of the agency, of the specific information listed in the NAIC Title Insurance Agent Statistical Data Plan.

(2) Information relating to the individual agencies filed with the commissioner under subsection (1) shall be kept confidential and not subject to public disclosure. However, nothing in this subsection (2) shall prohibit the commissioner from publishing data collected in an aggregate form, so as not to identify individual agencies' data, or from sharing particular agency data with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the information.

(3) The commissioner may establish rules, including rules providing statistical plans, for use by all title insurers and title insurance agents in the collection and reporting of demographic**,** revenue, expense and loss experience data in such form and detail as is necessary to aid him or her in the evaluation of the title insurance industry at the agency level.

Drafting note: States that require the data to be submitted electronically should establish a method of electronic signature verification that is acceptable to the commissioner.

Part G. Suggested Regulation on Reporting Requirements

Drafting Note: This is not a model regulation, but a suggested regulation/best practice for any necessary rules that may need to be promulgated for the implementation of the stat plan. When drafting regulations, take into account local statutes, practices, and customs and modify this regulation accordingly.

Section 1. Statement of Purpose

This regulation is intended to provide standards and direction for the collection and reporting of title agent data in accordance with the NAIC's Title Agent Statistical Data Plan. The regulation specifies the data required, due dates and time periods for collection and submission of data, methods of submission, and addresses the confidentiality of the data submitted.

Section 2. Statutory Authority

This regulation is issued based upon the authority granted the commissioner under (cite any enabling legislation and state law corresponding to market analysis, market regulation, and/or title insurance regulation).

Section 3. Applicability and Scope

Under this regulation, all operating title insurance agencies and underwriter direct operations are required to provide yearly report of their policy issuance, business income and expense, and loss experience (excluding losses forwarded to or paid by an underwriter). Agencies include independent title agencies, affiliated business arrangement (AfBA) title agencies, attorney firms/title agencies, and underwriter direct operations.

Drafting Note: Types of entities may vary by state.

Section 4. Definitions

1. Affiliated Business Arrangement (AfBA) – an arrangement in which a settlement producer, such as a real estate broker, developer, mortgage loan originator, or bank, or any other individual or entity that is in a position, directly or indirectly, to refer settlement business to a title entity, also maintains a direct or beneficial ownership interest in that title entity.

2. Affiliated title agency - a title agency that is owned, either wholly or in part, by a title insurance company/underwriter, but does not operate as an underwriter direct agency.

3. Attorney firm/title agency - a title agency that is owned and operated by an attorney or law firm.

4. Independent title agency - a title agency that is not part of an ownership arrangement with a real estate settlement producer, or with a title insurance company/underwriter.

5. NAIC title agent statistical data plan - also known as the "stat plan", this is the data reporting plan developed by the National Association of Insurance Commissioners Title Agent Statistical Data Plan Working Group, incorporated by reference herein.

6. Reporting entity - any title agency that is required to submit the information required under the stat plan, including independent, AfBA, attorney, and underwriter direct agencies.

7. Reporting period - the calendar year immediately preceding the current stat plan due date.

8. Stat plan due date - the due date for reporting entities to submit data to the commissioner. The standard due date under the stat plan is May 30 of each year.

9. Underwriter direct agency - a title agency that is wholly owned and operated by a title insurance company/underwriter.

Drafting Note: Individual states may have different definitions for some of the above items, or may have more or fewer definitions to include. In addition, definitions under Real Estate Settlement Procedures Act (RESPA) may vary from those listed above. States should update, add, or delete definitions, as well as add relevant statutory citations as necessary.

Section 5. Data Required

Incorporate reference to stat plan here, rather than including the actual plan (to accommodate for future amendments to plan)

Section 6. Due Dates/Time Periods for Collection

All reporting entities are required to submit the data referenced in Section 5 of this regulation on or before May 30 for the immediately preceding reporting period.

Section 7. Method of Submission

All reporting entities shall submit the data in a manner prescribed by the commissioner.

Drafting Note: States should develop a method for collecting data electronically, either through a database in which entities can log in to report or through a dedicated email address, as well as methods of communicating requirements and any changes to the industry. Such method should be noted in Section 7.

Section 8. Confidentiality and Sharing

Information filed with the commissioner relating to the experience of a particular agent shall be kept confidential unless the commissioner finds it in the public interest to disclose the information required of title insurers or title insurance agents under this section.

In order to assist in the performance of the commissioner's duties under this chapter, the commissioner may share data and information submitted by title insurance entities, including agencies, insurer direct operations, and title agent attorney firms, pursuant to Title Agent Statistical Plan data calls and collections, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the information. Additionally, nothing contained herein shall prohibit the commissioner from sharing or publishing data in an aggregate form with the above parties or any other stakeholder.

Drafting Note: States should ensure that the language that they use does not, nor can be construed as attempting to, limit the sharing or publication of aggregated data, since such publication may in fact make important disclosures regarding the experience of title agents in a particular geographic area or business demographic (i.e. by county, state or by agency type.)

Furthermore, States should contemplate whether or not they intend to publish aggregated data and the extent to which they are prepared to be required to publish or just may publish, etc.

Section 9. Enforcement

The commissioner may require that the information provided under this section be verified by oath of the insurer's or agent's president or vice president or secretary, as applicable. The commissioner may further require that the information required under this section be subject to an audit conducted by the commissioner. The commissioner shall have the authority to establish a minimum threshold level at which an audit would be required.

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions available in the [insert state] statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in [cite appropriate state laws concerning failure to respond, unfair business practices, etc.] may be applied.

Section 10. Severability

If any of the provisions of this regulation shall be held invalid or unenforceable, this regulation shall be construed as if not containing such provisions and the validity, legality, and enforceability of the remaining provisions shall not be affected or impaired in any way.

Section 11. Effective Date

This regulation is effective on [insert date] and applies to all transactions entered into after the effective date.

Chronological Summary of Actions (all references are to the Proceeding of the NAIC)

2011 Proc. 3rd Quarter, Vol. II 204, 208 (adopted).

TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE

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Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

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TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY

TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY

TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2011

TITLE AGENT STATISTICAL DATA PLAN IMPLEMENTATION GUIDELINE (#1650)

1. Description of the Project, Issues Addressed, etc.

The purpose of the Title Agent Statistical Data Plan (the "stat plan") is to give information that is more useful to state regulators about the business of title insurance at the agency level. In the 2007 United States Government Accountability Office (GAO) Report on Title Insurance, Actions Needed to Improve Oversight of the Title Industry and Better Protect Consumers (GAO-07-401), it was noted that "large insurers [tend] to use local or regional title agents to conduct their business." Additionally, the GAO stated "potentially understanding the relationship between costs and the amounts consumers pay could help regulators improve their ability to protect consumers." Finally, the report recommended that: "state regulators take action to (1) improve consumers' ability to shop for title insurance and (2) improve their oversight of title agents. As part of this process, we are recommending that these regulators consider evaluating the competitive benefits of publicizing complete title insurance cost information... including the collection of data on title agents' operations..."

The Title Statistical Plan (C) Working Group of the Title Insurance (C) Task Force first developed a *Title Insurance Agent Statistical Report*. This statistical report contains the various data elements title agents are to report on an annual basis to each jurisdiction. After developing the *Title Insurance Agent Statistical Report*, the Working Group developed a *Title Agent Statistical Data Plan Implementation Guideline* as a resource for regulators to implement the *Title Insurance Agent Statistical Report*.

2. Name of Group Responsible for Drafting the Model and States Participating

The Title Statistical Plan (C) Working Group of the Title Insurance (C) Task Force was chaired by Colorado with members participating from Arkansas, Florida, Maryland, Michigan, Missouri, Oregon and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

During the NAIC Winter 2008 National Meeting the Title Insurance Issues (C) Working Group, later became the Title Insurance (C) Task Force, decided a statistical plan for title insurers should attempt to measure, on a state-by-state basis, the profitability and competitiveness of the title industry and the reasonableness of title rates and charges. In addition to title insurance, the data captured would include non-regulated items such as escrow, closing and settlement revenues and charges. In order for the data to be meaningful, mandatory reporting would be needed. The Title Insurance Issues (C) Working Group was first charged by the Property and Casualty Insurance (C) Committee in 2009 to complete a study on the ability to undertake a uniform data collection system to capture title insurance premium and expense data that would allow for cross-jurisdiction premium comparisons. The data would include commissions and fees. The Working Group decided a survey of all jurisdictions needed to be completed. The survey was conducted in the autumn of 2009 of state laws on the collection of title agent data and other information. The survey results indicate that 61% of the states are authorized to require data reporting by title agents, and the Working Group believed it could assist states in developing data requests that will help in analyzing the marketplace. The Working Group became a Task Force in January 2010 and the Title Insurance (C) Task Force appointed the Title Statistical Plan Working Group to develop a nationwide title statistical plan that would include, if feasible, title agent data.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The *Title Insurance Agent Statistical Report* was developed by the Working Group. All conference calls were open to interested parties who participated in the development of the project throughout the process. The American Land Title Association (ALTA) reached out to member title insurance companies, title agents and to software vendors to participate in the conference calls.

After developing the *Title Insurance Agent Statistical Report*, the Working Group decided to proceed with drafting a guideline for jurisdictions to use in collecting and keeping the data confidential. Because some jurisdictions will not collect the data and some have the authority to collect the data, the NAIC membership will not be able to meet the requirements to promulgate a model law. The Working Group agreed the guideline will include a section with suggested wording for jurisdictions that need a statute or regulation to be able to implement the reporting requirements.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Title Statistical Plan (C) Working Group adopted an Aug. 6, draft of the *Title Insurance Agent Statistical Report*. The Property and Casualty Insurance (C) Committee adopted the report during the Summer 2010 National Meeting including the accompanying Single-State Agent, Multi-State Agent, Attorney Agent and Underwriter Direct Instructions. The report was subsequently adopted in the consent agenda of the Plenary Committee during the Fall 2010 National Meeting and is available on the Web site at
www.naic.org/documents/committees_c_title_stat_plan_tasp_final.xls.

Many of the same regulators and interested parties participated with the Working Group when it focused on developing the *Title Agent Statistical Data Plan Implementation Guideline in* September 2010. Ten conference calls produced eight drafts for review and consideration culminating in the July 28, 2011, draft.

The *Title Agent Statistical Data Plan Implementation Guideline* was adopted Sept. 1, by the Title Insurance (C) Task Force and the Property and Casualty Insurance (C) Committee Sept. 16, 2011.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

After reviewing information and hearing from interested parties the Working Group realized the data gathering of information regarding rate setting and profitability was not practical. During the conference call of March 18, 2010, the Working Group decided the focus is to collect data for market analysis and market regulation. There is recognition that the performance of the title business is based on the title agent, rather than the underwriter, in most jurisdictions. The current reporting is from title companies, and that reporting does not give regulators a complete picture of the profit, loss and expenses in the title insurance business. Because of this, jurisdictions need to obtain data from agents. The agent statistical plan should be a unique plan to capture critical data with the least amount of reporting. In addition, five basic categories of information would be collected: general information and agency information; risk assumption; income; expenses; and loss, loss mitigation.

The Working Group agreed that each jurisdiction would issue a statistical plan data call requesting the information. Completion of the form is expected by every agent/producer, and alternatively, a firm or agency can submit the information for each of the covered agents in an entity. Information would be collected from all agency operations, whether direct or independent and include attorney agents. Interested parties believed small operations and even attorney agents should be exempted from reporting, but the Working Group believed that leaving these smaller entities out would not provide the regulator with sufficient information of the marketplace as the aggregate amount of the proposed exempted entities would be significant. The Working Group decided the goal of the statistical report is to capture granular data that will be meaningful to regulators and yet not overly burdensome on the industry, particularly to small businesses.

The Working Group agreed that national data would not be collected, and each jurisdiction is to collect data uniformly if they choose to collect data. The statistical plan needs to be uniform no matter what the structure or unique nature is in a particular jurisdiction.

Another significant issue in developing the statistical plan is the Working Group agreed the plan would not be able to collect data on all issues avoided during the search and exam process (title problems avoided). The reason for this is that it would prove to be overly burdensome and costly to small agents, especially since there is no current technology that would make such collection feasible.

In developing the guideline, the Working Group conducted a survey in mid-2010 of all jurisdictions to determine what each jurisdiction needs to implement a data call, such as a statute or rule change to collect data and to keep the data confidential. The survey from 31 jurisdictions indicated: some jurisdictions do not plan to implement the data call; some jurisdictions currently have the authority to collect the data; jurisdictions generally have the technology available for electronic collection and compilation of data; jurisdictions need a statute and/or regulation change to collect the data; and jurisdictions need a statute and/or regulation change to keep the collected data confidential. The survey revealed the need to proceed with drafting a guideline for jurisdictions to use in collecting and keeping the data confidential. Because some jurisdictions will not collect the data and some have the authority to collect the data, the NAIC membership will not be able to meet the requirements to promulgate a model law.

7. Any Other Important Information (e.g., amending an accreditation standard).

The Working Group decided to include a confidentiality section and regulators will still be able to share individual agent information with other states.

The guideline includes language to clarify the intent of the report and the guideline is not to collect all the information that some jurisdictions may need for developing rates.

ANTIFRAUD PLAN GUIDELINE

Table of Contents

Preface

Insurance fraud costs insurers and consumers billions of dollars annually, and no line of insurance is immune to fraud. Because of this, state departments of insurance (DOIs) believe it is imperative that insurers make detection, investigation, and reporting of suspected fraud a priority in their overall operations. Failure to dedicate resources to the fight against insurance fraud can affect an insurer's financial stability as well as the rates charged to consumers. In light of this, insurers are encouraged to proactively take measures to minimize the cost of fraud.

To encourage insurers to take a proactive approach to fighting fraud, and minimize organizational risk, many states require the preparation and/or submission of an antifraud plan. Such plans are often audited and inspected for compliance purposes and/or reviewed in conjunction with market conduct and financial examinations.

While the development and submission of an antifraud plan is currently not mandated in all states, most state DOIs and fraud fighting agencies believe it is a best practice for all insurers, whether state mandated or not, to develop an antifraud plan that documents the antifraud efforts an insurer has put in place to prevent, detect, investigate, and report fraud. As such, this guideline is intended to serve as a guide for insurance company special investigation units (SIUs) and other interested parties in the preparation of antifraud plans that meet state mandates.

In the spirit of promoting uniformity among the states and providing insurers with added insight regarding key elements that should be considered when developing an antifraud plan, state fraud bureaus are encouraged to utilize this guideline to introduce new antifraud plan legislation or revise existing antifraud plan laws in their states.

To further uniformity in this area and assist both insurers and state DOIs with compliance efforts, the NAIC Antifraud Task Force intends to utilize this revised guideline as a basis for developing an antifraud plan submission repository/system that will streamline insurer antifraud plan compliance nationwide. Until such a system is developed and implemented, insurers are encouraged to utilize this guideline, and incorporate all information outlined within the document when developing or updating company antifraud plans.

Important Note: Unless this guideline is adopted by a state, this guideline does not preempt existing state laws.

Section 1. Application

The purpose of this guideline is to establish standards for insurance company special investigation units (SIUs) and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements of [insert Department of Insurance (DOI) name].

Drafting Note: In lieu of an agency name, states may amend this statement to incorporate a reference to a state law/rule.

Section 2. Definitions

A. "Insurance" means any of the lines of authority authorized by state law.

B. "Insurance commissioner" or "commissioner" means the insurance commissioner of this state.

C. "Insurer" means a company required to be licensed under the laws of this state to provide insurance products.

D. "Material or substantive change" means any change, modification or alteration of the operations, standards, methods, staffing, or outsourcing utilized by the insurer to detect, investigate and report suspected insurance fraud.

E. "National Association of Insurance Commissioners" (NAIC) means the organization of state insurance regulators from the fifty (50) states, the District of Columbia and all participating U.S. territories.

F. "Report in a timely manner" means in accordance with all applicable laws and rules of the state.

Drafting Note: States should insert a reference to a state law/rule if they feel it is necessary.

G. "Respond in a reasonable time" means to respond in accordance with all applicable laws and rules of the state.

Drafting Note: States should insert a reference to a state law/rule if they feel it is necessary.

H. "Special Investigation Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be made up of insurer employees or by contracting with other entities.

I. "Suspected Insurance Fraud" means any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include but are not limited to evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

Drafting Note: States can insert, modify, or delete definitions as needed and/or insert references to state law if necessary.

Section 3. Antifraud Plan Creation/Submission

A. An insurer, subject to [insert appropriate state code], shall create an antifraud plan that documents the insurer's antifraud efforts.

B. An insurer shall develop a written plan within [insert number of days based upon state law] days after obtaining its license to transact business within this state or within [insert number of days] days after beginning to engage in the business of insurance.

C. The DOI has the right to review an insurer's antifraud plan in order to determine compliance with appropriate state laws.

D. An insurer shall submit their antifraud plan in accordance with all state laws, regulations, and requirements.

Drafting Note: States should insert a reference to a state law/rule if they feel it is necessary.

E. If an insurer makes a material/substantive change in the manner in which they detect, investigate and/or report suspected insurance fraud, or there is a change in the person(s) responsible for the insurer's antifraud efforts, the insurer will be required to amend [and submit] their antifraud plan within [insert number of days] days of the change(s) being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.

Section 4. Antifraud Plan Requirements

A. An antifraud plan is an overview of the insurer's efforts to prevent, detect, investigate and report all aspects of suspected insurance fraud related to the different types of insurance offered by that insurer.

B. One antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities.

C. The following information should be included in the submitted antifraud plan to satisfy this Section:

(1) The insurer's name and NAIC individual and group code numbers.

(2) A description of the insurer's approved lines of authority.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility of the above noted information auto-populating based upon NAIC carrier data maintained by individual/group codes.

(3) An acknowledgment that the insurer has established criteria that will be used for the investigation of internal fraud and suspected fraud related to the different types of insurance offered.

(4) A statement as to whether the insurer has implemented an internal and/or external fraud awareness and/or outreach program to educate employees, applicants, policy holders and/or members of the general public about insurance fraud.

(5) A description of the insurer's external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.

(6) A description of the insurer's internal awareness/antifraud education and training initiatives of any personnel involved in antifraud related efforts. The description shall include:

(a) An overview of antifraud training provided to new employees.

(b) The internal positions the insurer offers regular education and training to, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.

(c) A description of training topics covered with employees.

(d) The method(s) in which training is provided.

(e) The frequency and minimum number of training hours provided.

(f) The method(s) in which employees, policyholders and members of the general public can report suspected fraud.

(7) A description of the insurer's corporate policies for preventing, detecting and investigating suspected internal fraud committed by company employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.

(a) The insurer shall include a description of their internal fraud reporting policy.

(b) The insurer shall identify the person and/or position within the organization who is ultimately responsible for the investigation of internal fraud.

(c) A description of the insurer's standard operating procedures (SOP) for investigating internal fraud.

(d) The insurer shall include a description of the reporting procedures it will follow upon a criminal and/or insurance law violation being identified as the result of an internal investigation conducted (i.e. agent misconduct, referral to Fraud Unit or law enforcement, etc.).

(8) A description of the insurer's corporate policies for preventing fraudulent insurance acts committed by first- or third-party claimants, medical or service providers, attorneys, or any other party associated with a claim.

(a) A description of the technology and/or detection procedures the insurer has put in place to identify suspected fraud.

(b) The criteria used to report suspicious claims of insurance fraud for investigation to an insurer's SIU.

(9) A statement as to whether the insurer has established an internal SIU to investigate suspected insurance fraud.

(a) A description as to whether the unit is part of any other department within the organization.

(b) A description or chart outlining the organizational arrangement of all internal SIU positions/ job titles.

(c) A general overview of each SIU position is required. In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the DOI.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility of insurers having the ability to upload an organization chart/list of SIU employees/position descriptions, etc.

(d) General contact information for the company's SIU as well as contact information for the person/position(s) responsible for overseeing the insurer's antifraud efforts.

(e) A description of the insurer's SOPs for investigating suspected insurance fraud.

(10) A statement as to whether the insurer utilizes an external/third party as their SIU or in conjunction with their internal SIU.

(a) If an external/third party is used to substantially perform the insurer's SIU function, the insurer shall provide the name of the company(ies) used and contact information for the company(ies).

(b) The insurer shall specify the internal persons or position responsible for maintaining contact with the external company(ies) which will serve as the insurer's SIU. The insurer shall provide a description of how they will monitor and/or gauge the external/third party's compliance with insurer antifraud mandates.

Drafting Note: If a state requires the disclosure of specific and/or all vendors for investigative activities conducted, this section can be modified accordingly.

(11) A description of the method(s) used to document SIU referrals received and investigations conducted.

(a) An overview of any case management system and/or computer program used to memorialize SIU referrals received and investigations conducted.

(b) The manner in which the insurer tracks SIU/investigative information for compliance purposes, i.e., the number of SIU referrals received, the number of investigations opened, the outcome of investigations conducted, etc.

Drafting Note: States that do not mandate fraud reporting or have other requirements should revise this section to reflect state requirements.

(12) A description of the procedures the insurer has established to ensure that suspected insurance fraud is timely reported to [agency/division name] pursuant to [insert reference to state law].

(13) A statement as to which individual(s) or group, within the organization is responsible for reporting suspected fraud on the insurer's behalf.

(a) When composing such a statement, companies may cite specific position descriptions in lieu of employee names.

(b) A description of the insurer's criteria or threshold for reporting fraud to the commissioner.

(c) A description of insurer's means of submission of suspected fraud reports to the commissioner (e.g. Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system, or other).

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Drafting Note: If a state has a mandatory reporting method, this section should be adjusted to reflect an acknowledgment of the reporting method.

(14) An insurer shall incorporate within its antifraud plan the steps it will take to ensure all information they, or a contracted party, possess about a specific claim or incident of suspected insurance fraud is provided in a timely and complete manner when a formal written request from the [insert agency/division name] has been received.

(a) For the purpose of this section, the timely release of information means by the deadline provided by the DOI.

Drafting Note: States who have a specific time period in which carriers must provide information can determine if a reference to a state statute or rule is warranted.

(b) Unless an insurer is able to cite legal grounds for withholding information, they must not redact or withhold any information that has been requested by the DOI.

(c) If an insurer has a reasonable belief that information cannot legally be provided to the DOI, the insurer will be required to provide, in writing, a description of any information being withheld, and cite the legal grounds for withholding such information.

Section 5. Regulatory Compliance

The DOI has the right, in accordance with Section [insert specific state code], to take appropriate administrative action against an insurer if it fails to comply with the mandated requirements and/or state laws.

Section 6. Confidentiality of Antifraud Plan

The submission of required information is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its antifraud plan or its antifraud related policies and procedures. The Commissioner shall maintain the antifraud plan as confidential. Submitted plans shall not be subject to the Freedom of Information Act (FOIA) if submitted properly under the state statutes or regulations which would afford protection of these materials [insert applicable state code].

Drafting Note: State will need to cite state specific privacy and protection authority.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2011 Proc. 1st Quarter, Vol. I 101, 114, 117, 472-477 (adopted).
2021 Spring National Meeting (amended),

ANTIFRAUD PLAN GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

ANTIFRAUD PLAN GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	KAN. STAT. ANN. § 40,2118 (2011).
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY

ANTIFRAUD PLAN GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY

ANTIFRAUD PLAN GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2021

ANTIFRAUD PLAN GUIDELINE (#1690)

1. Description of the Project, Issues Addressed, etc.

In 2020, the Antifraud (D) Task Force discussed implementation of the revised *Antifraud Plan Guideline* (#1690). Currently, 23 states require their insurers to file an Antifraud Plan with their insurance commissioner. The purpose of an Antifraud Plan is to describe in detail how the company detects, addresses and prevents insurance fraud.

2. Name of Group Responsible for Drafting the Model and States Participating

The Antifraud Technology (D) Working Group of the Antifraud (D) Task Force.

Chair: Utah. Participating states: Arizona, Arkansas, California, Florida, Louisiana, New Mexico, Ohio, Texas and Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

On Dec. 10, 2019, the Antifraud Technology (D) Working Group was given the charge to "[r]eview and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to centrally file their antifraud plan to all states/jurisdictions." The revision of Guideline #1690 was determined to be the first step in completing this charge. The Working Group continues to discuss potential recommendations for an Antifraud Plan Repository.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Antifraud Technology (D) Working Group initially sent a request for comments on Nov. 25, 2019, to the Antifraud (D) Task Force, interested state insurance regulators, and interested parties. The Working Group chair and the Ohio Working Group member drafted the initial revisions to Guideline #1690 that was exposed for comment in March 2020.

The Working Group met again Sept.17, 2020, to discuss additional comments received and review proposed revisions. The Working Group exposed a second draft for comment following the September call.

The Working Group met Oct. 14, 2020, to review the final draft and Oct. 29, 2020, to adopt the revised Guideline #1690.

Working Group members, state insurance regulators, and interested parties provided comments, and they were invited to participate in all Working Group calls. Revised drafts were released for comment following each Working Group call. The drafts were circulated via email and posted to the Task Force web page on the NAIC home page.

Written comments were received by the following groups:

Interested State Insurance Regulators

Minnesota, Ohio and Utah.

Interested Parties

The Center for Economic Justice (CEJ), the Coalition Against Insurance Fraud (CAIF), the National Association of Mutual Insurance Companies (NAMIC), and the National Insurance Crime Bureau (NICB).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The initial draft of Guideline #1690 was exposed in December 2019. Comments were received until Dec. 31, 2019. The Antifraud Technology (D) Working Group met in March 2020 to discuss the comments received.

A second draft was distributed following the call in March. Due to the COVID-19 pandemic, the activity of the Working Group was temporarily delayed, and the comment period was extended until September. The Working Group met in September and October to finalize and adopt the revisions to Guideline #1690.

In October 2020, the Antifraud (D) Task Force exposed the revised draft for comment. No comments were received on the revised draft. The Task Force met Nov. 16, 2020, to discuss the proposed revisions and adopt the revised Guideline #1690.

The Market Regulation and Consumer Affairs (D) Committee adopted the revised Guideline #1690 during the 2020 Fall National Meeting.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The purpose of Guideline #1690 is to bring greater uniformity among the states in antifraud plan requirements and to be used as a template in creating the Antifraud Plan Repository. This Antifraud Plan Repository is intended to streamline the process used by industry to submit their Antifraud Plans to all appropriate insurance departments and streamline the process for state review.

Ohio suggested incorporating a comprehensive narrative at the beginning of Guideline #1690 to explain its purpose as a best practice because not all states mandate the reporting of Antifraud Plans. Antifraud Technology (D) Working Group members, state insurance regulators, and industry representatives unanimously agreed that the language suggested by Ohio was not necessary. The Working Group decided to reorganize the structure of the existing Guideline #1690 and keep the existing language.

The Working Group added and changed definitions within Guideline #1690. The Antifraud (D) Task Force decided to modify these changes by using certain definitions from existing NAIC model laws.

The first definition added was "insurance commissioner" or "commissioner." The Working Group incorporated the definition used in the *Insurance Data Security Model Law* (#668).

The next definition added was for "insurer." In the initial draft, the Working Group defined "insurer" as a business entity who is in the process of obtaining or has obtained a certificate of authority to enter into arrangements of contracts of insurance or reinsurance and who agrees to: 1) pay or indemnify another as to loss from certain contingencies called "risks," including through reinsurance; 2) pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; 3) pay an annuity to another; or 4) act as surety. Except for using the language "including annuities," the Task Force decided to use language found in the *Suitability in Annuity Transactions Model Regulation* (#275) definition for "insurer." This language states that an "insurer is a company required to be licensed under the laws of this state to provide insurance products, including annuities."

The last definition added to was for the "NAIC" stating, "the NAIC is the organization of insurance regulators from 50 states, the District of Columbia and all participating U.S. territories."

The Task Force members, state insurance regulators, and interested parties unanimously agreed that Guideline #1690 should not be considered a regulation but rather a guideline to assist states that currently require the submission of an Antifraud Plan and encourage the remaining jurisdictions to adopt a requirement for insurers' submission of an Antifraud Plan.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

AUTOMOBILE INSURANCE FRAUD GUIDELINES

Table of Contents

Section 1. Application

These Guidelines relate to the use of runners, cappers, or steerers and police accident reports in solicitation schemes and attempts to fraudulently assert a claim against an insured or an insurance carrier.

Section 2. Definitions

A. **"Runner," "capper," or "steerer" defined.** A person who receives a pecuniary benefit from a practitioner or health care service provider, whether directly or indirectly, to solicit, procure or attempt to procure a client, patient, or customer at the direction or request of, or in cooperation with, a practitioner or health care service provider whose purpose is to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient, or customer. Runner, capper, or steerer does not include a practitioner or health care service provider who procures clients, patients, or customers through the use of public media or a health, mental health, or substance abuse information service that provides information upon request and without charge to consumers about providers of health care goods or services, providing the service does not attempt to steer or lead a consumer to select or consider selecting a particular health care provider or health care facility through any financial inducement, commission, rebate, bones, kickback, or in-kind reward, to include free transportation.

B. **"Practitioner" defined.** An attorney, health care professional, an owner or partial owner of a health care practice or facility, or any person employed or acting on behalf of any of the aforementioned persons.

C. **"Public media" defined.** Telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards and mailed or electronically transmitted written communications that do not involve in-person contact with a specific prospective client, patient or customer.

Section 3. Prohibition of Solicitation

A. It is unlawful for a practitioner or health care service provider, whether directly or through a paid intermediary or volunteer, to solicit for financial gain a client, patient, or customer within sixty (60) days of a motor vehicle accident for the purpose of seeking benefits under a contract of insurance or to assert a claim against an insured, a governmental entity, or an insurer on behalf of any person arising out of the accident occurrence.

Section 4. Unlawful Acts Regarding a Runner, Capper, or Steerer

A. It is unlawful for:

(1) Any person, in an individual capacity or in a capacity as a public or private employee, or for any firm, corporation, partnership or association to act as a runner, capper, or steerer, for any practitioner or health care service provider. A violation of this provision is a felony and is punishable by a period of confinement not to exceed five years and a fine not to exceed $5000 per violation. This provision shall not prohibit an attorney or health care provider from making a referral and receiving compensation as is permitted under applicable professional rules of conduct.

(2) Any practitioner or health care service provider to compensate or give anything of value to a person acting as a runner, capper, or steerer, or organization to recommend or secure his employment by a client, patient, or customer if such practitioners intent is to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient, or customer. A violation of this provision is a felony and is punishable by a period of confinement not to exceed five years and a fine of not to exceed $5000 per violation. This provision shall not include a practitioner or health care service provider who procures clients, patients, or customers through the use of public media.

Section 5. Unlawful Use or Procurement of Vehicle Accident Reports

A. With respect to a motor vehicle accident or crash report or related investigative report or supplemental report, for a period of sixty (60) days after the date the report is filed, no employee of any law enforcement, state or local agency shall allow any person, including a practitioner, an attorney, health care service provider, or their agents, to examine or obtain a copy of any accident or crash report or related investigative report or supplemental report when such employee knows or should reasonably know that the request for access to the report is for commercial solicitation purposes. For purposes of this subsection, a request to examine or obtain a copy of a report is for "commercial solicitation purposes" if made at a time when there is no relationship between the person or his principal requesting the report and any party to the accident, and there is no apparent reason for the person to request the report other than for purposes of soliciting a business or commercial relationship. A violation of this provision is a misdemeanor and is punishable by a period of confinement not to exceed one year and a fine not to exceed $1000 per violation.

B. No person, for a period of sixty (60) days after the date the report is filed, shall request any law enforcement, state or local agency to permit examination or to furnish a copy of any motor vehicle accident or crash report or related investigative report or supplemental report for commercial solicitation purposes. For purposes of this subsection, a request to examine or obtain a copy of a report is for "commercial solicitation purposes" if made at a time when there is no relationship between the person or his principal requesting the report and any party to the accident, and there is no apparent reason for the person to request the report other than for purposes of soliciting a business or commercial relationship. A violation of this provision is a misdemeanor and is punishable by a period of confinement not to exceed one year and a fine not to exceed $1000 per violation.

C. Motor vehicle accident or crash reports held by any law enforcement, state or local agency under Sections 5(A) and 5(B) may be made immediately available to the parties involved in the crash, their legal representatives, their licensed insurance agents, their insurers or insurers to which they have applied for coverage, persons under contract with such insurers to provide claims or underwriting information, prosecutorial authorities, state licensed or state authorized victim services programs, radio and television stations licensed by the Federal Communications Commission, newspapers qualified to publish legal notices under applicable state law published once a week or more often, available and of interest to the public generally for the dissemination of news. For the purposes of this section, the following products or publications are not newspapers as referred to in this section: those intended primarily for members of a particular profession or occupational group; those with the primary purpose of distributing advertising; and those with the primary purpose of publishing names and other personal identifying information concerning parties to motor vehicle crashes.

D. In addition to any other requirements and except as provided in subsection (3), a person requesting to inspect or copy a motor vehicle accident or crash report or related investigative report or supplemental report within sixty (60) days of the accident shall:

(1) Produce for inspection and copying a government issued photo identification; and

(2) Provide a written, signed sworn statement that:

(a) Identifies the requested report(s) and the requestor's relationship to the parties;

(b) Includes the printed name of the requestor; and

(c) Verifies that the requestor is not prohibited from obtaining the report pursuant to Section 5.

(d) Information from the reports will not be used for any commercial solicitation purpose of accident victims, or knowingly disclose to any third party for the purpose of such solicitation, during the sixty (60) day time period specified in Section 5(A) and (B).

(3) All parties involved in the crash, their legal representatives, their licensed insurance agents, their insurers or insurers to which they have applied for coverage, persons under contract with such insurers to provide claim or underwriting information, prosecutorial authorities are exempt from providing a written signed sworn statement. In lieu of requiring the governmental issued photo identification any law enforcement, state or local agency may provide reports by electronic means to an insurance producer, insurer, or employee or agent of the insurer of an individual involved in the accident or prosecutorial authorities.

(4) In lieu of requiring the written signed sworn statement, any law enforcement, state or local agency may provide reports by electronic means to third-party venders under contract with one or more insurers, but only when such contract states that information from a report made confidential and exempt by Section 5(A) and 5(B) will not be used for any commercial solicitation purpose of accident victims by the vendors, or knowingly disclose by the vendors to any third party for the purpose of such solicitation , during the sixty (60) day time period specified in Section 5(A) and (B), and only when a copy of such contract is furnished to the agency as proof of the vendor's claimed status.

E. For each request to inspect or copy a motor vehicle accident report or crash report or related investigative reports or supplement report made within 60 days of the accident, the law enforcement, state or local agency shall maintain for one year a copy of the requestor's photo identification and the statement provided pursuant to Section 5(D).

Section 6. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2007 Proc. 4th Quarter, Vol. I 116, 127, 137, 142-143, 187-189 (adopted).

AUTOMOBILE INSURANCE FRAUD GUIDELINES

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

AUTOMOBILE INSURANCE FRAUD GUIDELINES

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY

AUTOMOBILE INSURANCE FRAUD GUIDELINES

NAIC MEMBER	RELATED ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	N.J. ADMIN. CODE §§ 11:16-6.1 to 11:16-6.11 (2005/2014).
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY

AUTOMOBILE INSURANCE FRAUD GUIDELINES

NAIC MEMBER	RELATED ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2007

AUTOMOBILE INSURANCE FRAUD GUIDELINES (#1694)

1. Description of the Project, Issues Addressed, etc.

These Guidelines relate to the use of runners, cappers, and steerers and police accident reports in solicitation schemes and attempts to fraudulently assert a claim against an insured or an insurance carrier.

2. Name of Group Responsible for Drafting the Model and States Participating

Antifraud Liaison Working Group of the Antifraud (D) Task Force

3. Project Authorized by What Charge and Date First Given to the Group

Appoint an **Antifraud Liaison Working Group** to (1) develop initiatives and guidelines to enhance relationships with industry Special Investigation Units (SIUs), external private sector antifraud entities and antifraud organizations to include but not limited to training opportunities, model protocols and bench marking projects. Projects will include guidelines for working with insurance fraud prosecutors, state fraud bureaus, and industry referring fraud cases to state fraud bureaus. (2) Develop an Automobile Insurance Fraud Model Law. (3) Provide an advisory role for the merger of the Coalition Against Insurance Fraud, International Association of Special Investigation Unit (IASIU) and National Insurance Crime Bureau (NICB). (Essential)

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Members of the Antifraud Liaison Working Group and the Antifraud (D) Task force drafted the Guidelines. Interested parties and regulators participated, including Property Casualty Insurers Association of America (PCI), Coalition Against Insurance Fraud, National Insurance Crime Bureau (NICB), in the drafting process and comment periods. Drafts of the Guidelines were posted on the NAIC website and distributed at the national meetings for review.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The working group and task force held several public discussions during national meetings and open comment periods and offered and opportunity for the public and interested parties and regulators to comment on this paper. Beginning with the September 2006 National Meeting the working group opened the topic of developing the Automobile Insurance Fraud Model Act. December 2006 National Meeting the first draft of the Model were distributed and opened for discussion by the working group. September 27, 2006, and February 28, 2007, drafts were open for comment and both drafts were posted on the NAIC website. By the June 2007 National Meeting the new NAIC Model law requirements were implemented, and the Model Act was redrafted into the Automobile Insurance Fraud Guidelines. The July 17, 2007, draft was distributed at the June 2007 National Meeting and posted on the NAIC website for comment.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Interested parties were initially concerned that the intent of the act was to require insurers to provide photo identification and provide a written, signed sworn statement to obtain an accident or crash reports from law enforcement, state, or local agency. The Working Group's intent was to require proof of identification of who was obtaining the reports and to restrict access to accident or crash report for sixty (60) days after the date of the report being filed. Language was added to allow all parties involved in the accident, their legal representatives, their insurance agents, insurer or employee or agent of the insurer and prosecutors access to the report and are exempt from having to provide a written, signed sworn statement.

However, any person requesting access or copy of a motor vehicle accident or crash report or related investigative report or supplement report must provide a government issued photo identification. I lieu of requiring the government issued identification, any law enforcement, state, or local agency may provide reports by electronic means to an insurance agent, insurer, or employee or agent of the insurer of an individual involved in the accident.

7. Any Other Important Information (e.g., amending an accreditation standard).

No other information is available.

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY

Drafting Note: Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 provides for the orderly liquidation of certain financial companies, including qualifying insurance companies, with the Federal Deposit Insurance Corporation (FDIC) generally seeking the appointment as receiver. However, in the case of qualifying insurance companies, the liquidation or rehabilitation of such a financial company will be conducted as provided under state law pursuant to 12 U.S.C. § 5383(e). If at the end of the 60-day period provided for under 12 U.S.C. § 5383(e)(3) the commissioner (or other appropriate regulatory agency) has not filed the appropriate state judicial action to place the insurer into orderly liquidation, the FDIC shall have the authority to stand in the place of the commissioner and file the appropriate judicial action in the appropriate state court to place the insurer into orderly liquidation under the laws and requirements of the state. The following statutory language is not an amendment to the NAIC receivership models, but is intended as a Guideline for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal statute:

[ ] Orderly Liquidation Authority

In accordance with Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 with respect to an insurance company that is a covered financial company, as that term is defined under 12 U.S.C. § 5381:

A. The commissioner may file in the [insert proper court] court of this state a petition for an order of rehabilitation or liquidation on any of the following grounds:

(1) Upon a determination and notification given by the Secretary of Treasury (in consultation with the President) that the insurance company is a financial company satisfying the requirements of 12 U.S.C. § 5383(b), and the board of directors (or body performing similar functions) of the insurance company acquiesces or consents to the appointment of a receiver pursuant to 12 U.S.C. § 5382(a)(1)(A)(i), with such consent to be considered as consent to an order of rehabilitation or liquidation; or

(2) Upon an order of the United States District Court for the District of Columbia under 12 U.S.C. § 5382(a)(1)(A)(iv)(I) granting the petition of the Secretary of the Treasury concerning the insurance company under 12 U.S.C. § 5382(a)(1)(A)(i); or

(3) A petition by the Secretary of the Treasury concerning the insurance company is granted by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v).

B. Notwithstanding any other provision in this Act or other law, after notice to the insurance company, the receivership court may grant a petition for rehabilitation or liquidation within 24 hours of the filing of a petition pursuant to this section.

C. If the court does not make a determination on the petition for rehabilitation or liquidation filed pursuant to this section within 24 hours after the filing of the petition, it shall be deemed granted by operation of law upon the expiration of the 24 hour period. At the time that an order is deemed granted under this section, the provisions of [cite to applicable state law addressing rehabilitation or liquidation] shall be deemed to be in effect, and the receiver shall be deemed to be appointed [optional: affirmed] and have all of the applicable powers provided by [refer to applicable state law addressing rehabilitation or liquidation], regardless of whether an order has been entered. The receivership court shall expeditiously enter an order of rehabilitation or liquidation that:

(1) Is effective as of date that it is deemed granted by operation of law; and

(2) Conforms to [cite to applicable state law addressing rehabilitation or liquidation], as applicable.

D. Any order of rehabilitation or liquidation made pursuant to this section shall not be subject to any stay or injunction pending appeal.

E. Nothing in this section shall be construed to supersede or impair any other power or authority of the commissioner or state courts under this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2011 Proc. 3rd Quarter, Vol. I 113, 131, 136, 218-220 (adopted).

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	CAL. INS. CODE § 1011 (1935/2013).
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	215 ILL. COMP. STAT. 5/188.2 (1937/2013).
Indiana	NO CURRENT ACTIVITY
Iowa	IOWA CODE ANN. § 507C.17A (2013).
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	LA. REV. STAT. ANN. § 22:2005.1 (2012).
Maine	NO CURRENT ACTIVITY

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY

NAIC MEMBER	RELATED ACTIVITY
Rhode Island	R.I. GEN. LAWS § 27-14.3-22.1 (2012).
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	TEX. INS. CODE ANN. § 443.057(23) (2005/2011).
Utah	UTAH CODE ANN. § 31A-27a-611 (2007).
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2011

GUIDELINE FOR IMPLEMENTATION OF STATE ORDERLY LIQUIDATION AUTHORITY (#1700)

1. Description of the Project, Issues Addressed, etc.

Following passage of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) in 2010, the Receivership and Insolvency (E) Task force realized the need for a comprehensive review of how the state-based receivership community would respond in the event of a federal determination of systemic risk involving an insurance company or affiliate of an insurance. Specifically, Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 provides for the orderly liquidation of certain financial companies, including qualifying insurance companies, with the Federal Deposit Insurance Corporation (FDIC) generally seeking the appointment as receiver. However, in the case of qualifying insurance companies, the liquidation or rehabilitation of such a financial company will be conducted as provided under state law pursuant to 12 U.S.C. § 5383(e). If at the end of the 60-day period provided for under 12 U.S.C. § 5383(e)(3) the commissioner has not filed the appropriate state judicial action to place the insurer into orderly liquidation, the FDIC shall have the authority to stand in the place of the commissioner and file the appropriate judicial action in the appropriate state court to place the insurer into orderly liquidation under the laws and requirements of the state. The new model guideline statutory language is not an amendment to the NAIC receivership models but is intended as a Guideline for use by those states seeking to review their authority under existing state law for purposes of initiating rehabilitation or liquidation proceedings in accordance with the federal statute.

2. Name of Group Responsible for Drafting the Model and States Participating

The Dodd-Frank Receivership Implementation (E) Working Group was formed by the Task Force to address this issue. The states participating were Illinois, California, Connecticut, Florida, Iowa, Indiana, Louisiana, Ohio, Pennsylvania, and Texas.

The Working Group members consisted of: Patrick Hughes (IL), Harry Levine and David Wilson (CA), Jon Arsenault (CT), Wayne Johnson and Sha'ron James (FL), Jim Mumford (IA), Kevin Baldwin (IL), Cindy Donovan (IN), Arlene Knighten (LA), Kristen Brown and Lynda Loomis (OH), Laura Lyon-Slaymaker (PA), and James Kennedy (TX).

3. Project Authorized by What Charge and Date First Given to the Group

The charge was delegated from the Task Force to the Dodd-Frank Receivership Implementation (E) Working Group. The charge was as follows: Review and consider portions of the recently adopted Dodd-Frank Wall Street Reform and Consumer Protection Act to determine what, if any state laws, regulations or procedures are necessary for state receivers and the NAIC to be prepared for its requirements related to receivership activities, as well as, monitor, review and provide input on federal rulemaking and studies related to insurance receivership.

4. A General Description of the Drafting Process and Due Process

The Dodd-Frank Receivership Implementation (E) Working Group formed a Legal Issues Drafting Group that was tasked with drafting an NAIC model guideline to help some states better prepare for a Title II event. The Subgroup consisted of the following members: Kevin Baldwin (IL), Arlene Knighten (LA), Kristen Brown and Lynda Loomis (OH), and James Kennedy (TX). The drafting group met via regulator-to-regulator conference call on four separate occasions in 2011, spending considerable time deliberating the receivership implementation issues.

In January 2011, the Legal Issues Drafting Group drafted a document titled Preliminary Outline Of Legal Items For Consideration By The Dodd-Frank Receivership Implementation (E) Working Group.

On February 4, 2011, the Working Group met via conference call with interested parties and regulators. During the call Kevin Baldwin provided an update from the Legal Issues Drafting Group. The update discussed the legal issues outline which identified potential concerns with state laws and regulations in the event of a Dodd-Frank receivership. Also, the legal issues outline proposed the Working Group seek the authority to develop an NAIC model guideline that states could use, as opposed to a model law or regulation. The Working Group exposed the outline for public comment for a period of 19 days with a comment deadline of Wednesday, February 23, 2011.

The Working Group met at the NAIC Spring National Meeting on March 27, 2011. At the meeting, Mr. Hughes directed the Working Group to receive and discuss comments relating to the public exposure. Florida made a motion to receive the edits that were distributed and to approve the preliminary outline. California seconded the motion and it passed.

The Working Group held a conference call on June 3, 2011. During the call, Mr. Baldwin discussed that the intention of the model guideline is to provide guidance and serve as a template for potential state law drafting revisions. Mr. Baldwin discussed that individual states might want to review existing state law to ensure appropriate authority is available in the event of a Dodd-Frank Act determination with a domestic insurer. The guideline provides that any of the triggers for a Dodd-Frank Act receivership constitute an automatic ground for receivership under state law. It also provides for some timing and procedural rules that would work to effectively implement the state-based receivership in the rapid order that is called for under the Dodd-Frank Act. Mr. Baldwin stated that the guideline is included for the states to utilize, to the extent that they feel necessary, when changes need to be made to existing state laws. The document was once again exposed for public comment.

The Working Group held a conference call on August 1, 2011. The purpose of the call was to discuss comments received from the June 3 public exposure of the model guideline.

Following the Aug. 1 conference call, the document was revised and exposed for public comment on Aug. 8, with comments due by the close-of-business Aug.12. No comments were received within the deadline period.

The Working Group held a conference call on Aug. 16. A motion was proposed and accepted to send model guideline to the Receivership and Insolvency (E) Task Force (RITF). The Receivership & Insolvency Task Force adopted on August 30, 2011.

5. A Discussion of the Significant Issues

The following significant issue was discussed with regard to this model guideline.

Denied Commissioner Petition
Interested parties commented that there was ambiguity in the model guideline relating to circumstances where a state court has denied the commissioner's petition. The Working Group adjusted the preamble of the model guideline to provide clarity on the issue.

6. Any Other Important Information

None.

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE

Table of Contents

Section 1. Title

This Act may be cited as the "[State] Title Insurance Guaranty Association – Title Insurance Consumer Protection Fund."

Section 2. Purpose

The purpose of this Act is to provide a mechanism for continuation of coverage; to provide payment of covered claims under certain insurance policies; to avoid excessive delay in payment; to avoid financial loss to policyholders because of the insolvency of a title insurer; and to provide an Association to assess the costs of such protection.

Section 3. Scope

This Act applies to all title insurers authorized to transact insurance in this state.

Section 4. Definitions

A. "Association" means the title insurance guaranty association.

B. "Authorized to transact insurance" means a title insurer as defined in [insert appropriate citation to the state insurance code].

C. "Commissioner" means the chief regulatory insurance official of this state, whether referred to as Director, Superintendent, Commissioner, or other similar title.

D. "Covered claim" means an unpaid claim of an insured covered under, and not in excess of, the applicable limits of a title insurance policy insuring land located in this state issued by an insolvent insurer. Subject to applicable policy limits, the Association's liability for covered claims shall not exceed $300,000 per claim. The total amount that may be recovered from the Association by a claimant for all covered claims shall not exceed $600,000. "Covered claim" does not include supplementary payment obligations, including, but not limited to, adjustment fees and expenses, escrow or other closing protection claims; nor does it include punitive, exemplary, extra-contractual or bad-faith damages awarded by a court judgment against an insurer. "Covered claim" does not include any first-party or third-party claim by or against an insured whose net worth on December 31 of the year preceding the date the insurer becomes insolvent exceeds $25,000,000 ($25 million), provided the insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis, and the insured has not applied for or consented to appointment of a receiver, trustee, or liquidator for all or substantially all of its assets; filed a voluntary bankruptcy petition; or filed a proceeding under state law to

reorganize or receive protection under any insolvency law. The amount of a covered claim shall be reduced by the amount or other benefit that an insured recovers from any person, including an agent, regardless of whether an assignment is taken.

Drafting Note: States that desire to include additional claims in the fund may omit one or more of the exclusions from this definition.

E. "Insolvent insurer" means:

(1) An insurer authorized to transact business in this state at the time the policy was issued or an insurer that subsequently assumes such policy under an assumption agreement;

(2) An insurer against which an Order of Liquidation with a finding of insolvency has been entered after the effective date of this Act by a court or administrative agency of competent jurisdiction in the insurer's state of domicile, or of this state under [insert state liquidation law citation]; and

(3) An insurer against which an Order of Liquidation has not been stayed or been the subject of a writ that supersedes or other comparable Order.

F. "Insured" means a person entitled to payment for insured loss under a policy issued by the insolvent title insurance company on title to real property located in this state.

G. "Member insurer" means any person who is authorized to transact title insurance in this state.

Drafting Note: Some states may authorize property and casualty insurers to transact title insurance. Other states may limit the transaction of title insurance to monoline title insurers.

H. "Net direct title premium" means direct gross premiums written in this state on insurance policies to which this Act applies.

I. "Person" means any individual, corporation, partnership, association, trust, or voluntary organization.

J. "Policy" means a title insurance policy, or assumption certificate whose subject of coverage or protection is title to real property located in this state; and "Title Policy" means any written instrument or contract by means of which title insurance liability is assumed by a title insurer.

K. "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require.

L. "Servicing facility" means a person or persons delegated by the Board of Directors to settle or compromise claims and to expend Association assets to pay claims.

Section 5. Organization of Association

There is hereby created a nonprofit legal entity to be known as the [State] Title Insurance Guaranty Association. All member insurers shall maintain membership in the Association as a condition of their authority to transact title insurance in this state. The Association may take any appropriate form of legal entity available under the laws of this state, including, but not limited to, a corporation or receivership association as approved by the Commissioner.

Section 6. Board of Directors

A. The Board of Directors of the Association shall consist of not less than five (5), and not more than eleven (11), persons serving terms as established in the Plan of Operation. In addition to the voting members of the board, the Commissioner or his/her designated representative shall be an ex-officio non-voting member of the board. The members of the board shall be selected by member insurers subject to the approval of the Commissioner and shall have as a majority of its members, persons who are employed by member insurers. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner.

B. In approving selections to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the Board of Directors shall not receive compensation for serving as members of the Board of Directors, or any committees thereof, but may be reimbursed from the administrative account for actual expenses incurred by them as members of the Board of Directors.

Section 7. Powers and Duties of the Association

A. The Association shall:

(1) Be obligated to the extent of the amount of covered claims not resolved, whether reported or not, prior to the determination of insolvency, except that the Association shall not be obligated as to policies that have been replaced by another title insurance policy issued by a solvent authorized title insurer. In no event shall the Association be obligated for an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises;

Drafting Note: The phrase "not resolved" includes claims that are unpaid or otherwise unresolved by the member insurer as of the insolvency determination date, including claims that may not have been asserted but exist due to a defect in title or other event covered under the terms of the title policy issued by the insolvent member insurer. If another title insurance company assumes or otherwise issues a replacement policy, there should be no covered claims under the original, now insolvent, title insurance company policy. States may want to cut off claims by requiring the Association, or the Commissioner as liquidator, to cancel title insurance policies after five years. Alternatively, as reflected in this Act, states may not want to have a guaranty fund claim cut-off.

(2) Have no liability for the alleged bad faith of the insolvent insurer in the handling of any claim prior to the determination of insolvency or for any exemplary or punitive damages;

(3) Investigate claims made against the policies of an insolvent insurer and adjust, negotiate, resolve, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. The designation of a servicing facility is subject to the approval of the Board of Directors, but the designation of such insurer may be declined by the member insurer; and

(4) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the covered claims and expenses, including loss adjustment expenses, and receivership expenses for the coming year if, at the end of any calendar year, the Board of Directors finds that the assets of the Association in the fund exceed the liabilities of that account.

B. The Association may, subject to approval by the Board of Directors:

(1) Employ or retain persons or companies as servicing facilities necessary to handle claims and perform other duties of the Association;

(2) Review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to in order to determine the extent to which such settlements, releases, and judgments may be properly contested;

(3) Borrow funds necessary to affect the purposes of this Act in accordance with the Plan of Operation;

(4) Sue or be sued and intervene in any court or arbitration forum having jurisdiction over an insolvent member insurer;

(5) Negotiate and become a party to contracts necessary to carry out the purposes of this Act, including assumption or reinsurance agreements relating to the title policies of an insolvent insurer;

(6) Take actions as provided in Subsection A and Subsection B of this section prior to an insurer being declared insolvent by a court, where an insurer is potentially unable to fulfill its contractual obligations or is determined to be impaired; and

(7) Perform other acts necessary or proper to effectuate the purposes of this Act.

C. If the Association fails to act within a reasonable time, the Commissioner shall assume the powers and duties of the Board of Directors of the Association and cause it to act as appropriate.

Section 8. Plan of Operation

A. The Association shall submit to the Commissioner a Plan of Operation and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the Association. The Plan of Operation and any amendments thereto shall become effective upon the approval in writing by the Commissioner. If, at any time, the Association fails to submit suitable amendments to the Plan of Operation, the Commissioner shall, after notice and hearing, adopt rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the Commissioner or superseded by a plan or amendments submitted by the Association and approved by the Commissioner.

B. All member insurers shall comply with the Plan of Operation, subject to the provisions of this Act.

C. The Plan of Operation, among other things, shall establish procedures for conducting the business of the Association, for handling its assets, for keeping records, and for the conduct of other activities necessary for execution of the powers and duties of the Association.

D. The Plan of Operation may provide that any and all powers and duties of the Association, except those under Section 6 and Section 7 of this Act that are to be performed by the Board of Directors, or be delegated to a corporation, association or other organization that performs, or will perform, functions similar to those of the Association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid by the Association for its costs incurred in performance of such functions.

Section 9. Duties and Powers of Commissioner

A. The Commissioner shall:

(1) Serve on the Association a copy of any complaint seeking an Order of Liquidation with a finding of insolvency against a member insurer domiciled in this state at the same time that such complaint is filed with a court of competent jurisdiction; and

(2) Notify the Association of the existence of an insolvent insurer not later than three (3) days after receipt of notice of the determination of the insolvency; and, upon request of the Board of Directors, provide the Association with a statement of the reported direct premiums written for the [insert time period] of each member insurer.

B. The Commissioner may:

(1) Suspend or revoke, after notice and hearing, the Certificate of Authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the Plan of Operation. As an alternative, the Commissioner may levy a civil penalty on any member insurer that fails to pay an assessment when due. The civil penalty shall not exceed five percent (5%) of the unpaid assessment per month, except that no civil penalty shall be less than one hundred dollars ($100) a month; and

(2) Revoke the designation of any servicing facility if the Commissioner finds claims are being handled unsatisfactorily.

Section 10. Coordination Among Guaranty Associations

A. The Association may join one or more organizations of other state title guaranty associations of similar purposes, to further the purposes and administer the powers and duties of the Association. The Association may designate one or more of these organizations to act as a liaison for the Association and to the extent which the Association authorizes, to bind the Association in agreements or settlements with the receiver of the insolvent insurer or his or her designated representative.

B. The Association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with the receiver, or his or her designated representative, in the most efficient and uniform manner.

Section 11. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned his or her rights under the policy to the Association to the extent of his recovery from the Association. Every insured seeking the protection of this Act shall cooperate with the Association to the same extent as he or she would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against an insured for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association do not operate to reduce the liability of the insured to the receiver, liquidator, or statutory successor for unpaid assessments.

B. The court having jurisdiction shall grant such claims assigned pursuant to Subsection A of this section and the expenses of the Association or similar organization in another state the same priority as the claims and expenses of policyholders. The Association may make application to the receivership court for reimbursement of such reasonable claims and expenses and upon proper showing to the court for reimbursement of such amounts the court shall order appropriate reimbursement of reasonable claims and expenses to be made.

C. The receiver for the insolvent insurer shall, each time a request for funds is submitted to the Association, but not less than once every six (6) months within the time set by the receivership court, file with the Commissioner or liquidator court of the insolvent insurer, a statement of the covered claims paid, reserves for unpaid claims, claims expense incurred, and the balance of funds then in the possession of the receiver.

Section 12. Non-Duplication of Recovery

Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer that is also a covered claim, shall be required to first exhaust his or her rights under such policy. Any amount payable on a covered claim under this Act shall be reduced by the amount of any recovery or value thereof received under such insurance policy**.**

Section 13. Examination of Association; Financial Reports

The Association is subject to examination and shall complete audited financial statements. The Board of directors shall submit to the Commissioner and its member insurers, not later than June 30 of each year, a financial report for the preceding year in a form approved by the Commissioner.

Section 14. Assessment Authority of Commissioner and Association

A. Making of Assessment

(1) If the Commissioner determines that a title insurance company has become insolvent, the Association shall promptly estimate the amount of additional money needed to supplement the assets of the impaired title insurance company to pay all covered claims and administrative expenses.

(2) The Association shall assess title insurance companies in writing an amount as determined under Subsection B of this section. A member insurer does not incur real or contingent liability under this Act until the Association provides the member insurer with a written assessment.

B. Amount of Assessment: Proration of Payment

(1) The Association shall assess member insurers the amount necessary to pay: (a) the Association's obligations under this Act and the expenses of handling covered claims subsequent to an insolvency; and (b) other expenses authorized by this Act.

(2) The assessment of each member insurer must be in the proportion that the net direct written title premiums of that company for the calendar year preceding the assessment bear to the net direct written title premiums of all member insurers for that year.

(2) The total assessment of a member insurer in a year may not exceed an amount equal to two percent (2%) of the member's net direct title premium earned for the calendar year preceding the assessment. If the maximum assessment and the Association's other assets are insufficient in any one year to make all necessary payments, the money available shall be prorated and the unpaid portion shall be paid in subsequent years.

C. Notice and Payment

(1) Not later than the forty-fifth (45th) day before the date an assessment is due, the Association shall notify member insurers of the amount of the assessment.

(2) Not later than the forty-fifth (45th) day after the date an assessment is made, the member insurer shall pay the Association the amount of the assessment.

D. Exemption for Impaired Title Insurance Company

A member insurer is exempt from assessment during the period beginning on the date the Commissioner designates the company as an impaired member insurer and ending on the date the Commissioner determines that the company is no longer an impaired member insurer.

Drafting Note: The term "hazardous financial condition" or "inability to meet obligations" may be substituted for the term "impaired."

E. Deferment

(1) At the discretion of the Commissioner, the Association may defer, in whole or in part, an assessment of a member insurer that would cause the member's financial statement to show amounts of capital or surplus less than the minimum amount required for a Certificate of Authority in any jurisdiction in which the company is authorized to engage in the business of insurance.

(2) The member insurer shall pay the deferred assessment when payment will not reduce capital or surplus below required minimums. The payment shall be refunded to or credited against future assessments of any member insurer receiving a larger assessment because of the deferment, as elected by that member.

(3) During a period of deferment, the member insurer may not pay a dividend to shareholders or policyholders.

F. Accounting; Reports

(1) The Association shall adopt accounting procedures to show how money received from assessments or partial assessments is used.

(2) The Association shall make interim accounting reports as the Commissioner requires.

(3) The Association shall make a final report to the Commissioner showing how money received from assessments or partial assessments has been used, including a statement of any final balance of that money.

G. Use of Assessments

The Association may use money from assessments to negotiate and consummate contracts of reinsurance, assumption of liabilities, or replacement policies from authorized title insurers to provide for outstanding liabilities of covered claims. Assessments shall be used to pay the Association's general expenses and statutory obligations.

H. Failure to Pay

(1) The Association shall promptly report to the Commissioner a failure of a member insurer to pay an assessment when due.

(2) On failure of a member insurer to pay an assessment when due, the Commissioner may take any action as provided in Section 9B of this Act.

(3) A member insurer whose certificate of authority is canceled or surrendered is liable for any unpaid assessments made before the date of the cancellation or surrender.

I. Recovery of Assessment in Rates; Tax Credit

(1) The surcharge on title insurance policies shall be based on historical need and include amounts sufficient to recoup a sum equal to the amounts paid to the Association by the member insurers, less any amounts returned to the member insurers by the Association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurers.

(2) Unless the Commissioner determines that all amounts paid as assessments by each member insurer have been recovered under Subsection A of this section, for any amount not recovered the member insurer is entitled to a credit against its premium tax [include reference to state law providing for premium taxes]. The credit may be taken at a rate of twenty percent (20%) each year for five (5) successive years following the date of assessment and, if the member insurer elects, may be taken over an additional number of years.

Drafting Note: State law may not permit this tax offset, as premium taxes are for general fund purposes and assessments as provided in this Act are for a specific purpose.

(3) An amount of a tax credit allowed by this section that is unclaimed may be shown in the member insurer's books and records as an admitted asset for all purposes, including an annual financial statement under [include reference to state law].

Drafting Note: State law may not permit this tax offset; therefore Subsection (2) and Subsection (3) may be omitted.

Section 15. Immunity and Confidentiality

A. There shall be no liability on the part of, and cause of action of any nature shall arise against, any member insurer, the Association or its officers, agents or employees, the Board of Directors, any individual director, or the Commissioner or his or her representative for any action taken by them in the performance of their powers and duties under this Act or for failure to prevent any insolvency.

B. The meetings, activities, recommendations, and decisions of the Board of Directors of the Association as required or permitted in this Act shall not be open to public inspection, nor considered public documents pursuant to [insert relevant state law]. No representative of a member insurer shall be excluded from any meeting of the Board of Directors, with the exception of a representative of an insolvent insurer.

Section 16. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall, subject to waiver of the Association for specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in this state, whichever is later, to permit proper defense by the Association of all pending causes of action.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this Act shall permit access by the Board of Directors, or its authorized representative, to such of the insolvent insurer's records that are necessary for the Board of Directors in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the Board of Directors, or its authorized representative, with copies of those records upon the request by the Board of Directors and at the expense of the Board of Directors.

Section 17. Termination; Distribution of Funds

A. The Commissioner shall by Order terminate the operation of the Association if he or she finds, after hearing, that there is in effect a statutory or voluntary plan which:

(1) Is a permanent plan that is adequately funded or for which an adequate means of funding is provided; and

(2) Extends, or will extend, to the policyholders of this state protection and benefits with respect to insolvent member insurers not substantially less favorable and effective to the policyholders than the protection provided under this Act.

B. If operation of the Association is terminated or if the Association has no further known obligations, the Association, as soon as possible thereafter, shall distribute the balance of money and assets remaining, after discharge of the functions of the Association, with respect to prior insurer insolvencies not covered by another plan, together with expenses, to the member insurers or former member insurers, pro rata upon the basis of the aggregate of such payments made by the respective insurers during the period of five (5) years next preceding the date of the Order.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2015 Proc. 2nd Quarter, Vol. I 126, 145, 151, 160, 230-239 (adopted).

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	N.M. STAT. ANN. §§ 59A-30A-1 to 59A-30A-18 (1999).
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	TEX. INS. CODE ANN. §§ 2602.001 to 2602.453 (2003/2019).
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2015

TITLE INSURANCE CONSUMER PROTECTION FUND GUIDELINE (#1750)

1. Description of the Project

In 2011, during discussions at Title Insurance (C) Task Force meetings, it was pointed out that only a few states had guaranty funds that would protect title insurance policyholders in the event of a title insurance company insolvency. The Task Force committed to perform a review of the need for a model law or guideline that states that did not already have a title guaranty fund could use to establish a fund in their state. Working with the Receivership and Insolvency (E) Task Force, the Title Insurance (C) Task Force appointed the Title Insurance Guaranty Fund (C/E) Working Group of the Title Insurance (C) Task Force and Receivership and Insolvency (E) Task Force. The Working Group was chaired by Cindy Donovan (IN) and John Finston (CA).

With the assistance of NAIC staff, the Working Group developed information about past title insolvencies and how title consumers were affected. The research focused on the following questions:

1. Is there a serious title insolvency problem?
2. Is a 50-state guaranty fund the best way to address this problem?
3. How has the public been affected by title company insolvencies?
4. What is the scope of title guaranty fund payments?
5. How have title insolvencies played out in the past (both with and without title guaranty funds)?
6. Have guaranty funds worked in the states that have them?
7. What steps would a guaranty fund take to manage insolvency?

2. Name of Group Responsible for Drafting the Model and States Participating

The Title Insurance Guaranty Fund (C/E) Working Group. Participating states include: California; Colorado; District of Columbia; Indiana; Kansas; Minnesota; Missouri; Nebraska; New Mexico; Oklahoma; Rhode Island; and Texas.

3. Project Authorized by What Charge and Date First Given to the Group

"Appoint a Title Insurance Guaranty Fund (C/E) Working Group to consider whether a title insurance guaranty fund model law or guideline should be developed. Determine the attributes of recent title company financial failures. Report the results by the Summer National Meeting."—*Fall 2012 Meeting. Charge adopted for 2013.*

4. A General Description of the Drafting Process and Due Process

- The following charge was proposed at the 2011 Fall National Meeting: "Consider Development of Model Law or Guideline on Title Insurance Guaranty Association Model Act" (Nov. 4, 2012, National Meeting). The charge was not adopted for the Property and Casualty Insurance (C) Committee, but it was decided instead to form a joint Title Insurance Guaranty Fund (C/E) Working Group.

- At the 2012 Spring National Meeting, the Task Forces authorized the Title Insurance Guaranty (C/E) Working Group to continue research on title insurance insolvencies, agent defalcations and states with existing title guaranty funds.

- In 2012, the NAIC conducted research regarding title insurance company insolvencies and title agent defalcations and presented the results to the Working Group Nov. 13, 2012.

- Other parties participating in the Working Group discussions were: Agents National Title Insurance Company; American Land Title Association (ALTA); Center for Economic Justice (CEJ); ClosingCorp; Demotech; Fidelity National Title; First American Title; October Research; Old Republic Title Insurance Company (ORTIG); PricewaterhouseCoopers; Security Title Guarantee Corporation of Baltimore; Stewart Title Guaranty Company; Title Insurance Company; and Westcor Land.

- The Working Group chairs recommended that a model law not be developed due to a lack of evidence and instead focus on continued work related to administrative controls identified in the *Title Insurance Escrow Theft White Paper* rather than develop a title insurance guaranty fund model law or guideline.

- Working Group members voted to proceed with the development of a "Title Guaranty Fund Guideline" that states could implement (Feb. 14, 2013).

- A draft guideline was developed by David Cox (MO) and modified by members of the Working Group and NAIC legal staff (May 28, 2013). The draft guideline was exposed for public comment (July 10, 2013). Written comments were received from ALTA, the American Insurance Association (AIA); and the National Conference of Insurance Guaranty Funds (NCIGF).

- ALTA submitted an alternative "Option 3" version (Dec. 30, 2013). It was rejected in a letter to ALTA after review by the Working Group chairs and NAIC legal staff (January 2014). Additional revisions to the draft were subsequently proposed by ALTA and the Working Group chair.

- The Working Group exposed a revised June 26, 2014, draft "Title Insurance Guaranty Association – Title Insurance Consumer Protection Fund Guideline" (July 8, 2014).

- Comments were received from ALTA and Fidelity National Title (August 11, 2014). In response to comments, additional edits were made to the draft, and the title of the Guideline was revised to *Guaranty Association for Title Insurance*.

- The Working Group renamed the document to "Title Insurance Guaranty Association-Title Insurance Consumer Protection Fund Guideline" (Sept. 30, 2014).

- On Oct. 23, 2014, the Working Group voted to expose the revised draft for public comment a second time for a four-week period ending Nov. 20, 2014. No additional comments were received.

- A conference call was held Dec. 10, 2014, and an e-vote was conducted to approve forwarding the document to the Title Insurance (C) Task Force and Receivership and Insolvency (E) Task Force for further consideration (Dec. 15, 2014). The motion passed.

- The Title Insurance (C) Task Force and the Receivership and Insolvency (E) Task Force adopted the Guideline at the 2015 Spring National Meeting.

5. Discussion of Significant Issues

Initial studies did not indicate that there were enough title insurance company insolvencies or agent defalcations to merit the formation of an NAIC model law for all states. A consumer advocate group, the CEJ, challenged this finding and encouraged the group to continue working on a model law. The Working Group reconsidered discontinuing work on the project and decided that it would be worthwhile to develop guidelines that states that did not have a guaranty fund could consider should they decide to form one.

Initial drafts of guidelines were challenged by industry groups that disagreed with assessment language for guaranty association member companies. Numerous drafts were presented and modified before the Working Group approved a final version in December 2014.

6. Any Other Important Information

Not applicable.

PROPERTY AND CASUALTY MODEL RATING LAW (FILE AND USE VERSION)

Table of Contents

Section 1. Purposes of Act

The purposes of this Act are:

A. To prohibit price fixing agreements and other anticompetitive behavior by insurers;

B. To protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

C. To promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;

D. To provide regulatory procedures for the maintenance of appropriate data reporting systems;

E. To provide regulatory controls in the absence of competition;

F. To improve availability, fairness and reliability of insurance;

G. To authorize essential cooperative action among insurers in the ratemaking process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly;

H. To encourage the most efficient and economical marketing practices; and

I. To cause the provision of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets.

Section 2. Definitions

A. "Advisory organization" means any entity, including its affiliates or subsidiaries, which either has two (2) or more member insurers or is controlled either directly or indirectly by two (2) or more insurers, and which assists insurers in ratemaking-related activities such as enumerated in Sections 10 and 11. Two (2) or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for purposes of this definition.

B. "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

C. "Commercial risk" means any kind of risk which is not a personal risk.

D. "Commissioner" means the Commissioner of Insurance of this state.

E. "Competitive market" means a market which has not been found to be noncompetitive pursuant to Section 4.

F. "Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

G. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees.

H. "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

I. "Joint underwriting" means a voluntary arrangement established to provide insurance coverage for a risk pursuant to which two (2) or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers.

J. "Loss adjustment expense" means the expenses incurred by the insurer in the course of settling claims.

K. "Trending" means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

L. "Market" means the interaction between buyers and sellers consisting of a product component and a geographic component. A product component consists of identical or readily substitutable products including but not limited to consideration of coverage, policy terms, rate classifications and underwriting. A geographic component is a geographical area in which buyers seek access to the insurance product through sales outlets and other distribution mechanisms. Determination of a geographic component shall consider existing distribution patterns.

M. "Noncompetitive market" means a market for which there is a ruling in effect pursuant to Section 4 that a reasonable degree of competition does not exist.

N. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes and other property and casualty insurance for personal, family or household needs.

O. "Pool" means a voluntary arrangement, established on an on-going basis, pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement.

P. "Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

Q. "Rate" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

R. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

S. "Special assessments" means guaranty fund assessments, Second Injury Fund assessments, Vocational Rehabilitation Fund Assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

Drafting Note: A state may wish to add "assessments for residual market mechanisms" or other assessments as one of the listed special assessments.

T. "Statistical agent" means an entity that has been licensed by the commissioner to collect statistics from insurers and provide reports developed from these statistics to the commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers under this Act.

U. "Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule and any other similar information needed to determine the applicable rate in effect or to be in effect.

Drafting Note: A "plan of rates" filed by an insurer would contain final rates including provisions for expenses and profit. A "plan of rates" filed by an advisory organization would contain only prospective loss costs which would exclude provisions for expenses (other than loss adjustment expenses) and profit.

V. "Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer;

(2) The interpretation of any other data relied upon by the filer;

(3) Descriptions of methods used in making the rates; and

(4) Any other information required by the commissioner to be filed.

Section 3. Scope of Act

This Act applies to all forms of casualty insurance, including fidelity, surety and guaranty bond, to all forms of fire, marine and inland marine insurance, and to any combination of any of the foregoing, on risks or operations located in this State. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the commissioner, or as established by general custom of the business, as inland marine insurance.

Drafting Note: The kinds of insurance are named herein in their generally accepted trade sense unless otherwise defined by statute or regulation. The wording of the section should be fitted to any laws of the state which classify insurance.

This Act shall not apply to:

A. Reinsurance, other than statutorily authorized joint reinsurance mechanisms to the extent stated in Section 13;

B. Accident and health insurance;

C. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine insurance as determined by the commissioner;

D. Title insurance;

E. Insurance;

Drafting Note: Here should be listed (a) other kinds of insurance, if any, and (b) particular types of insurers, if any, to which this Act is not to apply in the state or jurisdiction adopting the Act. The specific exemption of aircraft hull and liability insurance contained in the 1946 NAIC Model Bills is omitted from Section 3 of this Act. A number of states have, since 1946, provided for regulation of aircraft hull and liability insurance rates.

Section 4. Competitive Market

A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues a ruling to that effect. Such a rule shall expire no later than one year after issue unless the commissioner renews the rule after hearings and a finding as to the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of competition exists, the commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers.

Drafting Note: Any state desiring an alternative section incorporating specific examples of tests of workable competition may wish to use the following:

[A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues a ruling to that effect. Such a rule shall expire no later than one year after issue, unless the commissioner renews the rule after hearing and a finding as to the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of competition exists, the commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers. Such tests may include, but are not limited to, the following: size and number of firms actively engaged in the market; market shares and changes in market shares of firms; ease of entry and exit from a given market; underwriting restrictions; whether profitability for companies generally in the market segment is unreasonably high; availability of consumer information concerning the product and sales outlets or other sales mechanisms; and efforts of insurers to provide consumer information. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.]

Section 5. Rate Standards

Rates shall be made in accordance with the following provisions:

A. Rates shall not be excessive, inadequate or unfairly discriminatory.

(1) Excessive Rates.

(a) Competitive market. A rate in a competitive market is not excessive.

(b) Noncompetitive market. A rate in a noncompetitive market is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

(2) Inadequate Rates. A rate is not inadequate unless such rate is clearly insufficient to sustain projected losses, expenses and special assessments in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

Drafting Note: The following paragraph may modify Section 5A(2). It is presented for those states that wish to supplement the financial regulatory laws:

[A rate is not inadequate unless: (a) the rate is unreasonably low for the insurance provided and the continued use of the rate endangers the solvency of the insurer using it; or unless (b) the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has, or if continued will have, the effect of destroying competition or creating a monopoly.]

(3) Unfairly Discriminatory Rates. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a group, franchise or blanket policy or a mass marketed plan. As used in this paragraph, a mass marketed plan means a method of selling property-liability insurance wherein:

(a) The insurance is offered to employees of particular employers or to members of particular associations or organizations or to persons grouped in other ways, except groupings formed principally for the purpose of obtaining such insurance; and

(b) The employer, association or other organization, if any, has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or members.

(4) Rating Methods. In determining whether rates comply with the excessiveness standard in a noncompetitive market under Paragraph (1)(b), the inadequacy standards under Paragraph (2) and the unfair discrimination standard under Paragraph (3), the following criteria shall apply:

(a) Basic factors in rates. Due consideration shall be given to past and prospective loss experience within and outside this State; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers; to past and prospective expenses both countrywide and those specially applicable to this State; and to provisions for special assessments and to all other relevant factors within and outside this State.

(b) Classification. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the insured.

(c) Expenses. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and its anticipated expenses.

(d) Profits. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to all investment income attributable to the line of insurance.

Section 6. Rate Filings

A. (1) Every insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 14. Every such filing shall state the effective date, and shall indicate the character and extent of the coverage contemplated.

(2) Every insurer shall file or incorporate by reference to material which has been filed with or approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or consist of a reference to:

(a) The experience or judgment of the insurer or information filed by the advisory organization on behalf of the insurer as permitted by Section 14;

(b) Its interpretation of any statistical data it relies upon;

(c) The experience of other insurers or advisory organizations; or

(d) Any other relevant factors.

A filing and any supporting information shall be open to public inspection upon receipt of the filing.

(3) When a filing is not accompanied by the information upon which the insurer supports such filing, the commissioner may require such insurer to furnish the information upon which it supports such filing and in that event the waiting period shall commence as of the date such information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed nor available for use by the insurer. If the requested information is not provided within a reasonable time period, the filing may be returned to the insurer as not filed and not available for use.

(4) After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss, special assessment and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may use or supplement its experience with information filed with the commissioner by an advisory organization or statistical agent.

(5) Insurers utilizing the services of an advisory organization must provide with their rate filing, at the request of the commissioner, a description of the rationale for such use, including its own information and method of utilization of the advisory organization's information.

Drafting Note: States may desire to move Paragraphs (2), (3) and (4) to Section 6D. If these paragraphs are moved to Section 6D, then the following language should be added to Section 6B: "The commissioner may require an insurer to furnish any additional information."

B. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this Act.

C. In a competitive market, every insurer shall file with the commissioner the information specified in Subsection A of this section that it will use in this state. The rates and supplementary rating information shall be filed on or before the effective date. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least [insert number of days] before the effective date, all such rates and supplementary rating information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

D. In a noncompetitive market, subject to the exception specified in Subsection E of this section, each filing shall be on file for a waiting period of [insert number of days] days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed [insert number of days] days if written notice is given within such waiting period to the insurer or advisory organization which made the filing that additional time is needed for the consideration of the filing. Upon written application by the insurer, the commissioner may authorize a filing which has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this Act unless disapproved by the commissioner within the waiting period or any extension thereof.

Drafting Note: The waiting period specified in current state statutes ranges from 15 to 90 days.

E. Under such rules and regulations as may be adopted, the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, for which the rates cannot practicably be filed before they are used. The commissioner may make such examination as deemed advisable to ascertain whether any rates affected by such order meet the standards set forth in Section 5.

F. Upon the written application of the insurer and insured, stating its reasons therefore, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

G. No insurer shall make or issue a contract or policy except in accordance with the filings which have been approved and are in effect for said insurer as provided in this Act or in accordance with Subsections E or F of this section. This subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required.

H. A rate for a residual market in which insurers are mandated by law to participate shall not become effective until approved by the commissioner.

Drafting Note: To accommodate the transition from a prior rating law to this model, consideration should be given to inclusion of "transitional language" such as:

"Nothing in this Act shall be construed to require an advisory organization or its members or its subscribers to immediately refile final rates or premium charges previously approved by the commissioner. Members or subscribers of an advisory organization are authorized to continue to use insurance rates or premium charges approved before the effective date of this act or decreases from those rates or premium charges filed by the advisory organization and subsequently approved after the effective date of this section. "

Section 7. Disapproval of Filings

A. For filings made in a noncompetitive market and residual market filings, if within the waiting period or any extension thereof as provided in Section 6D, the commissioner finds that a filing does not meet the requirements of this Act, written notice of disapproval shall be sent to the insurer or advisory organization which made the filing, specifying therein in what respects the filing fails to meet the requirements of this Act and stating that such filing shall not become effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. If at any time after a rate has been approved and for filings made in a competitive market, the commissioner finds that the rate no longer meets the requirements of this Act, the commissioner may order the discontinuance of use of the rate. The order of discontinuance may be issued after a hearing with at least ten (10) days' prior notice for all insurers affected by the order. The order must be in writing and state the grounds for the order. It shall also state when, within a reasonable time thereafter, the filing will be deemed no longer effective. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order. The commissioner's order may include a provision for a premium adjustment for contracts or policies made or issued after the effective date of the order.

C. Any insured aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon. The application shall specify the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, a hearing shall be held within thirty (30) days after receipt of such application upon not less than ten (10) days' written notice to the applicant and to every insurer and advisory organization which made such filing.

If, after such hearing, the commissioner finds that the filing does not meet the requirements of this Act, an order shall issue specifying in what respects such filing fails to meet the requirements of this Act, and stating when, within a reasonable period thereafter, such filing shall no longer be deemed to be in effect. Copies of the order shall be sent to the applicant and to every such insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

D. Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interest of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When the new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are *de minimis* shall not be required.

Section 8. Monitoring Competition

In determining whether or not a competitive market exists pursuant to Section 4, the commissioner shall monitor the degree of competition in this State. In doing so, the commissioner shall utilize existing relevant information, analytical systems and other sources; cause or participate in the development of new relevant information, analytical systems and other sources; or rely on some combination thereof. Such activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner.

Section 9. Information to be Furnished Insureds: Hearings and Appeals of Insureds

A. Every advisory organization and every insurer shall, within a reasonable time after receiving written request, furnish to any insured affected by a rate made by the insurer, or to the authorized representative of the insured, all pertinent information as to such rate. Every advisory organization and every insurer shall provide within this State reasonable means whereby the insured aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on written request to review the manner in which such rating system has been applied in connection with the insurance afforded the insured. If the advisory organization or insurer fails to grant or reject such request within thirty (30) days after it is made, the applicant may proceed in the same manner as if the application had been rejected. The insured affected by the action of the advisory organization or insurer on such request may, within thirty (30) days after written notice of such action, appeal to the commissioner, who, after a hearing held upon not less than ten (10) days' written notice to the appellant and to the advisory organization or insurer, may affirm or reverse such action.

Drafting Note: Language could be inserted here which would allow an insurer or advisory organization to charge a reasonable fee to cover the expense of providing any information requested under this section, but charges should not be permitted when the information relates to the specific application of an experience rating modification or a schedule rating modification.

B. If, after a hearing held under this section, it is determined that the rates charged by an insurer are in excess of the otherwise appropriate rate, such overcharge shall be refunded to the insured.

Section 10. Consumer Information

The commissioner shall utilize, develop or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private passenger nonfleet automobile, or property insurance for personal, family or household needs. The commissioner may utilize, develop or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified herein. Such activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner. To the extent deemed necessary and appropriate by the commissioner, insurers, advisory organizations, statistical agents and other persons or organizations involved in conducting the business of insurance in this State, to which this section applies, shall cooperate in the development and utilization of a consumer information system(s).

Drafting Note: For jurisdictions that need a separate and distinct means of funding a consumer information system the following provision may be added to Section 10:

The cost of complying with this section shall be assessed against insurers subject to this Act and authorized to write types of business subject to a consumer information system. The assessments shall be made on an equitable and practicable basis established, after hearing, in a rule promulgated by the commissioner. This activity shall be conducted in a reasonably economical manner consistent with the purposes of this Act.

Section 11. Licensing Advisory Organizations and Statistical Agents

A. No advisory organization or statistical agent shall provide any service relating to statistical collection or the rates of any insurance subject to this Act, and no insurer shall utilize the services of such organization for such purposes unless the organization has obtained a license under Subsection C.

B. No advisory organization or statistical agent shall refuse to supply any services for which it is licensed in this State to any insurer authorized to do business in this State and offering to pay the fair and usual compensation for the services.

C. Licensing.

(1) An advisory organization or statistical agent applying for a license shall include with its application:

(a) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of one or more residents of this State upon whom notices, process affecting it, or orders of the commissioner may be served;

(d) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(e) A biography of the ownership and management of the organization; and

(f) Any other relevant information and documents that the commissioner may require.

(2) Every organization which has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

(3) If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of the law are met; he or she shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in any market.

(4) Licenses issued pursuant to this section shall remain in effect for one year unless the license is suspended or revoked. The commissioner may at any time, after hearing, revoke or suspend the license of an advisory organization or statistical agent which does not comply with the requirements and standards of this Act.

(5) Advisory organizations wishing to operate as statistical agents may be so authorized under their license as an advisory organization. A separate license is not required.

Note: States may wish to insert language here providing for an annual license fee for advisory organizations and statistical agents.

Section 12. Insurers and Advisory Organizations: Prohibited Activity

A. No insurer or advisory organization shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market.

(2) Engage in a boycott, on a concerted basis, of an insurance market.

B. (1) No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner.

The fact that two (2) or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

(2) Two (2) or more insurers having a common ownership or operating in this State under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this Act as if they constituted a single insurer.

C. No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or unreasonably lessening competition in the business of insurance.

Section 13. Advisory Organizations and Statistical Agents: Prohibited Activity

In addition to the other prohibitions contained in this Act, except as specifically permitted under Section 14, no advisory organization or statistical agent shall compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses) or profit.

Section 14. Advisory Organizations: Permitted Activity

Any advisory organization in addition to other activities not prohibited, is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Prepare, file and distribute prospective loss costs which may include provisions for special assessments;

D. Prepare, file and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;

E. Prepare, file and distribute manuals of rating rules, rating schedules and other supplementary rating information that do not include final rates, expense provisions, profit provisions or minimum premiums;

F. Distribute information that is required or directed to be filed with the commissioner;

G. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

H. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;

I. Conduct research in order to discover, identify and classify information relating to causes or prevention of losses;

J. Conduct research relating to the impact of statutory changes upon prospective loss costs and special assessments;

K. Prepare, file and distribute policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

L. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

M. Conduct on-site inspections to determine rating classifications for individual insureds;

N. For workers' compensation insurance, establish a committee which may include insurance company representatives to review the determination of the rating classification for individual insureds and suggest modifications to the classification system.

O. Collect, compile and publish past and current prices of individual insurers, provided such information is also made available to the general public at a reasonable cost;

P. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;

Q. File final rates, at the direction of the commissioner, for residual market mechanisms;

R. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 15. Statistical Agents: Permitted Activity

In addition to other activities not prohibited, any statistical agent is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Distribute information that is required or directed to be filed with the commissioner;

D. Collect, compile and distribute past and current prices of individual insurers and publish such information;

E. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings, and

F. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 16. Advisory Organizations: Filing Requirements

Every advisory organization shall file with the commissioner for approval every statistical plan, all prospective loss costs, provisions for special assessments and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this State. Such filings shall be subject to the provisions of Sections 6 and 7 and other provisions of this Act relating to filings made by insurers.

Section 17. Joint Underwriting, Joint Reinsurance Pool and Residual Market Activities

A. Notwithstanding Section 12B(1), insurers participating in joint underwriting, joint reinsurance pools or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools and residual market mechanisms shall not be deemed advisory organizations.

B. Except to the extent modified by this section, insurers, joint underwriting, joint reinsurance pool and residual market mechanism activities are subject to the other provisions of this Act.

C. If, after hearing, the commissioner finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of this Act, the commissioner may issue a written order and require the discontinuance of such activity or practice.

D. Every pool shall file with the commissioner a copy of its constitution; its articles of incorporation, agreement or association; its bylaws, rules and regulations governing its activities; its members; the name and address of a resident of this State upon whom notices or orders of the commissioner or process may be served; and any changes in amendments or changes in the foregoing.

E. Any residual market mechanism, plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for consideration and approval, together with such information as may be reasonably required. The commissioner shall approve only such agreements as are found to contemplate: (i) the use of rates which meet the standards prescribed by this Act, and (ii) activities and practices that are not unfair, unreasonable or otherwise inconsistent with the provisions of this Act. At any time after such agreements are in effect, the commissioner may review the practices and activities of the adherents to such agreements and if, after a hearing, the commissioner finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with the provisions of this Act, the commissioner may issue a written order to the parties and either require the discontinuance of such acts or revoke approval of any such agreement.

Section 18. Examinations

The commissioner may, as often as he or she may deem it expedient, make or cause to be made an examination of each advisory organization or statistical agent referred to in Section 11 and of each group, association or other organization referred to in Section 17, provided that each statistical agent and advisory organization licensed in this state shall be examined at least once every five (5) years. The reasonable costs of any such examination shall be paid by the advisory organization, statistical agent or group, association or other organization examined. The officers, manager, agents and employees of such advisory organization, statistical agent, or group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. In lieu of any such examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

Drafting Note: Under the laws of several of the states, reports on examination are not made public until the organization examined has had an opportunity to review the proposed report and to have a hearing with reference thereto, after which the report is filed for public inspection and becomes admissible in evidence as a public record. In any state that has no such law, it is suggested that provisions to this effect be adopted. Examinations of statistical agents and advisory organizations require specialized expertise; commonly require the hiring of contractors, and can be expensive. States adopting mandatory examination provisions should plan for personnel to be able to undertake or oversee these examinations, and check whether the costs for examinations, even though charged to the organization being examined, must go through the insurance department's budget.

Section 19. Workers' Compensation

A. Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating system filed with the commissioner by an advisory organization designated by the commissioner.

B. Every workers' compensation insurer shall report its experience in accordance with the statistical plans and other reporting requirements in use by an advisory organization designated by the commissioner.

C. A workers' compensation insurer may develop subclassifications of the uniform classification system upon which rates may be made. Such subclassifications and their filing shall be subject to the provisions of this Act applicable to filings generally.

D. A workers' compensation insurer may develop rating plans which identify loss experience as a factor to be used. Such rating plans and their filing shall be subject to the provisions of the Act applicable to filings generally.

E. The commissioner shall disapprove subclassifications, rating plans, or other variations from manual rules filed by a workers' compensation insurer if the insurer fails to demonstrate that the data thereby produced can be reported consistent with the uniform classification system and experience rating system and in such a fashion so as to allow for the application of experience rating filed by the advisory organization.

Section 20. Statistical and Rate Administration

A. The commissioner may adopt reasonable rules for use by companies to record and report to the commissioner their rates and other information determined by the commissioner to be necessary or appropriate for the administration of this Act and the effectuation of its purposes.

B. The commissioner may promulgate reasonable rules to assure that the experience of all insurers is made available at least annually in such form and detail as is necessary to aid in effecting the purposes of this Act. The commissioner may designate one or more advisory organizations or statistical agents to assist in gathering such experience and making compilations thereof. The scope of such rules may include the data which must be reported by insurers, definitions of data elements, the timing and frequency of statistical reporting by insurers, data quality standards, data edit and audit requirements, data retention requirements, reports to be generated by advisory organizations or statistical agents to fulfill the requirements of this section, and the timing of such reports.

Drafting Note: States that want the commissioner to be required to promulgate rules for the collection of statistical experience can replace the "may" in the first line of Subsection B with "shall".

C. The following provisions apply only to the disclosure of data and reports provided to the commissioner pursuant to this section and of reports produced by the commissioner from data and reports provided to the commissioner pursuant to this section:

(1) Data shall not be disclosed when it is likely to identify individual policyholders or claimants, or where there is reason to suspect that individual open claim reserves may be identified with individual policyholders or claimants.

Drafting Note: Paragraph (1) should be amended for states that wish to provide for the release of the names of individual policyholders without their permission for the purpose of assigned risk depopulation programs. The amendment should allow the commissioner to release such names on a basis designed to protect policyholder privacy by restricting distribution to producers and insurers interested in writing this business on a voluntary basis.

(2) The commissioner may agree in advance to withhold data from public disclosure when confidentiality is requested by the insurer, advisory organization or statistical agent providing the data to the commissioner, but only if the data include data elements that the commissioner had not required, prior to their writing or occurrence, to be recorded by insurers.

(3) Unless exempted by Paragraph (1) or (2), reports from a statistical agent or advisory organization in which the information is summed and presented on a combined basis for the insurers reporting to that statistical agent or advisory organization shall be open to disclosure.

D. Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

E. In order to assist in the performance of the commissioner's duties under this Act, the commissioner may share documents, materials and other information, including confidential and privileged documents, materials or information with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information.

Section 21. Rules and Regulations

The commissioner may make reasonable rules and regulations necessary, including definitions of the rate standards contained in Section 5, to effect the purposes of this Act.

Section 22. False or Misleading Information

No person or organization shall willfully withhold information which will affect the rates or premiums chargeable under this Act from, or knowingly give false or misleading information to the commissioner, any statistical agent, any advisory organization or any insurer. A violation of this section shall subject the one guilty of such violation to the penalties provided in Section 25 of this Act.

Section 23. Assigned Risks

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is taken from the Casualty and Surety Model Bill approved in 1946 by the NAIC. Since then a number of states have enacted assigned risk provisions of more limited scope. There is no intent here to recommend extension of assigned risk provisions in present state statutes.

This section does not purport to deal with the questions as to whether Assigned Risk Plans should be voluntary or statutory, nor as to what features, including judicial review, should be contained in such plans. If these questions are to be dealt with by statutory provision, such provision should preferably be in another statute.

Section 24. Exemptions

The commissioner may by his or her own initiative or upon request of any person, by rule exempt any market from any or all of the provisions of this Act, if and to the extent that the exemption is necessary to achieve the purposes of this chapter.

Section 25. Penalties

The commissioner may, upon a finding that any person or organization has violated any provision of this Act, impose a penalty of not more than $10,000 for each such violation, but if the violation is found to be willful, a penalty of not more than $25,000 may be imposed for each violation. Such penalties may be in addition to any other penalty provided by law.

For purposes of this section, any insurer using a rate for which the insurer has failed to file the rate, supplementary rate information, underwriting rules or guides, or supporting information as required by this Act, shall have committed a separate violation for each day such failure continues.

The commissioner may suspend or revoke the license of any advisory organization, statistical agent or insurer which fails to comply with an order of the commissioner within the time limited by such order, or any extension thereof which the commissioner may grant.

The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him or her, unless the commissioner modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner stating his or her findings, made after hearing.

Drafting Note: States may wish to insert a section here regarding hearing procedure and judicial review which references the state's administrative procedures act.

Section 26. Laws Repealed

Sections [insert applicable sections] of the statutes of this state are hereby repealed. All other laws or parts of laws inconsistent with the provisions of this Act are hereby repealed.

Section 27. Severability

If any section, subsection, subdivision, paragraph, sentence or clause of this Act is held invalid or unconstitutional, such decision shall not affect the remaining portions of this Act.

Section 28. Effective Date

This Act shall take effect [insert effective date].

Drafting Note: The effective date of this Act should be set to allow state insurance departments, insurance companies and advisory organizations to prepare themselves to carry out the purposes of the Act. One year is recommended.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1981 Proc. I 47, 51, 255-256, 340-341, 342-352 (adopted).
1981 Proc. II 27, 35, 428, 474, 478-488 (amended).
1983 Proc. I 6, 35 (amended).
1993 Proc. 1st Quarter 3, 33, 315, 321-332 (amended and reprinted).
1997 Proc. 2nd Quarter 25-26, 838, 1047-1048, 1053-1065 (amended and reprinted).
2002 Proc. 1st Quarter 241-244 (language adopted later is printed here).
2002 Proc. 4th Quarter 8, 27 (amended).
2009 Proc. 2nd Quarter, Vol. I 118, 380, 595 (converted to guideline).

PROPERTY AND CASUALTY MODEL RATING LAW
(File and Use Version)

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY MODEL RATING LAW
(File and Use Version)

NAIC MEMBER	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-13-1 to 27-13-105 (1971); ALA. ADMIN. CODE r. 482-1-152-.01 to 482-1-152-.09 (2013).
Alaska	ALASKA STAT. §§ 21.39.010 to 21.39.070 (1966/2005); ALASKA ADMIN. CODE tit. 3, §§ 29.200 to 29.300 (1992/1993).
American Samoa	NO CURRENT ACTIVITY
Arizona	ARIZ. REV. STAT. ANN. §§ 20-341 to 20-344; §§ 20-356 to 20-359 (1954/2003).
Arkansas	ARK. CODE ANN. §§ 23-67-206 to 23-67-222 (1987/2005); § 23-79-109 (1959/1999); §§ 23-67-501 to 23-67-510 (2005) (medical malpractice); CODE ARK. R. 054.00.23 (1981/1991).
California	CAL. INS. CODE §§ 1850.4 to 1851.1 (1949); § 1853.5 (1948); §§ 1853.8 to 1853.97 (1948); §§ 1855 to 1857.9 (1991); §§ 1858 to 1858.7 (1978) (portions of 1963 model); CAL. CODE REGS. tit. 10, §§ 2641.1 to 2647.1 (1991/1992); §§ 2632.4 to 2632.11 (1994/2009); BULLETIN B-5.18 (2009).
Colorado	COLO. REV. STAT. §§ 10-4-401 to 10-4-418 (1979/2010); COLO. REV. STAT. §§ 10-4-1401 to 10-4-1404 (1999); 5 COLO. CODE REGS. §1-13 (2000/2006); 5 COLO. CODE REGS. § 1-10 (1991/2009); BULLETIN B-5.18 (2009); BULLETIN B-5.33 (2013).
Connecticut	CONN. GEN. STAT. §§ 38a-663 to 38a-680 (1969/1989) (commercial lines); §§ 38a-684 to 38a-694 (1982/2013) (personal risk insurance); BULLETIN PC-8 (1990).
Delaware	DEL. CODE ANN. tit. 18, §§ 2501 to 2531 (1953/2009); DEL. CODE ANN. tit. 19, §§ 2601 to 2623 (1993) (workers' comp.); BULLETIN 5 (1990/1992).
District of Columbia	D.C. CODE §§ 31-2701 to 31-2710 (1973/2004); BULLETIN 90-1 (1990).
Florida	FLA. STAT. §§ 627.011 to 627.381 (1982/2014); FLA. ADMIN. CODE ANN. r. 69O-170.007 (1990); MEMORANDUM 2006-012 (2015).
Georgia	GA. CODE ANN. §§ 33-9-1 to 33-9-38 (1967/1987); Directive NO. 90-PC-6 (1990); GA. COMP. R. & REGS. 120-2-77 (1999/2000).
Guam	GUAM GOV'T CODE §§ 43385 to 43387 (1978).
Hawaii	HAW. REV. STAT. §§ 431:14-101 to 431:14-120 (1988/2009).
Idaho	IDAHO CODE ANN. §§ 41-1401 to 41-1441 (1969/2005).
Illinois	ILL. ADMIN. CODE tit. 50, § 754.
Indiana	IND. CODE §§ 27-1-22-1 to 27-1-22-24 (1967/2006); §§ 27-1-22-2.5 to 27-1-22-4 (1999); BULLETIN 67 (1991).
Iowa	IOWA CODE §§ 515F.1 to 515F.19 (1990); IOWA ADMIN. CODE r. 191-20.1 to 191-20.4 (1975/2014); DIRECTIVE dated April 6, 1990 (1990).

PROPERTY AND CASUALTY MODEL RATING LAW
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NAIC MEMBER	RELATE ACTIVITY
Kansas	KAN. STAT. ANN. §§ 40-951 to 40-967 (1997/1999); KAN. ADMIN. REGS. §§ 40-3-46 to 40-3-47 (1991); BULLETIN 2010-1 (2010).
Kentucky	KY. REV. STAT. §§ 304.13-011 to 304.13-390 (1982/2006); § 304.11-020 (1970/2000).
Louisiana	LA. REV. STAT. ANN. §§ 22:1401 to 22:1422 (1979/2005); § 22:620 (1999); § 22:972 (1958/2010); LA. ADMIN. CODE tit. 37 §§ XIII.9001 to XIII.9021 (Regulation 72) (2000).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2301 to 2330 (1970/2006); § 2412-A (1999); BULLETIN 241 (1995).
Maryland	MD. CODE ANN., INS. §§ 11-101 to 11-232 (1945/2006); §§ 11-301 to 11-344 (1984/1997); MD. CODE REGS. 31.07.01.01 to 31.07.01.08 (1990/2008); §§ 31.04.19.01 to 31.04.19.06 (2006).
Massachusetts	MASS. GEN. LAWS ch. 174A, §§ 1 to 19; MASS. GEN. LAWS ch. 175A, §§ 1 to 20 (1947/2014); MASS. GEN. LAWS ch. 175, §§ 224 to 225 (2004); BULLETIN SRB-90-5 (1990).
Michigan	MICH. COMP. LAWS §§ 500.2301 to 500.2352 (workers' compensation); §§ 500.2400 to 500.2484 (casualty insurance rates); § 500.2603 (rate making provisions-uniformity); BULLETIN 2006-05 (2006).
Minnesota	MINN. STAT. §§ 70A.01 to 70A.23 (1969/1987).
Mississippi	MISS. CODE ANN. §§ 83-2-1 to 83-2-31 (1988/2014).
Missouri	MO. REV. STAT. §§ 379.316 to 379.361 (1972/2002); MO. CODE REGS. ANN. tit. 20, § 500-4.200 (1990).
Montana	MONT. CODE ANN. §§ 33-16-101 to 33-16-405 (1969/1999); MONT. ADMIN. R. 6.6.3001 to 6.6.3007 (1990).
Nebraska	NEB. REV. STAT. §§ 44-7501 to 44-7535 (2001/2010); 210 NEB. ADMIN. CODE § 73 (2001); BULLETIN CB-50 (2001).
Nevada	NEV. REV. STAT. §§ 686B.010 to 686B.1779 (1971/2013); NEV. ADMIN. CODE §§ 686B.400 to 686B.460 (1990/2006).
New Hampshire	N.H. REV. STAT. ANN. §§ 412:1 to 412:16 (2004); §§ 413:1 to 413:10 (1947/2004) (rating organizations); §§ 414:1 to 414:9 (1947/2004) (fire and casualty); N.H. CODE ADMIN. R. ANN. INS. 2801.01 to 2801.07 (1990/1992).
New Jersey	N.J. REV. STAT. §§ 17:29AA-1 17:29AA-32 (1982) (commercial lines); §§ 17:29A-1 to 17:29A-32 (1944/1950); P.L. 1990 c.8 (Fair Automobile Insurance Reform Act of 1990); N.J. ADMIN. CODE §§ 11:1-2.1 to 11:1-2.7 (2002/2014); §§ 11:3-16.1 to 11:3-16.10 (1990/2014); §§ 11:13-8.1 to 11:13-8.5 (1993/2002); §§ 11:4-9.1 to 11:4-9.5 (1995/2000).
New Mexico	N.M. STAT. ANN. §§ 59A-17-1 to 59A-17-35 (1985/2013); N.M. CODE R. §§ 13.8.2.1 to 13.8.2.26 (1997/2006).

PROPERTY AND CASUALTY MODEL RATING LAW
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NAIC MEMBER	RELATED ACTIVITY
New York	N.Y. INS. LAW §§ 2301 to 2344 (1984/1990); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 161.0 to 161.9 (Regulation No. 129) (1986).
North Carolina	N.C. GEN. STAT. §§ 58-40-1 to 58-40-140 (1977/2013); 11 N.C. ADMIN. CODE §§ 10.1601 to 10.1604 (1991/1992).
North Dakota	N.D. CENT. CODE §§ 26.1-25-01 to 26.1-25-18 (1983/1991); BULLETIN 90-1 (1990).
Northern Marianas	NO CURRENT ACTIVITY
Ohio	OHIO REV. CODE ANN. §§ 3935.01 to 3935.99; §§ 3937.01 to 3997.99 (1947-1948/2013); BULLETIN 91-1 (1991).
Oklahoma	OKLA. STAT. tit. 36, §§ 981 to 998 (1999/2007); §§ 901 to 938 (1957/2006); OKLA. ADMIN. CODE §§ 570:10-1-3 to 570:10-1-41 (1992/2005); §§ 365:15-7-1 to 365:15-7-24 (2005/2006).
Oregon	OR. REV. STAT. §§ 737.007 to 737.560 (1967/1987); BULLETIN INS-90-4 (1990).
Pennsylvania	40 PA. CONS. STAT. §§ 65-101 to 65-119 (1947/1994); §§ 67-101 to 67-119 (1961/1994); §§ 66-101 to 66-119 (1998); DIRECTIVE dated July 16, 1990 (1990).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 1201 to 1240 (1979).
Rhode Island	R.I. GEN. LAWS §§ 27-44-1 to 27-44-22 (1988/2005) (use for competitive market); §§ 27-6-1 to 27-6-52; §§ 27-9-1 to 27-9-52 (1948/2013) (use for non-competitive market); §§ 27-7.1-1 to 27-7.1-25 (1985/2005) (workers' compensation); §§ 27-65-1 to 27-65-2 (1999); BULLETIN dated April 27, 1990 (1990).
South Carolina	S.C. CODE ANN. §§ 38-73-10 to 38-73-1540 (1988/2004).
South Dakota	S.D. CODIFIED LAWS §§ 58-24-1 to 58-24-74 (1966/2014); BULLETIN 94-3 (1994).
Tennessee	TENN. CODE ANN. §§ 56-5-301 to 56-5-318 (1983).
Texas	TEX. INS. CODE ANN. §§ 5.01 to 5.54 (1951/2005).
Utah	UTAH CODE ANN. §§ 31A-19a-101 to 31A-19a-210 (1986/2013); UTAH ADMIN. CODE r. 590-140 (1990/2000); BULLETIN 90-6 (1990).
Vermont	VT. STAT. ANN. tit. 8, §§ 4681 to 4708 (1984/1990); BULLETIN 99 (1990).
Virgin Islands	NO CURRENT ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1900 to 38.2-2027 (1986/2015); ADMIN. LETTER 1990-5 (1990); ADMIN. LETTER 1993-10 (1993).
Washington	WASH. REV. CODE ANN. §§ 48.19.010 to 48.19.440 (1947/2003); WASH. ADMIN. CODE 284-24-010 to 284-24-120 (1982/2008).

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NAIC MEMBER	RELATED ACTIVITY
West Virginia	W. VA. CODE §§ 33-20-1 to 33-20-16 (1957/1986); INFORMATIONAL LETTER No. 68 (1990).
Wisconsin	WIS. STAT. §§ 625.01 to 625.35 (1969/1979); BULLETIN dated June 11, 1990 (1990).
Wyoming	WYO. STAT. ANN. §§ 26-14-101 to 26-14-118 (1983/2005).

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM LAW GUIDELINE

Table of Contents

Section 1. Purposes of Act

The purposes of this Act are:

A. To prohibit price fixing agreements and other anticompetitive behavior by insurers;

B. To protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

C. To promote beneficially competitive markets and to protect insurance consumers from the absence of beneficially competitive markets;

D. To provide regulatory procedures for the maintenance of appropriate data reporting systems;

E. To improve availability, fairness and reliability of insurance;

F. To authorize essential cooperative action among insurers in the ratemaking process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly;

G. To promote loss prevention through rating and policy forms;

H. To cause the provision of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets; and

I. To regulate insurance contracts to the end that they not be contrary to the laws of the state, misleading, illusory, ambiguous, deceptive, contrary to public policy, unreasonably restrictive, or likely to mislead or deceive the policyholder, or contain inconsistent provisions.

Section 2. Definitions

A. "Advisory organization" means an entity, including its affiliates or subsidiaries, that either has two (2) or more member insurers or is controlled either directly or indirectly by two (2) or more insurers, and that assists insurers in promulgation of forms and ratemaking-related activities such as enumerated in Sections 17, 18 and 19. Two (2) or more insurers having a common ownership or operating in this state under common management or control constitute a single insurer for purposes of this definition.

B. "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

C. "Commercial risk" means any kind of risk that is not a personal risk.

D. "Commissioner" means the Commissioner of Insurance of this state.

E. "Common underwriting management" means an arrangement by which insurers, whether financially related or not, share underwriting facilities.

F. "Competitive market" means a market that has not been found to be noncompetitive pursuant to Section 4.

G "Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those that are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

H. "Exempt commercial policyholder" means an entity to which specified aspects of rate or form regulation do not apply or have been relaxed in accordance with regulations adopted pursuant to Section 11 of this Act.

I. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees but shall not include loss-adjustment expenses.

J. "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

K. "Insurer" means an insurer as defined in [refer to the general cite for the definition of insurer], except that two (2) or more insurers that are managed by the same persons or entity for the underwriting of individual risks, for the pricing of individual risks, or for the appointment of agents shall, for purposes of this Act, be considered as a single insurer.

L. "Joint underwriting" means a voluntary arrangement established on an individual-risk basis by which two (2) or more insurers jointly contract to provide insurance coverage for insureds whose property values to be covered or limits of liability to be provided exceed those that a single insurer is able and willing to provide.

M. "Loss adjustment expense" means the expenses incurred by the insurer in the course of settling claims.

N. "Trending" means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

O. "Market" means the interaction between buyers and sellers consisting of a product component and a geographic component. A product component consists of identical or readily substitutable products including but not limited to consideration of coverage, policy terms, rate classifications and underwriting. A geographic component is a geographical area in which buyers seek access to the insurance product through sales outlets and other distribution mechanisms. Determination of a geographic component shall consider existing distribution patterns.

P. "Noncompetitive market" means a market for which there is a ruling in effect pursuant to Section 4 that a reasonable degree of competition does not exist.

Q. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes and other property and casualty insurance for personal, family or household needs.

R. "Policy form" means the insurance contract language, including the declaration or information page, any endorsements or other contract language that constitute the contractual agreement between an insurer and its policyholder.

S. "Pool" means a voluntary arrangement, established on an on-going basis, pursuant to which two (2) or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement.

T "Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

U. "Rate" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

V. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

W. "Special assessments" means guaranty fund assessments, Second Injury Fund assessments, Vocational Rehabilitation Fund Assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

Drafting Note—Residual Market Assessments: A state may wish to add "assessments for residual market mechanisms" or other assessments as one of the listed special assessments.

X. "Statistical agent" means an entity that has been licensed by the commissioner to collect statistics from insurers and provide reports developed from these statistics to the commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers under this Act.

Y. "Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fees, rating rules or any other similar information needed to determine the applicable rate or premium. This shall include underwriting rules, but only to the extent necessary to determine the rate or premium that will be applicable to a risk should the insurer decide to provide coverage. This does not include guidelines that relate to the selection of those risks that are acceptable to an insurer.

Drafting Note—Plan of Rates: A "plan of rates" filed by an insurer would contain final rates including provisions for expenses and profit. A "plan of rates" filed by an advisory organization would contain only prospective loss costs which would exclude provisions for expenses (other than loss adjustment expenses) and profit.

Z. "Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer;

(2) The interpretation of any other data relied upon by the filer;

(3) Descriptions of methods used in making the rates; and

(4) Any other information required by the commissioner to be filed.

Drafting Note—Commercial Service Contract Definition: States exempting commercial service contracts from this Act (see drafting note under Section 3) may wish to add the following definition:

AA. "Commercial service contract" means a service contract or other similar agreement for a separately stated consideration to indemnify or provide for the repair, replacement or similar service of goods, equipment, machinery or other property normally used for commercial or business purposes for the operational or structural failure due to a defect in materials or workmanship or normal wear and tear, with or without additional provision for incidental expenses, provided that the obligor under the service contract or other similar agreement (a) has procured an insurance policy issued by an insurer authorized to transact insurance in this state or issued pursuant to [insert code section permitting surplus lines business] that provides reimbursement coverage or coverage to the obligee in the event the obligor becomes insolvent, ceases to transact business, or fails to perform the obligations and liabilities under the terms of the commercial service contract; or (b) has provided another form of financial responsibility approved by the commissioner."

Section 3. Scope of Act

This Act applies to all forms of casualty insurance, including fidelity, surety and guaranty bond, to all forms of fire, marine and inland marine insurance, and to any combination of any of the foregoing, on risks or operations located in this state. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the commissioner, or as established by general custom of the business, as inland marine insurance. In determining whether new types of inland marine insurance fall under this exemption, the commissioner shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.

Drafting Note—Kinds of Insurance: The kinds of insurance are named herein in their generally accepted trade sense unless otherwise defined by statute or regulation. The wording of the section should be fitted to any laws of the state which classify insurance.

Drafting Note—Commercial Service Contracts: States that consider commercial service contracts to be insurance may wish to exempt all such contracts, or those contracts exceeding thresholds relating to size or consumer sophistication, or both, from the Act.

This Act shall not apply to:

A. Reinsurance, other than statutorily authorized joint reinsurance mechanisms to the extent stated in Section 13;

B. Accident and health insurance;

C. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine insurance as determined by the commissioner;

D. Title insurance;

E. Financial guaranty insurance;

F. Insurance.

Drafting Note—Types of Insurance: Here should be listed (a) other kinds of insurance, if any, and (b) particular types of insurers, if any, to which this Act is not to apply in the state or jurisdiction adopting the Act. The specific exemption of aircraft hull and liability insurance contained in the 1946 NAIC Model Bills is omitted from Section 3 of this Act. A number of states have, since 1946, provided for regulation of aircraft hull and liability insurance rates.

Prefatory Drafting Note Regarding Rate Regulation—Reliance on Competition: The NAIC long ago concluded that competition could be an effective regulator of property/casualty insurance rates. Recent consideration of commercial lines rate regulation has led to the conclusion that commercial insurance consumers will generally be better served by less restrictive regulatory schemes, i.e., by greater reliance on competition. Consistent with these two conclusions, the rate-regulatory provisions that follow reflect a file and use rate-regulatory scheme. It should be noted, however, that the NAIC has not taken a position respecting any particular line of insurance in any particular state. While this model law "defaults" to file and use, it is expected that each state will consider whether other approaches are more appropriate for specific lines or all lines. Drafting notes following the main body of sections 4 through 7 contemplate several alternative approaches, providing for greater or lesser degrees of reliance on competition, which a state may determine to be preferable.

The movement of states away from prior approval of rates has been more pronounced in connection with commercial lines than personal lines. It has occurred less rapidly in connection with workers' compensation insurance than with most other commercial lines. Although many states have adopted competitive rating approaches for medical professional liability insurance, each state will want to consider the extent to which that state's marketplace for such insurance is, in fact, structured in such a way that reliance upon competition is a viable approach. Each state will also want to consider the extent to which the reverse-competitive market structures of credit property insurance, credit involuntary unemployment insurance and mortgage guaranty insurance either suggest or demand a more guarded regulatory approach than is used for other lines of insurance.

"Reverse competition" means competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or who may control, the placement of the insurance with insurers. Reverse competition tends to increase insurance premiums or to prevent lowering of premiums in order that greater commissions or other allowances may be paid to persons for such business as a means of obtaining the placement of business controlled by the person with the insurers paying the highest commissions. In such situations, the competitive pressure to obtain business by paying high commissions or providing other compensation or services to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise.

Section 4. Competitive Market

A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues a ruling to that effect. Such a rule shall expire no later than one year after issue unless the commissioner renews the rule after hearings and a finding as to the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of competition exists, the commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers.

Drafting Note—Competitive Market Alternative: Any state desiring an alternative section incorporating specific examples of tests of workable competition may wish to use the following:

[A competitive market is presumed to exist unless the commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the commissioner issues a ruling to that effect. Such a rule shall expire no later than one year after issue, unless the commissioner renews the rule after hearing and a finding as to the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of competition exists, the commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers. Such tests may include, but are not limited to, the following: size and number of firms actively engaged in the market; market shares and changes in market shares of firms; ease of entry and exit from a given market; underwriting restrictions; whether profitability for companies generally in the market segment is unreasonably high; availability of consumer information concerning the product and sales outlets or other sales mechanisms; and efforts of insurers to provide consumer information. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.]

Section 5. Rate Standards

Rates shall be made in accordance with the following provisions:

A. Rates shall not be excessive, inadequate or unfairly discriminatory.

(1) Excessive Rates.

(a) A rate is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

(b) A rate in a competitive market is presumed not to be excessive.

(2) Inadequate Rates. A rate is not inadequate unless: (a) its continued use would endanger the solvency of the insurer, or (b) the rate is clearly insufficient to sustain projected losses, expenses and special assessments in the class of business to which it applies and the use of the rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

(3) Unfairly Discriminatory Rates. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a group, franchise or blanket policy or a mass marketed plan. As used in this paragraph, a mass marketed plan means a method of selling property-liability insurance wherein:

(a) The insurance is offered to employees of particular employers or to members of particular associations or organizations or to persons grouped in other ways, except groupings formed principally for the purpose of obtaining such insurance; and

(b) The employer, association or other organization, if any, has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or members.

(4) Rating Methods. In determining whether rates comply with the excessiveness standard under Paragraph (1)(a), the inadequacy standards under Paragraph (2) and the unfair discrimination standard under Paragraph (3), the following criteria shall apply:

(a) Basic factors in rates. Due consideration shall be given to past and prospective loss experience within and outside this state; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers; to past and prospective expenses both countrywide and those specially applicable to this state; and to provisions for special assessments and to all other relevant factors within and outside this state.

(b) Classification. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the insured.

(c) Expenses. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and its anticipated expenses.

(d) Profits. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to all investment income attributable to the line of insurance.

(5) Two (2) or more insurers operating under common underwriting management for a line or kind of insurance or subdivision of a line or kind in this state shall, for that line or kind of insurance or subdivision, be treated as a single insurer for purposes of this section in order to prevent unfair discrimination between similarly situated policyholders.

Drafting Note—Disallowed Expenses in Rates: If a state desires to provide the commissioner with explicit guidance regarding certain categories of expenses that may not be included in insurers' rates, it should consider the following language instead of that provided in Section 5A(4)(c): "Expenses. The expense provisions included in the rates to be used by an insurer shall reflect the reasonable operating methods of the insurer and its reasonable anticipated expenses. Insurers' rates shall not include provisions for disallowed expenses. Disallowed expenses include [insert specific expenses, if any] and any unreasonably incurred expenses as determined by the commissioner." Such expenses may include lobbying expenses; amounts paid by an insurer as damages in a suit against the insurer for bad faith or as fines or penalties for violations of the law; contributions to organizations engaged in legislative advocacy; fees and penalties imposed upon the insurer for civil or criminal violations of the law; fees or penalties paid by the insurer to settle administrative enforcement actions; and contributions to social, religious, political or fraternal organizations.

Section 6. Rate Filings

A. (1) Every insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. The filing shall include underwriting rules to the extent necessary to determine the applicable rate. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 18. The filing shall contain sufficient information to allow the commissioner to meet his or her obligation to provide consumer information under Sections 13 and 14. The filing shall state the effective date, and shall indicate the character and extent of the coverage contemplated.

(2) Every insurer shall file or incorporate by reference to material which has been filed with or approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or consist of a reference to:

(a) The experience or judgment of the insurer or information filed by the advisory organization on behalf of the insurer as permitted by Section 18;

(b) Its interpretation of any statistical data it relies upon;

(c) The experience of other insurers or advisory organizations; or

(d) Any other relevant factors.

A filing and any supporting information shall be open to public inspection upon receipt of the filing.

(3) When a filing is not accompanied by the information upon which the insurer supports the filing, the commissioner may require the insurer to furnish the information upon which it supports the filing and in that event the waiting period shall commence as of the date the information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed nor available for use by the insurer. If the requested information is not provided within a reasonable time period, the filing may be returned to the insurer as not filed and not available for use.

(4) After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss, special assessment and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may use or supplement its experience with information filed with the commissioner by an advisory organization or statistical agent.

(5) Insurers utilizing the services of an advisory organization must provide with their rate filing, at the request of the commissioner, a description of the rationale for such use, including its own information and method of utilization of the advisory organization's information.

Drafting Note—Filing Review: States may desire to move Paragraphs (2), (3) and (4) to Section 6D. If these paragraphs are moved to Section 6D, then the following language should be added to Section 6B: "The commissioner may require an insurer to furnish any additional information."

B. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this Act.

C. (1) In a competitive market, every insurer shall file with the commissioner the information specified in Subsection A of this section that it will use in this state. The rates and supplementary rating information shall be filed on or before the effective date. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least [insert number of days] before the effective date, all such rates and supplementary rating information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

(2) In a competitive market, Section 6C(1) not withstanding, the commissioner may, after a hearing, determine that the filing for review of rates and/or supplementary and supporting information by insurers is not necessary for all or for portions of one or more commercial lines of insurance. In these cases, the commissioner instead may require, on a purely advisory or informational basis, the filing of rates and such other information as he or she needs to monitor competition and to provide consumer information. Any determination by the commissioner to waive filing requirements may be revoked at any time and the commissioner may order that rates in effect at the time of revocation shall be filed within a reasonable period of time as specified in the order.

Drafting Note—Rate Filing Waiver Authority: Section 6C(2) may be deleted, and Section 6C(1) renumbered to be Section 6C, if states do not wish to grant the commissioner authority to waive rate filing requirements. Section 6C(2) could also be modified so as to limit waiver authority to supplementary and/or supporting information alone, rather than to actual rate filings. Alternatively, the word "commercial" could be deleted from Section 6C(2) if a state wishes to extend the commissioner's waiver authority to include personal lines coverages.

D. In a noncompetitive market, for advisory organization filings and for the following lines of insurance [insert prior approval lines, if any], subject to the exception specified in Subsection E of this section, each filing shall be on file for a waiting period of thirty (30) days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty (30) days if written or electronic notice is given within the waiting period to the insurer or advisory organization that made the filing that additional time is needed for the consideration of the filing. Upon written or electronic application by the insurer, the commissioner may authorize a filing that has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this Act unless disapproved by the commissioner within the waiting period or any extension thereof. The operation of the deemer provision shall be suspended during a period of not more than sixty (60) days upon written or electronic notice to the insurer or advisory organization that made the filing that additional information is needed to complete the review of the filing. Failure of the insurer or advisory organization to provide the requested information within sixty (60) days shall be deemed a request to withdraw the filing from further consideration. The commissioner shall either approve or disapprove the filing within thirty (30) days of receipt of the requested additional information. Failure of the commissioner to act within the thirty-(30)-day period shall result in the filing being deemed to meet the requirements of the Act. Neither the insurer nor the commissioner may waive the timeliness requirements of the deemer provisions in this section.

E. Under such rules and regulations as may be adopted, the commissioner may, by written or electronic order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, for which the rates cannot practicably be filed before they are used. The commissioner may make such examination as deemed advisable to ascertain whether any rates affected by such order meet the standards set forth in Section 5.

F. Upon the written or electronic application of the insurer and insured, stating its reasons therefore, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk. The commissioner may, by rule, waive the requirement that excess rates be filed for approval. The commissioner may examine the books and records of the insurer to determine if a pattern or practice of business exists that would indicate that the insurer is avoiding the filing requirements of this Act by extensive use of this section to issue its policies.

G. No insurer shall make or issue a contract or policy except in accordance with the filings that have been approved and are in effect for the insurer as provided in this Act or in accordance with Subsections E or F of this section. This subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required.

H. A rate for a residual market in which insurers are mandated by law to participate shall not become effective until approved by the commissioner.

Section 7. Disapproval of Rate Filings

A. For filings made in a noncompetitive market, for advisory organization filings the following lines of insurance [insert prior approval lines, if any] and residual market filings, if within the waiting period or any extension thereof as provided in Section 6D, the commissioner finds that a filing does not meet the requirements of this Act, written or electronic notice of disapproval shall be sent to the insurer or advisory organization which made the filing, specifying therein in what respects the filing fails to meet the requirements of this Act and stating that such filing shall not become effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. If at any time after a rate has been approved and for filings made in a competitive market, the commissioner finds that the rate no longer meets the requirements of this Act, the commissioner may order the discontinuance of use of the rate. The order of discontinuance may be issued after a hearing with at least ten (10) days' prior notice for all insurers affected by the order. The order shall be in writing or electronically transmitted and state the grounds for the order. It shall also state when, within a reasonable time thereafter, the filing will be deemed no longer effective. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order. The commissioner's order may include a provision for a premium adjustment for contracts or policies made or issued after the effective date of the order.

C. Any insured aggrieved with respect to any filing that is in effect may make application to the commissioner for a hearing. The application shall be written or transmitted in a manner designated by the commissioner. The application shall specify the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that the grounds otherwise justify holding a hearing, a hearing shall be held within thirty (30) days after receipt of the application upon not less than ten (10) days' written or electronic notice to the applicant and to every insurer and advisory organization that made a filing.

If, after the hearing, the commissioner finds that the filing does not meet the requirements of this Act, an order shall issue specifying in what respects the filing fails to meet the requirements of this Act, and stating when, within a reasonable period thereafter, the filing shall no longer be deemed to be in effect. Copies of the order shall be sent or electronically transmitted to the applicant and to every such insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

D. Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interest of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When the new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are *de minimis* shall not be required.

Section 8. Policy Form Standards

A. Policy forms shall not:

(1) Contain provisions, exceptions or conditions that are misleading, illusory, inconsistent, ambiguous, deceptive, contrary to public policy, that unreasonably affect the risk purported to be assumed in the general coverage of the policy, or that encourage misrepresentation of the coverage; or

(2) Violate or fail to comply with any provision of the insurance code or the laws of this state.

B. The insurer shall include the following elements in its policy either by placing them in the main policy form or by attaching an endorsement or other contract language to the policy form:

(1) A statement that specifies when a policy may be cancelled or nonrenewed and provides at least the following minimum notice in the event of cancellation or nonrenewal of the policy:

(a) Ten (10) days advance notice for cancellation because of fraud, misrepresentation or because the insured has failed to pay premium when due. Premium includes any amounts due from the insured in accordance with policy provisions;

(b) Thirty (30) days advance notice for all other cancellations for cause that are allowed under the insurance code; and

(c) Forty-five (45) days advance notice when the insurer decides that it will not offer to renew the policy for another term; and

(2) For personal lines, a statement that any return premium due the insured will be tendered by the insurer within ten (10) days of the effective date of cancellation regardless of whether the cancellation is initiated by the insurer or the insured. For cancellation at the request of the insured, the policy may provide for the application of less than a full pro rata return of premium, provided that insurer shall not demand a penalty greater than ten percent (10%) of the unearned premium for the remaining term of the policy. The terms and conditions of any penalty for early cancellation by the insured shall be clearly stated in the policy form or an endorsement;

Drafting Note: States may wish to consider adding one or more of these specific requirements for policy forms to the list of requirements in Section 8:

(1) A declaration or information page that shows the individuals or entities insured and the property to which the insurance applies, if applicable, shows the limit of the insurer's liability for each coverage provided, shows the effective date and time for policy inception and expiration and shows the premium consideration;

(2) An insuring agreement that clearly states who and what is covered under the policy;

(3) The conditions under which the coverage will apply;

(4) Any exclusion where coverage is not applicable;

(5) Any definitions needed to clarify the intent of the coverage provided in the policy;

(6) A statement that the bankruptcy or insolvency of the insured shall not relieve the insurer of its obligations under the policy;

(7) A statement concerning procedures for resolution of policy disputes. Insurers may choose to provide for mediation, arbitration, appraisal or other methods of dispute resolution that are acceptable to the commissioner that encourage policyholders to informally resolve policy disputes without the need to request a formal hearing; and

(8) A statement that the policy form, any endorsements and other contract language shall constitute the entire contract.

Section 9. Policy Form Filings

A. Policy forms, endorsements and other contract language and related attachment rules shall comply with the following provisions:

(1) Except as provided in Subsections A(3) and B(2) of this section, an insurer shall file all policy forms, endorsements and other contract language and any related attachment rules with the commissioner prior to use. The filing shall state its proposed effective date and shall explain the intended use of the forms.

(2) An insurer may authorize an advisory organization to file policy forms, endorsements and other contract language and related attachment rules on its behalf.

(3) Policy forms, endorsements and other contract language unique in character and designed for and used with regard to a particular risk shall be exempt from filing, except that the commissioner may by regulation or order make specific restrictions relating to this exemption. In making a determination, the commissioner shall consider whether the policy forms, endorsements and other contract language otherwise exempt would be likely to meet the requirements of Section 8 and the extent to which it would be practical to file the forms prior to their use for specific risks. Insurers shall not use this provision to avoid the consent-to-form provisions of Subsection A(4) of this section.

(4) Policy forms, endorsements and other contract language providing coverage that is more restrictive than that provided by a filing otherwise applicable may be used on specific risk upon the prior written or electronic application of the insured, stating reasons therefore, filed with and approved by the commissioner. The application and any correspondence relating thereto shall be considered a confidential communication and shall not be made public by the commissioner except as may be compiled by the department in summaries of activity.

(5) The commissioner may, by regulation, allow commercial policy forms, endorsements and other contract language that is more expansive, and in no respect more restrictive, than that provided by an approved filing otherwise applicable, to be used without prior approval by the commissioner. Any such commercial policy forms, endorsements, and other contract language shall, by regulation, be filed prior to use either (a) in all cases, or (b) to the extent needed to meet regulatory purposes.

B. Filings of policy forms, endorsements and other contract language shall comply with the following provisions:

(1) Each filing shall be on file for a waiting period of thirty (30) days before it becomes effective except as provided in Paragraph (2). The waiting period may be extended for an additional period not to exceed thirty (30) days if the commissioner gives written notice within the waiting period to the insurer or advisory organization that made the filing that additional time is needed for the consideration of the filing. Upon written or electronic application by the insurer or advisory organization, the commissioner may authorize a filing to become effective before the expiration of a waiting period. A filing shall be deemed to meet the requirements of the Act unless disapproved by the commissioner within the waiting period or any extension thereof. The operation of the deemer provision shall be suspended during a period of not more than sixty (60) days upon written or electronic notice to the insurer or advisory organization that made the filing that additional information is needed to complete the review of the filing. Failure of the insurer or advisory organization to provide the requested information within sixty (60) days shall be deemed a request to withdraw the filing from further consideration. A filing and any supporting information shall be open to public inspection upon receipt of the filing.

(2) The commissioner may by regulation or order suspend or modify the filing requirements of Subsection A or B of this section as to any line or kind of insurance or subdivision or combination of such line or kind of insurance or as to classes of risks for which rating systems or forms cannot practicably be filed before they are used. The commissioner may make an examination if he or she deems it necessary to ascertain whether any policy forms, endorsements and other contract language affected by the regulation or order meet the requirements of Section 8.

(3) An insurer shall not issue a contract or policy except in accordance with the filings that have been approved and are in effect for the insurer as provided in this Act or in accordance with Subsection A(4) of this section. This subdivision shall not apply to forms or rating systems to the extent that they are exempt or have been exempted by Subsection A(3) or B(2) of this section.

(4) Upon the written or electronic application of the insurer and insured, stating its reasons therefore, filed with and approved by the commissioner, a policy form that differs from any provided by a filing otherwise applicable to the insurer may be used on any specific risk. This section applies only to manuscript forms or other policies that are unique to a specific risk. The commissioner may, by rule, waive the requirement that these unique manuscript forms be filed for approval. The commissioner may examine the books and records of the insurer to determine if a pattern or practice of business exists that would indicate that the insurer is avoiding the filing requirements of this Act by extensive use of this section to issue its policies.

Section 10. Disapproval of Policy Form Filings

A. If, within the waiting period provided by Section 9 or any extension thereof, the commissioner finds that a filing does not meet the requirements of the Act, he or she shall send written or electronic notice of disapproval to the insurer or advisory organization that made the filing specifying in what respects the filing fails to meet the requirements of the Act and stating that the filing shall not become effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. If, at any time after approval, the commissioner finds that a policy form, an endorsement and other contract language or attachment rule relating thereto, does not meet or no longer meets the requirements of the Act, the commissioner shall hold a hearing in accordance with Section 29.

C. Any insured aggrieved with respect to any filing that is in effect may make written or electronic application to the commissioner for a hearing thereon. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, or that such grounds otherwise justify holding a hearing, then a hearing shall be held in accordance with Section 29.

D. If after a hearing pursuant to subsection B or C of this section, the commissioner finds that a filing does not meet the requirements of the Act, he or she shall issue an order stating in what respects the filing fails to meet the requirements and when, within a reasonable period thereafter, the policy form, endorsement or other contract language or related attachment rule, shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Section 11. Exemption from the Requirement for Insurers to Use Filed Rates and Forms for Certain Commercial Policyholders

A. The commissioner shall, by regulation, establish a class of large commercial policyholders, to be known as exempt commercial policyholders (ECPs), which shall be exempt from all rate and form requirements established by this Act, except for form provisions relating to [insert description of any form provisions that ECPs must adhere to, if any. An example of such provisions might be workers' compensation mandatory coverage provisions.].

B. In the promulgation of this regulation, the commissioner shall consider the following factors in determining the definition of an ECP:

(1) The characteristics of insureds that are likely to study and understand the details of their business risks, insurance coverages and exclusions;

(2) The characteristics of insureds that are likely to avail themselves of regular price comparisons between competing insurers and are likely to study and understand the differences and details of pricing proposals that they receive;

(3) The characteristics of insureds that are likely to require individually written policies, as contrasted to insureds that can customarily have their coverage needs met through a compilation of forms with applicability to other insureds as well;

(4) The characteristics of insureds for which filed rates and rating plans are less likely to provide the lowest premiums otherwise consistent with the provisions of this Act;

(5) The favorable or adverse experiences with exemptions from regulatory requirements, especially the experience in this state;

(6) The extent to which commercial insureds primarily located in another jurisdiction are subject to similar exemptions or waivers in that jurisdiction; and

(7) Any other relevant factor.

C. The commissioner may, by regulation, waive some or all of the diligent search requirements related to placement of risks in the approved surplus lines market for some or all ECPs.

Drafting Note—Restriction of Exemption Powers: States wishing to restrict the commissioner from exempting specific lines of commercial lines insurance may use the language that follows. The inclusion of this drafting note should not be construed as a recommendation that these provisions be inapplicable to any commercial line of insurance. Rather, it is inserted to recognize that some states may wish to provide such restrictions.

D. The regulation adopted pursuant to this section may not alter [insert description, including whether the restriction applies to rates, forms or both.].

Drafting Note—Legislative Determination of Qualification Requirements For Exempt Commercial Policyholders: Legislatures wishing to establish dollar amounts and other specific qualification requirements for exempt commercial policyholders, instead of directing the commissioner to make this determination, may wish to use the criteria listed in Subsection B of this section in making their determinations. The NAIC's white paper, Regulatory Re-engineering of Commercial Lines Insurance, contained the following definition of an ECP:

An "ECP" is an entity that meets any two of the following criteria:

- Net worth of over $50 million;
- Net revenues or sales of over $100 million;
- More than 500 employees per individual company or 1,000 per holding company aggregate;
- Procures its insurance through use of a risk manager, employed or retained;
- Aggregate premiums of over $500,000;
- Is a not for profit, or public entity with an annual budget or assets of at least $45 million, or
- Is a municipality with a population of over 50,000.

It should be noted that in legislative sessions subsequent to the white paper, some states adopted ECP definitions similar to or the same as those in the white paper, while other states opted to enact much lower ECP definitions, in some cases with exemptions applying only to filing requirements and not rate and policy form standards.

Section 12. Form Approval Requirements Applying to Multistate Commercial Risks

The commissioner shall adopt reasonable regulations to provide that this state's form approval requirements shall apply only to insurance written for individual commercial risks that are primarily located in this state.

A. In the development of practical requirements for insurers to use in determining whether a risk is primarily located in this state, the commissioner shall consider whether the headquarters of the risk is located in this state and whether contracts of insurance are purchased by officers or employees that are primarily located in this state. For purposes of this section, the location of the headquarters shall be primarily determined by the location where the officers and senior management are physically located.

B. The regulations shall provide that the requirements of [insert appropriate statutory references] will not apply when in conflict with a policy written for a commercial risk primarily located in another state.

C. Regulations adopted pursuant to this section may not allow the alteration of mandatory coverage provisions in workers' compensation policies [or mandatory coverage provisions required by the state's automobile insurance law].

Section 13. Monitoring Competition

In determining whether or not a competitive market exists pursuant to Section 4, the commissioner shall monitor the degree of competition in this state. In doing so, the commissioner shall utilize existing relevant information, analytical systems and other sources; cause or participate in the development of new relevant information, analytical systems and other sources; or rely on some combination thereof. The activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors or in any other appropriate manner.

Drafting Note: The following language provides a more definitive alternative way for states to monitor competition. (See drafting note at the end of the model law).

Section 14. Information to be Furnished Insureds: Hearings and Appeals of Insureds

A. Every advisory organization and every insurer shall, within a reasonable time after receiving written or electronic request, furnish to any insured affected by a rate made by the insurer, or to the authorized representative of the insured, all pertinent information as to such rate. Every advisory organization and every insurer shall provide within this state reasonable means whereby the insured aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on written request to review the manner in which the rating system has been applied in connection with the insurance afforded the insured. If the advisory organization or insurer fails to grant or reject the request within thirty (30) days after it is made, the applicant may proceed in the same manner as if the application had been rejected. The insured affected by the action of the advisory organization or insurer on the request may, within thirty (30) days after written or electronic notice of action, appeal to the commissioner, who, after a hearing held upon not less than ten (10) days' written notice to the appellant and to the advisory organization or insurer, may affirm or reverse the action.

Drafting Note: Language could be inserted here which would allow an insurer or advisory organization to charge a reasonable fee to cover the expense of providing any information requested under this section, but charges should not be permitted when the information relates to the specific application of an experience rating modification or a schedule rating modification.

B. If, after a hearing held under this section, it is determined that the rates charged by an insurer are in excess of the otherwise appropriate rate, such overcharge shall be refunded to the insured.

Section 15. Consumer Information

The commissioner shall utilize, develop or cause to be developed a consumer information system that will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private passenger nonfleet automobile, or property insurance for personal, family or household needs. The commissioner may utilize, develop or cause to be developed a consumer information system that will provide and disseminate price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified in this Act. The activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner. To the extent deemed necessary and appropriate by the commissioner, insurers, advisory organizations, statistical agents and other persons or organizations involved in conducting the business of insurance in this state, to which this section applies, shall cooperate in the development and utilization of a consumer information system.

Drafting Note: For jurisdictions that need a separate and distinct means of funding a consumer information system the following provision may be added to Section 14:

"The cost of complying with this section shall be assessed against insurers subject to this Act and authorized to write types of business subject to a consumer information system. The assessments shall be made on an equitable and practicable basis established, after hearing, in a rule promulgated by the commissioner. This activity shall be conducted in a reasonably economical manner consistent with the purposes of this Act."

Section 16. Licensing Advisory Organizations and Statistical Agents

A. No advisory organization or statistical agent shall provide any service relating to statistical collection or the rates of any insurance subject to this Act, and no insurer shall utilize the services of such an organization for these purposes unless the organization has obtained a license under Subsection C.

B. No advisory organization or statistical agent shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

C. Licensing.

(1) An advisory organization or statistical agent applying for a license shall include with its application:

(a) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served;

(d) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(e) A biography of the ownership and management of the organization; and

(f) Any other relevant information and documents that the commissioner may require.

(2) Every organization which has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. An amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

(3) If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of the law are met; he or she shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in any market.

(4) Licenses issued pursuant to this section shall remain in effect for one year unless the license is suspended or revoked. The commissioner may at any time, after hearing, revoke or suspend the license of an advisory organization or statistical agent that does not comply with the requirements and standards of this Act.

(5) Advisory organizations wishing to operate as statistical agents may be so authorized under their license as an advisory organization. A separate license is not required.

Note: States may wish to insert language here providing for an annual license fee for advisory organizations and statistical agents.

Section 17. Insurers and Advisory Organizations: Prohibited Activity

A. No insurer or advisory organization shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market.

(2) Engage in a boycott, on a concerted basis, of an insurance market.

B. (1) No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner. The fact that two (2) or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

(2) Two (2) or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this Act as if they constituted a single insurer.

C. No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person that has the purpose or effect of unreasonably restraining trade or unreasonably lessening competition in the business of insurance.

Section 18. Advisory Organizations and Statistical Agents: Prohibited Activity

In addition to the other prohibitions contained in this Act, except as specifically permitted under Section 19, no advisory organization or statistical agent shall compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses) or profit.

Section 19 Advisory Organizations: Permitted Activity

An advisory organization in addition to other activities not prohibited, is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Prepare, file and distribute prospective loss costs which may include provisions for special assessments;

D. Prepare, file and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;

E. Prepare, file and distribute manuals of rating rules, rating schedules and other supplementary rating information that do not include final rates, expense provisions, profit provisions or minimum premiums;

F. Distribute information that is required or directed to be filed with the commissioner;

G. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

H. Consult with public officials regarding public fire protection, building codes and other loss prevention or mitigation measures as it would affect members, subscribers and others;

I. Conduct research in order to discover, identify and classify information relating to causes or prevention of losses;

J. Conduct research relating to the impact of statutory changes upon prospective loss costs and special assessments;

K. Prepare, file and distribute policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

L. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

M. Conduct on-site inspections to determine rating classifications for individual insureds;

N. For workers' compensation insurance, establish a committee which may include insurance company representatives to review the determination of the rating classification for individual insureds and suggest modifications to the classification system.

O. Collect, compile and publish past and current prices of individual insurers, provided such information is also made available to the general public at a reasonable cost;

P. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;

Q. File final rates, at the direction of the commissioner, for residual market mechanisms; and

R. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 20. Statistical Agents: Permitted Activity

In addition to other activities not prohibited, a statistical agent is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Distribute information that is required or directed to be filed with the commissioner;

D. Collect, compile and distribute past and current prices of individual insurers and publish such information;

E. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings; and

F. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 21. Advisory Organizations: Filing Requirements

Every advisory organization shall file with the commissioner for approval every statistical plan, all prospective loss costs, provisions for special assessments and all supplementary rating information, all policy forms, endorsements and other contractual language and every change or amendment or modification of any of the foregoing proposed for use in this state. The filings shall be subject to the provisions of Sections 6, 7, 9 and 10 and other provisions of this Act relating to filings made by insurers.

Section 22. Joint Underwriting, Joint Reinsurance Pool and Residual Market Activities

A. Notwithstanding Section 16B(1), insurers participating in joint underwriting, joint reinsurance pools or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, endorsements and other contractual language, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools and residual market mechanisms shall not be deemed advisory organizations.

B. Except to the extent modified by this section, insurers, joint underwriting, joint reinsurance pool and residual market mechanism activities are subject to the other provisions of this Act.

C. If, after hearing, the commissioner finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of this Act, the commissioner may issue a written or electronic order and require the discontinuance of the activity or practice.

D. Every pool shall file with the commissioner a copy of its constitution; its articles of incorporation, agreement or association; its bylaws, rules and regulations governing its activities; its members; the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served; and any changes in amendments or changes in the foregoing.

E. A residual market mechanism, plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing or electronically transmitted to the commissioner for consideration and approval, together with such information as may be reasonably required. The commissioner shall approve only agreements found to contemplate: (i) the use of rates and forms that meet the standards prescribed by this Act, and (ii) activities and practices that are not unfair, unreasonable or otherwise inconsistent with the provisions of this Act. At any time after the agreements are in effect, the commissioner may review the practices and activities of the adherents to the agreements and if, after a hearing, the commissioner finds that a practice or activity is unfair or unreasonable, or is otherwise inconsistent with the provisions of this Act, the commissioner may issue a written order to the parties and either require the discontinuance of the acts or revoke approval of the agreement.

Section 23. Examinations

The commissioner may, as often as he or she may deem it expedient, make or cause to be made an examination of each advisory organization or statistical agent referred to in Section 15 and of each group, association or other organization referred to in Section 21, provided that each statistical agent and advisory organization licensed in this state shall be examined at least once every five (5) years. The reasonable costs of the examination shall be paid by the advisory organization, statistical agent or group, association or other organization examined. The officers, managers, agents and employees of the advisory organization, statistical agent or group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. In lieu of an examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

Drafting Note: Under the laws of several of the states, reports on examination are not made public until the organization examined has had an opportunity to review the proposed report and to have a hearing with reference thereto, after which the report is filed for public inspection and becomes admissible in evidence as a public record. In any state that has no such law, it is suggested that provisions to this effect be adopted. Examinations of statistical agents and advisory organizations require specialized expertise; commonly require the hiring of contractors, and can be expensive. States adopting mandatory examination provisions should plan for personnel to be able to undertake or oversee these examinations, and check whether the costs for examinations, even though charged to the organization being examined, must go through the insurance department's budget.

Section 24. Workers' Compensation

A. Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating system filed with the commissioner by an advisory organization designated by the commissioner.

B. Every workers' compensation insurer shall report its experience in accordance with the statistical plans and other reporting requirements in use by an advisory organization designated by the commissioner.

C. A workers' compensation insurer may develop sub-classifications of the uniform classification system upon which rates may be made. Such sub-classifications and their filing shall be subject to the provisions of this Act applicable to filings generally.

D. A workers' compensation insurer may develop rating plans which identify loss experience as a factor to be used. The rating plans and their filing shall be subject to the provisions of the Act applicable to filings generally.

E. The commissioner shall disapprove sub-classifications, rating plans or other variations from manual rules filed by a workers' compensation insurer if the insurer fails to demonstrate that the data thereby produced can be reported consistent with the uniform classification system and experience rating system and in such a fashion so as to allow for the application of experience rating filed by the advisory organization.

Section 25. Statistical and Rate Administration

A. The commissioner may adopt reasonable regulations for use by companies to record and report to the commissioner their rates and other information determined by the commissioner to be necessary or appropriate for the administration of this Act and the effectuation of its purposes.

B. The commissioner may adopt reasonable regulations to assure that the experience of all insurers is made available at least annually in such form and detail as is necessary to aid in determining whether rating systems comply with the standards set forth in Section 5. The commissioner may designate one or more advisory organizations or statistical agents to assist in gathering the experience and making compilations thereof, and the compilations shall be public documents. The scope of the regulations may include the data to be reported by insurers, definitions of data elements, the timing and frequency of statistical reporting by insurers, data quality standards, data edit and audit requirements, data retention requirements, reports to be generated by advisory organizations or statistical agents to fulfill the requirements of this section, and the timing of the reports.

Drafting Note: States that want the commissioner to be required to promulgate rules for the collection of statistical experience can replace the "may" in the first line of Subsection B with "shall."

C. Reasonable regulations and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

D. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer, advisory organization and statistical agent may exchange information and experience data with insurance supervisory officials, insurers and advisory organizations in other states and may consult with them with respect to the application of rating systems and the collection of statistical data.

Section 26. Regulations

The commissioner may make reasonable regulations necessary to effect the purposes of this Act.

Section 27. False or Misleading Information

No person or organization shall willfully withhold information that will affect the rates or premiums chargeable under this Act from, or knowingly give false or misleading information to the commissioner, any statistical agent, any advisory organization or any insurer. A violation of this section shall subject the one guilty of such violation to the penalties provided in Section 32 of this Act.

Section 28. Assigned Risks

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is taken from the Casualty and Surety Model Bill approved in 1946 by the NAIC. Since then a number of states have enacted assigned risk provisions of more limited scope. There is no intent here to recommend extension of assigned risk provisions in present state statutes. This section does not purport to deal with the questions as to whether assigned risk plans should be voluntary or statutory, nor as to what features, including judicial review, should be contained in such plans. If these questions are to be dealt with by statutory provision, the provision should preferably be in another statute.

Section 29. Hearing; Request

An insurer, insurer engaged in joint underwriting, joint-reinsurance pool, or advisory organization aggrieved by any order or decision of the commissioner made without a hearing may, within thirty (30) days after notice of the order, make written or electronic request to the commissioner for a hearing thereon in accordance with Section 29. Pending hearing and decision, the commissioner may suspend the effective date of his or her action.

Section 30. Hearing; Procedure

If a hearing is being held at the request of a party other than the commissioner, unless mutually agreed upon by the commissioner and all interested parties, notice of hearing shall be provided within thirty (30) days of the commissioner's receipt of a written or electronic request for a hearing. Notice of the hearing shall be given to all interested parties and shall state the time, place and purpose of the hearing. Unless mutually agreed upon by the commissioner and all interested parties, the hearing shall be held not less than (10) days after notice is served. In addition, unless mutually agreed upon by the commissioner and all interested parties or unless the hearing is being held at the request of the commissioner, the hearing shall be held not more than thirty (30) days after notice is served.

Section 31. Appeals

An order or decision of the commissioner made pursuant to the Act may be appealed by any party in interest. The appeal shall be in accordance with the [insert reference to the state Administrative Procedures Act].

Section 32. Exemptions

The commissioner may by his or her own initiative or upon request of any person, by regulation exempt any market from any or all of the provisions of this Act, if and to the extent that the exemption is necessary to achieve the purposes of this Act.

Section 33. Penalties

A. The commissioner may, upon a finding that any person or organization has violated any provision of this Act, impose a penalty of not more than $10,000 for each violation, but if the violation is found to be willful, a penalty of not more than $25,000 may be imposed for each violation. These penalties may be in addition to any other penalty provided by law.

B. For purposes of this section, any insurer using a rate or insurance contract for which the insurer has failed to file the rate, supplementary rate information, policy form, endorsement or other contractual language, shall, if this Act requires such materials to be filed, have committed a separate violation for each day such failure continues.

C. The commissioner may suspend or revoke the license of any advisory organization, statistical agent or insurer that fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof which the commissioner may grant.

D. The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him or her, unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded or reversed.

E. No penalty shall be imposed and no license shall be suspended or revoked except upon a written or electronically transmitted order of the commissioner stating his or her findings, made after hearing.

Drafting Note: States may wish to insert a section here regarding hearing procedure and judicial review which references the state's administrative procedures act.

Section 34. Laws Repealed

Sections [insert applicable sections] of the statutes of this state are hereby repealed. All other laws or parts of laws inconsistent with the provisions of this Act are hereby repealed.

Section 35. Severability

If any section, subsection, subdivision, paragraph, sentence or clause of this Act is held invalid or unconstitutional, such decision shall not affect the remaining portions of this Act.

Section 36. Effective Date

This Act shall take effect [insert effective date].

DRAFTING NOTES

Drafting Note: The effective date of this Act should be set to allow state insurance departments, insurance companies and advisory organizations to prepare themselves to carry out the purposes of the Act. One year is recommended.

Flexible Rating Drafting Note: For states that are not completely comfortable with a competitive rating environment, flexible rating allows the combination of the features of a file and use law with those of a prior approval law. For rate filings within a legislatively determined range of values, a file and use system is allowed to operate. For rate filings that exceed or go below the threshold, prior approval of the filings is required. The following language will allow a state to adopt a flexible rating system for a specified line of coverage.

A. Except as provided in Subsection B of this section, overall average (for all coverages combined) rate level increases or decreases of [insert desired percentage range] percent above or below the insurer's rates in effect may take effect without prior approval with respect to rates for policies covering [insert lines of insurance to which flexible rating applies].

B. Notwithstanding any other provisions of this Act, for any policies governed by this section, filings that produce rate level changes within the limitation specified in Subsection A of this section shall become effective without prior approval pursuant to [insert appropriate statutory reference]. However:

(1) No more than one rate increase within the limitation specified in Subsection A of this section may be implemented during any twelve-month (12) period; and

(2) No rate increase within the limitation specified in Subsection A of this section may be implemented until the onset of the new policy period and unless the insurer, at least thirty (30) but not more than sixty (60) days in advance of the end of the policy period, mails or delivers to the named insured, at the address shown in the policy, a written or electronic notice of its intention to change the rate. The specific reason or reasons for the rate change shall be stated in or shall accompany the notice.

C. The commissioner shall promulgate rules and regulations implementing the provisions of this section.

D. On or before [date] the commissioner shall report to the legislature on the effectiveness of the flexible rating. The report shall analyze the impact of flexible rating on the extent and nature of competition; size and significance of coverage; level and range of rates and rate changes among insurers; extent of consumer complaints to the insurance department; volume of cancellations and non-renewals; changes in the number of policies, by territory, and by class in each territory, written under a plan or plans approved by the commissioner; and the number of new insureds, non-renewed insureds and business written by each insurer.

A variation of the flexible rating approach involves the establishment by the regulator of benchmark rates by coverage, rating class, and rating territory, which, in conjunction with a flexibility band, or range of rate variation, creates a rate range within which insurers may file and use rates without prior approval. Rates outside the range must be approved prior to use. This system may be useful if a state wishes to provide guidance on risk classifications.

Prior Approval Drafting Note: For states not at all comfortable with a competitive rating environment for selected lines of insurance, prior approval of rates may be deemed more appropriate than either file and use or flexible rating. To designate certain lines of business as prior approval lines, they should be listed in Sections 6D and 7A in the first sentence as indicated by the brackets.

Use & File Drafting Note: For states wishing to use a use and file system to regulate rates, the following changes could be made to Sections 6C to implement a use and file system in place of the file and use system specified in the model. The principle advantage of a use and file system is that insurers will be able to bring new products to market and make rate adjustments in a more timely fashion. The principle disadvantage is that that rates that do not meet statutory standards may be charged to consumers prior to review by insurance regulators and marketing materials containing those noncomplying rates may be distributed to the public in advance of receipt of a filing hindering the regulator's ability to assist consumers with their insurance purchases or deal with questions and problems.

Use & File Alternative to Section 6. Rate Filings

C. In a competitive market, every insurer shall file with the commissioner the information specified in Subsection A of this section that it will use in this state. The rates and supplementary rating information shall be filed within thirty (30) days of the effective date. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least [insert number of days] before the effective date, all rates and supplementary rating information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

Drafting Note: For states wishing to use a file and use system to regulate policy forms endorsements and other contract language, the following changes could be made to Sections 9B and 10 to implement that type of change. The principle advantage of a file and use system is that insurers will be able to bring new products and amendments to market in a more timely fashion. The principle disadvantage is that forms not meeting statutory standards may be sold to consumers prior to review by insurance regulators and marketing materials may be distributed to the public in advance of receipt of a filing hindering the regulator's ability to assist consumers with their insurance purchases.

Alternative Section 9. Policy Form Filings

B. Filings of policy forms, endorsements and other contract language shall comply with the following provisions:

(1) Each filing shall be filed on or before the date it becomes effective except as provided in Subsection B(2). A filing and any supporting information shall be open to public inspection upon receipt of the filing;

(2) The commissioner may by regulation or order suspend or modify the filing requirements of Subsection A or B of this section as to any line or kind of insurance or subdivision or combination of such line or kind of insurance or as to classes of risks for which rating systems or forms cannot practicably be filed before they are used. The commissioner may make an examination as he or she deems necessary to ascertain whether any policy forms, endorsements and other contract language affected by the regulation or order meet the requirements of Section 8; and

(3) No insurer shall issue a contract or policy except in accordance with the filings that have been filed and are in effect for the insurer as provided in the Act or in accordance with Subsection A(4) of this section. This subdivision shall not apply to forms or rating systems to the extent that they are exempt or have been exempted by Subsection A(3) or B(2) of this section.

Alternative Section 10. Disapproval of Policy Form Filings

A. If the commissioner finds that a filing does not meet the requirements of the Act, he or she shall send written or electronic notice of disapproval to the insurer or advisory organization that made the filing specifying in what respects the filing fails to meet the requirements of the Act and stating when the filing shall no longer be effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. Any insured aggrieved with respect to any filing that is in effect may make written or electronic application to the commissioner for a hearing. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, or that the grounds otherwise justify holding a hearing, then a hearing shall be held in accordance with Section 29.

C. If after a hearing pursuant to Subsection B of this section, the commissioner finds that a filing does not meet the requirements of the Act, he or she shall issue an order stating in what respects the filing fails to meet the requirements and when, within a reasonable period thereafter, the policy form, endorsement or other contract language or attachment rule relating thereto, shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Drafting Note: For states wishing to use a use and file system to regulate policy forms endorsements and other contract language, the following changes could be made to Sections 9B and 10 to implement that type of change. The principle advantage of a use and file system is that insurers will be able to bring new products and amendments to market in a more timely fashion. The principle disadvantage is that that forms not meeting statutory standards may be sold to consumers prior to review by insurance regulators and marketing materials may be distributed to the public and products may actually be sold in advance of receipt of a filing hindering the regulator's ability to assist consumers with their insurance purchases or deal with questions and problems.

Alternative Section 9. Policy Form Filings

B. Filings of policy forms, endorsements and other contract language shall comply with the following provisions:

(1) Each filing shall be filed within thirty (30) days after it becomes effective except as provided in Subsection B(2). A filing and any supporting information shall be open to public inspection upon receipt of the filing;

(2) The commissioner may by rule or order suspend or modify the filing requirements of Subsection A or B of this section as to any line or kind of insurance or subdivision or combination of such line or kind of insurance or as to classes of risks for which rating systems or forms cannot practicably be filed before they are used. The commissioner may make an examination as he or she deems necessary to ascertain whether any policy forms, endorsements and other contract language affected by such rule or order meet the requirements of Section 8; and

(2) No insurer shall issue a contract or policy except in accordance with the filings that have been filed and are in effect for the insurer as provided in the Act or in accordance with Subsection A(4) of this section. This subdivision shall not apply to forms or rating systems to the extent that they are exempt or have been exempted by Subsection A(3) or B(2) of this section.

Alternative Section 10. Disapproval of Policy Form Filings

A. If the commissioner finds that a filing does not meet the requirements of the Act, he or she shall send written or electronic notice of disapproval to the insurer or advisory organization that made the filing specifying in what respects the filing fails to meet the requirements of the Act and stating when the filing shall no longer be effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. Any insured aggrieved with respect to any filing that is in effect may make written or electronic application to the commissioner for a hearing. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, or that the grounds otherwise justify holding a hearing, then a hearing shall be held in accordance with Section 29.

C. If after a hearing pursuant to Subsection B of this section, the commissioner finds that a filing does not meet the requirements of the Act, he or she shall issue an order stating in what respects the filing fails to meet the requirements and when, within a reasonable period thereafter, the policy form, endorsement or other contract language or attachment rule relating thereto, shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Drafting Note—Alternative System for Monitoring Competition

For states wishing to implement a more structured methodology for monitoring competition within a given market, the following alternative Section 12 may be considered. The advantage of the more structured approach is that state legislatures may have a greater comfort level that a hands-off rate-regulatory approach is working if there is some periodic scheduled oversight of the inner workings of the market. This alternative section provides states with that structure and encourages legislators to select the method that they believe will work best given the market realities faced in each state, for each line of business. For example, the alternative Section 12 might be applied to auto insurance, homeowners, medical malpractice and workers' compensation, while the less structured Section 12 might be applied to other property/ casualty lines. A definition of "reverse competition" would need to be added.

Section 2. Definitions

Add:

"Reverse competition" means competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or who may control, the placement of the insurance with insurers. Reverse competition tends to increase insurance premiums or to prevent lowering of premiums in order that greater commissions or other allowances may be paid to persons for such business as a means of obtaining the placement of business controlled by the person with the insurers paying the highest commissions. In such situations, the competitive pressure to obtain business by paying high commissions or providing other compensation or services to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise.

Section 12. Monitoring Competition

A. In determining whether or not a competitive market exists pursuant to Section 4, the commissioner shall hold a public hearing and issue a tentative report detailing the state of competition in for the following property or casualty lines of insurance [insert reference to applicable lines of insurance]. The report shall be based on relevant economic tests, including but not limited to those in Subsection C. The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition. The report shall include a certification of whether or not competition exists in each form of insurance.

B. Not later than [DATE] and every other year thereafter, the commissioner shall issue a final report that shall include a final certification of whether or not competition exists in each form of insurance. The final report and certification shall be supported by substantial evidence.

C. All of the following may be considered by the commissioner for purposes of Subsections A and B:

(1) The extent to which the largest insurer groups control the insurance marketplace. A specific insurance market shall be considered competitive, from the standpoint of market concentration, so long as, measured by premium volume, the cumulative share of the market controlled by the four (4) largest insurer groups in the specific market does not exceed fifty percent (50%). If the fifty percent (50%) threshold is surpassed, other measures of concentration, such as the Herfindahl-Hirshman Concentration Index, should also be considered, on the basis of both premium volume and policy counts, in determining the extent to which market concentration may be limiting market competition;

(2) Whether the total number of companies writing the form of insurance in this state is sufficient to provide multiple options to the public;

(3) The extent to which insurer entries and exits, considered over several years, suggest the presence or lack of entry or exit barriers or both;

(4) The degree to which the insurance products offered to consumers are homogenous in nature and, thus, comparable;

(5) The availability of insurance coverage in all geographic areas. A review of changes in residual market shares, if applicable, may be used as an indication of availability;

(6) The overall rate level which is not excessive, inadequate or unfairly discriminatory;

(7) The profitability of each form of insurance over a period of several years;

(8) The level of knowledge of market participants and the extent to which comparative pricing information has been made readily available to consumers;

(9) The extent to which the market for each type of insurance is growing;

(10) The presence of conditions indicating reverse competition; and

(11) Any other factors the commissioner considers relevant.

D. The reports and certifications required under Subsections A and B shall be forwarded to the governor and all relevant members of the state legislature and shall be available to the public.

E. It is rebuttably presumed that competitive markets exist. However, if the commissioner certifies that a reasonable degree of competition does not exist with respect to a form of insurance on a statewide basis or any geographic areas, or that insurance is unavailable to a segment of the market who are, in good faith, entitled to obtain insurance through ordinary means, the commissioner shall take steps to enhance competition or availability where it does not exist. A plan for enhancing competition or availability adopted pursuant to this section shall be included in a final certification of noncompetition. The plan shall only relate to those geographic areas, classifications or kinds of risks where adequate competition has been certified not to exist. The plan may include methods designed to enhance competition or availability that the commissioner considers necessary, and may provide for the commissioner to do one or more of the following:

(1) Authorize, by order, joint underwriting activities in a manner specified in the commissioner's order; and

(2) Modify the rate approval process in a manner to increase competition or availability, while at the same time providing for reasonably timely rate approvals, including reverting to prior approval of all filings.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2010 Proc. 2nd Quarter, Vol. I 103, 124, 129-130, 360-388, 391-395 (adopted).

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM LAW GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM LAW GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	3 COLO. CODE REGS. 702-5:5-1-10 (2012).
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM LAW GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM LAW GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROPERTY AND CASUALTY MODEL RATING LAW (PRIOR APPROVAL VERSION)

Table of Contents

Section 1. Purpose of Act

The purpose of this Act is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate limited cooperative action among insurers in ratemaking-related activities and in other matters within the scope of this Act. Nothing in this Act is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit or encourage, except to the extent necessary to accomplish the aforementioned purpose, uniformity in rating systems, rating plans or practices. This Act shall be liberally interpreted to carry into effect the provisions of this section.

Section 2. Definitions

A. "Advisory organization" means any entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities such as enumerated in Sections 10 and 11. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for purposes of this definition.

B. "Commercial risk" means any kind of risk which is not a personal risk.

C. "Commissioner" means the Commissioner of Insurance of this state.

D. "Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

E. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees.

F. "Joint underwriting" means a voluntary arrangement established to provide insurance coverage for a commercial risk pursuant to which two or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers.

G. "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

H. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes and other property and casualty insurance for personal, family or household needs.

I. "Pool" means a voluntary arrangement, established on an on-going basis, pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement.

J. "Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future date.

K. "Rate" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

L. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

M. "Special assessments" means guaranty fund assessments, Second Injury Fund assessments, Vocational Rehabilitation Fund Assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

Drafting Note: A state may wish to add "assessments for residual market mechanisms" or other assessments as one of the listed special assessments.

N. "Statistical agent" means an entity that has been licensed by the commissioner to collect statistics from insurers and provide reports developed from these statistics to the commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers under this Act.

O. "Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule and any other similar information needed to determine the applicable rate in effect or to be in effect.

Drafting Note: A "plan of rates" filed by an insurer would contain final rates including provisions for expenses and profit. A "plan of rates" filed by an advisory organization would contain only prospective loss costs which would exclude provisions for expenses (other than loss adjustment expenses) and profit.

P. "Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer;

(2) The interpretation of any other data relied upon by the filer;

(3) Descriptions of methods used in making the rates; and

(4) Any other information required by the commissioner to be filed.

Section 3. Scope of Act

This Act applies to all forms of casualty insurance, including fidelity, surety and guaranty bond, to all forms of fire, marine and inland marine insurance, and to any combination of any of the foregoing, on risks or operations located in this State. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the commissioner, or as established by general custom of the business, as inland marine insurance.

Drafting Note: The kinds of insurance are named herein in their generally accepted trade sense unless otherwise defined by statute or regulation. The wording of the section should be fitted to any laws of the state which classify insurance.

This Act shall not apply to:

A. Reinsurance, other than statutorily authorized joint reinsurance mechanisms to the extent stated in Section 14;

B. Accident and health insurance;

C. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine insurance as determined by the commissioner;

D. Title insurance;

E. Insurance;

Drafting Note: Here should be listed (a) other kinds of insurance, if any, and (b) particular types of insurers, if any, to which this Act is not to apply in the state or jurisdiction adopting the Act. The specific exemption of aircraft hull and liability insurance contained in the 1946 NAIC Model Bills is omitted from Section 3 of this Act. A number of states have, since 1946, provided for regulation of aircraft hull and liability insurance rates.

Section 4. Rate Standards

Rates shall be made in accordance with the following provisions:

A. Rates shall not be excessive, inadequate or unfairly discriminatory.

Drafting Note: The specific standards for excessiveness, inadequacy or unfair discrimination may be defined or explained through regulation.

B. Due consideration shall be given to past and prospective loss experience within and outside this State; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers; to past and prospective expenses both countrywide and those specially applicable to this State; and to provisions for special assessments and to all other relevant factors within and outside this State. In determining the reasonableness of the profit, consideration shall be given to investment income.

C. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the insured.

D. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and its anticipated expenses.

Drafting Note: Specific reference to "rating schedules" is omitted as unnecessary, because the "rating schedules" referred to in Section 3(a) of the Fire and Marine Model Bill as approved by the NAIC in 1946 are regarded as an example of permissible modification of classification rates.

Section 5. Rate Filings

A. (1) Every insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. An insurer may file its rates by either filing its final rates or by filing a multiplier to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 11. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated.

(2) Every insurer shall file or incorporate by reference to material which has been approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or consist of a reference to:

(a) The experience or judgment of the insurer or information filed by the advisory organization on behalf of the insurer as permitted by Section 11,

(b) Its interpretation of any statistical data it relies upon,

(c) The experience of other insurers or advisory organizations, or

(d) Any other relevant factors.

A filing and any supporting information shall be open to public inspection upon receipt of the filing.

(3) When a filing is not accompanied by the information upon which the insurer supports such filing, the commissioner may require such insurer to furnish the information upon which it supports such filing and in that event the waiting period shall commence as of the date such information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed nor available for use by the insurer. If the requested information is not provided within a reasonable time period, the filing may be returned to the insurer as not filed and not available for use.

(4) After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss, special assessment and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may use or supplement its experience with information filed with the commissioner by an advisory organization or statistical agent.

(5) Insurers utilizing the services of an advisory organization must provide with their rate filing, at the request of the commissioner, a description of the rationale for such use, including its own information and method of utilization of the advisory organization's information.

B. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this Act.

C. Subject to the exception specified in Subsection D of this section, each filing shall be on file for a waiting period of [insert number] days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed [insert number] days if written notice is given within such waiting period to the insurer or advisory organization which made the filing that additional time is needed for the consideration of the filing. Upon written application by the insurer, the commissioner may authorize a filing which has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this Act unless disapproved by the commissioner within the waiting period or any extension thereof.

Drafting Note: The waiting period specified in current state statutes ranges from 15 to 90 days.

D. Under such rules and regulations as may be adopted, the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, for which the rates cannot practicably be filed before they are used. The commissioner may make such examination as deemed advisable to ascertain whether any rates affected by such order meet the standards set forth in Section 4.

E. Upon the written application of the insurer and insured, stating its reasons therefore, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

F. No insurer shall make or issue a contract or policy except in accordance with the filings which have been approved and are in effect for said insurer as provided in this Act or in accordance with Subsections D or E of this section. This subsection shall not apply to contracts or policies for inland marine risks as to which filings are not required.

Drafting Note: To accommodate the transition from a prior rating law to this model, consideration should be given to inclusion of "transitional language" such as:

"Nothing in this Act shall be construed to require an advisory organization or its members or its subscribers to immediately refile final rates or premium charges previously approved by the commissioner. Members or subscribers of an advisory organization are authorized to continue to use insurance rates or premium charges approved before the effective date of this Act or decreases from those rates or premium charges filed by the advisory organization and subsequently approved after the effective date of this section."

Section 6. Disapproval of Filings

A. If within the waiting period or any extension provided in Section 5C, the commissioner finds that a filing does not meet the requirements of this Act, written notice of disapproval shall be sent to the insurer or advisory organization which made the filing, specifying therein in what respects the filing fails to meet the requirements of this Act and stating that such filing shall not become effective. If a filing is disapproved by the commissioner, the insurer or advisory organization may request a hearing on the disapproval within thirty (30) days and the commissioner shall schedule that hearing within thirty (30) days of the receipt of the request. The insurer or advisory organization bears the burden of proving compliance with the standards established by this Act.

B. If at any time after a rate has been approved, the commissioner finds that the rate no longer meets the requirements of this Act, the commissioner may order the discontinuance of use of the rate. The order of discontinuance may be issued after a hearing with at least ten (10) days' prior notice for all insurers affected by the order. The order must be in writing and state the grounds for the order. It shall also state when, within a reasonable time thereafter, the filing will be deemed no longer effective. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order. The commissioner's order may include a provision for a premium adjustment for contracts or policies made or issued after the effective date of the order.

C. Any insured aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon. The application shall specify the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, a hearing shall be held within thirty (30) days after receipt of such application upon not less than ten (10) days' written notice to the applicant and to every insurer and advisory organization which made such filing.

If, after such hearing, the commissioner finds that the filing does not meet the requirements of this Act, an order shall issue specifying in what respects such filing fails to meet the requirements of this Act, and stating when, within a reasonable period thereafter, such filing shall no longer be deemed to be in effect. Copies of the order shall be sent to the applicant and to every such insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Section 7. Information to be Furnished Insureds: Hearings and Appeals of Insureds

A. Every advisory organization and every insurer shall, within a reasonable time after receiving written request, furnish to any insured affected by a rate made by the insurer, or to the authorized representative of the insured, all pertinent information as to such rate. Every advisory organization and every insurer shall provide within this state reasonable means whereby the insured aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on written request to review the manner in which such rating system has been applied in connection with the insurance afforded the insured. If the advisory organization or insurer fails to grant or reject such request within thirty (30) days after it is made, the applicant may proceed in the same manner as if the application had been rejected. The insured affected by the action of the advisory organization or insurer on such request may, within thirty (30) days after written notice of such action, appeal to the commissioner, who, after a hearing held upon not less than ten (10) days' written notice to the appellant and to the advisory organization or insurer, may affirm or reverse such action.

Drafting Note: Language could be inserted here which would allow an insurer to charge a reasonable fee to cover the expense of providing any information requested under this section, but charges should not be permitted when the information relates to the specific application of an experience rating modification or a schedule rating modification.

B. If, after a hearing held under this section, it is determined that the rates charged by an insurer are in excess of the otherwise appropriate rate, such overcharge shall be refunded to the insured.

Section 8. Licensing Advisory Organizations and Statistical Agents

A. No advisory organization or statistical agent shall provide any service relating to statistical collection or the rates of any insurance subject to this Act, and no insurer shall utilize the services of such organization for such purposes unless the organization has obtained a license under Subsection C.

B. No advisory organization or statistical agent shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this State and offering to pay the fair and usual compensation for the services.

C. Licensing.

(1) An advisory organization or statistical agent applying for a license shall include with its application:

(a) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of one or more residents of this State upon whom notices, process affecting it, or orders of the commissioner may be served;

(d) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(e) A biography of the ownership and management of the organization; and

(f) Any other relevant information and documents that the commissioner may require.

(2) Every organization which has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

(3) If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of the law are met; he or she shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in any market.

(4) Licenses issued pursuant to this section shall remain in effect for one year unless the license is suspended or revoked. The commissioner may at any time, after hearing, revoke or suspend the license of an advisory organization or statistical agent which does not comply with the requirements and standards of this Act.

(5) Advisory organizations wishing to operate as statistical agents may be so authorized under their license as an advisory organization. A separate license is not required.

Drafting Note: States may wish to insert language here providing for an annual license fee for advisory organizations and statistical agents.

Section 9. Insurers and Advisory Organizations: Prohibited Activity

A. No insurer or advisory organization shall:

(1) Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market.

(2) Engage in a boycott, on a concerted basis, of an insurance market.

B. (1) No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner.

The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

(2) Two or more insurers having a common ownership or operating in this State under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this Act as if they constituted a single insurer.

C. No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance.

Section 10. Advisory Organizations and Statistical Agents: Prohibited Activity

In addition to the other prohibitions contained in this Act, except as specifically permitted under Section 11, no advisory organization or statistical agent shall compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses) or profit.

Section 11. Advisory Organizations: Permitted Activity

Any advisory organization in addition to other activities not prohibited, is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Prepare and distribute prospective loss costs which may include provisions for special assessments;

D. Prepare and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;

E. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions or minimum premiums;

F. Distribute information that is required or directed to be filed with the commissioner;

G. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

H. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;

I. Conduct research in order to discover, identify and classify information relating to causes or prevention of losses;

J. Conduct research relating to the impact of statutory changes upon prospective loss costs and special assessments;

K. Prepare policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

L. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

M. Conduct on-site inspections to determine rating classifications for individual insureds;

N. For workers' compensation insurance, establish a committee which may include insurance company representatives to review the determination of the rating classification for individual insureds and suggest modifications to the classification system.;

O. Collect, compile and distribute past and current prices of individual insurers and publish such information;

P. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;

Q. File final rates, at the direction of the commissioner, for residual market mechanisms; and

R. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 12. Statistical Agents: Permitted Activity

In addition to other activities not prohibited, any statistical agent is authorized, on behalf of its members and subscribers, to:

A. Develop statistical plans including territorial and class definitions;

B. Collect statistical data from members, subscribers or any other source;

C. Distribute information that is required or directed to be filed with the commissioner;

D. Collect, compile and distribute past and current prices of individual insurers and publish that information;

E. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings, and

F. Furnish other services, as approved or directed by the commissioner, related to those enumerated in this section.

Section 13. Advisory Organizations: Filing Requirements

Every advisory organization shall file with the commissioner for approval all prospective loss costs, provisions for special assessments and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this state. Such filings shall be subject to the provisions of Sections 5 and 6 and other provisions of this Act relating to filings made by insurers.

Section 14. Joint Underwriting, Joint Reinsurance Pool and Residual Market Activities

A. Notwithstanding Section 9B(1), insurers participating in joint underwriting, joint reinsurance pools or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools and residual market mechanisms shall not be deemed a advisory organizations.

B. Except to the extent modified by this section, insurers, joint underwriting, joint reinsurance pool and residual market mechanism activities are subject to the other provisions of this Act.

C. If, after hearing, the commissioner finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of this Act, the commissioner may issue a written order and require the discontinuance of such activity or practice.

D. Every pool shall file with the commissioner a copy of its constitution; its articles of incorporation, agreement or association; its bylaws, rules and regulations governing its activities; its members; the name and address of a resident of this State upon whom notices or orders of the commissioner or process may be served; and any changes in amendments or changes in the foregoing.

E. Any residual market mechanism, plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for consideration and approval, together with such information as may be reasonably required. The commissioner shall approve only such agreements as are found to contemplate: (i) the use of rates which meet the standards prescribed by this Act, and (ii) activities and practices that are not unfair, unreasonable or otherwise inconsistent with the provisions of this Act. At any time after such agreements are in effect, the commissioner may review the practices and activities of the adherents to such agreements and if, after a hearing, the commissioner finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with the provisions of this Act, the commissioner may issue a written order to the parties and either require the discontinuance of such acts or revoke approval of any such agreement.

Section 15. Examinations

The commissioner may, as often as he or she may deem it expedient, make or cause to be made an examination of each advisory organization or statistical agent referred to in Section 8 and of each group, association or other organization referred to in Section 14, provided that each statistical agent and advisory organization licensed in this state shall be examined at least once every five (5) years. The reasonable costs of any such examination shall be paid by the advisory organization, statistical agent or group, association or other organization examined. The officers, manager, agents and employees of such advisory organization, statistical agent, or group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. In lieu of any such examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

Drafting Note: Under the laws of several of the states, reports on examination are not made public until the organization examined has had an opportunity to review the proposed report and to have a hearing with reference thereto, after which the report is filed for public inspection and becomes admissible in evidence as a public record. In any state that has no such law, it is suggested that provisions to this effect be adopted. Examinations of statistical agents and advisory organizations require specialized expertise; commonly require the hiring of contractors, and can be expensive. States adopting mandatory examination provisions should plan for personnel to be able to undertake or oversee these examinations, and check whether the costs for examinations, even though charged to the organization being examined, must go through the insurance department's budget.

Section 16. Workers' Compensation

A. Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating system filed with the commissioner by an advisory organization designated by the commissioner.

B. Every workers' compensation insurer shall report its experience in accordance with the statistical plans and other reporting requirements in use by an advisory organization designated by the commissioner.

C. A workers' compensation insurer may develop subclassifications of the uniform classification system upon which rates may be made. Such subclassifications and their filing shall be subject to the provisions of this Act applicable to filings generally.

D. A workers' compensation insurer may develop rating plans which identify loss experience as a factor to be used. Such rating plans and their filing shall be subject to the provisions of the Act applicable to filings generally.

E. The commissioner shall disapprove subclassifications, rating plans, or other variations from manual rules filed by a workers' compensation insurer if the insurer fails to demonstrate that the data thereby produced can be reported consistent with the uniform classification system and experience rating system and in such a fashion so as to allow for the application of experience rating filed by the advisory organization.

Section 17. Statistical and Rate Administration

A. The commissioner may adopt reasonable rules for use by companies to record and report to the commissioner their rates and other information determined by the commissioner to be necessary or appropriate for the administration of this Act and the effectuation of its purposes.

B. The commissioner may promulgate reasonable rules to assure that the experience of all insurers is made available at least annually in such form and detail as is necessary to aid in effecting the purposes of this Act. The commissioner may designate one or more advisory organizations or statistical agents to assist in gathering such experience and making compilations thereof. The scope of such rules may include the data which must be reported by insurers, definitions of data elements, the timing and frequency of statistical reporting by insurers, data quality standards, data edit and audit requirements, data retention requirements, reports to be generated by advisory organizations or statistical agents to fulfill the requirements of this section, and the timing of such reports.

Drafting Note: States that want the commissioner to be required to promulgate rules for the collection of statistical experience can replace the "may" in the first line of Subsection B with "shall".

C. The following provisions apply only to the disclosure of data and reports provided to the commissioner pursuant to this section and of reports produced by the commissioner from data and reports provided to the commissioner pursuant to this section:

(1) Data shall not be disclosed when it is likely to identify individual policyholders or claimants, or where there is reason to suspect that individual open claim reserves may be identified with individual policyholders or claimants.

Drafting Note: Paragraph (1) should be amended for states that wish to provide for the release of the names of individual policyholders without their permission for the purpose of assigned risk depopulation programs. The amendment should allow the commissioner to release such names on a basis designed to protect policyholder privacy by restricting distribution to producers and insurers interested in writing this business on a voluntary basis.

(2) The commissioner may agree in advance to withhold data from public disclosure when confidentiality is requested by the insurer, advisory organization or statistical agent providing the data to the commissioner, but only if the data include data elements that the commissioner had not required, prior to their writing or occurrence, to be recorded by insurers.

(3) Unless exempted by Paragraph (1) or (2), reports from a statistical agent or advisory organization in which the information is summed and presented on a combined basis for the insurers reporting to that statistical agent or advisory organization shall be open to disclosure.

D. Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

E. In order to assist in the performance of the commissioner's duties under this Act, the commissioner may share documents, materials and other information, including confidential and privileged documents, materials or information with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information.

Section 18. Rules and Regulations

The commissioner may make reasonable rules and regulations necessary, including definitions of the rate standards contained in Section 4, to effect the purposes of this Act.

Section 19. False or Misleading Information

No person or organization shall willfully withhold information which will affect the rates or premiums chargeable under this Act from, or knowingly give false or misleading information to the commissioner, any statistical agent, any advisory organization or any insurer. A violation of this section shall subject the one guilty of such violation to the penalties provided in Section 22 of this Act.

Section 20. Assigned Risks

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is taken from the Casualty and Surety Model Bill approved in 1946 by the NAIC. Since then a number of states have enacted assigned risk provisions of more limited scope. There is no intent here to recommend extension of assigned risk provisions in present state statutes.

This section does not purport to deal with the questions as to whether Assigned Risk Plans should be voluntary or statutory, nor as to what features, including judicial review, should be contained in such plans. If these questions are to be dealt with by statutory provision, such provision should preferably be in another statute.

Section 21. Exemptions

The commissioner may by his or her own initiative or upon request of any person, by rule exempt any market from any or all of the provisions of this Act, if and to the extent that the exemption is necessary to achieve the purposes of this chapter.

Section 22. Penalties

The commissioner may, upon a finding that any person or organization has violated any provision of this Act, impose a penalty of not more than $10,000 for each such violation, but if the violation is found to be willful, a penalty of not more than $25,000 may be imposed for each violation. Such penalties may be in addition to any other penalty provided by law.

For purposes of this section, any insurer using a rate for which the insurer has failed to file the rate, supplementary rate information, underwriting rules or guides, or supporting information as required by this Act, shall have committed a separate violation for each day such failure continues. The commissioner may suspend or revoke the license of any advisory organization, statistical agent or insurer which fails to comply with an order of the commissioner within the time limited by such order, or any extension thereof which the commissioner may grant.

The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him or her, unless the commissioner modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner stating his or her findings, made after hearing.

Drafting Note: States may wish to insert a section here regarding hearing procedure and judicial review which references the state's administrative procedures act.

Section 23. Laws Repealed

Sections [insert applicable sections] of the statutes of this state are hereby repealed. All other laws or parts of laws inconsistent with the provisions of this Act are hereby repealed.

Section 24. Severability

If any section, subsection, subdivision, paragraph, sentence or clause of this Act is held invalid or unconstitutional, such decision shall not affect the remaining portions of this Act.

Section 25. Effective Date

This Act shall take effect [insert effective date].

Drafting Note: The effective date of this Act should be set to allow state insurance departments, insurance companies and advisory organizations to prepare themselves to carry out the purposes of the Act. One year is recommended.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1963 Proc. I 22, 226, 228-235, 245 (adopted).
1963 Proc. II 651-652, 654, 655-662 (reaffirmed and reprinted).
1990 Proc. I 14, 722, 734-741 (amended at special plenary session September 1989).
1990 Proc. II 17, 687, 689-697, 701 (amended and reprinted).
1992 Proc. II 8, 12, 749, 754, 756-764 (amended and reprinted).
1997 Proc. 2nd Quarter 25-26, 838, 1047-1048, 1065-1074 (amended and reprinted).
2002 Proc. 1st Quarter 241-244 (language adopted later is printed here).
2002 Proc. 4th Quarter 8, 27 (amended).
2009 Proc. 2nd Quarter, Vol. I 118, 380, 595 (converted to guideline).

This model was designed to combine two earlier NAIC models:

Fire, Marine and Inland Marine Rate Regulatory Bill

1946 Proc. 396, 410-422 (adopted).
1947 Proc. 411-413 (amended).
1960 Proc. II 639-647 (reprinted).
1962 Proc. II 502, 503, 504-516, 525 (amended).

Casualty and Surety Rate Regulatory Bill

1946 Proc. 396, 397-410 (adopted).
1947 Proc. 411-413 (amended).
1960 Proc. II 617-625 (reprinted).
1962 Proc. II 502, 503, 504-516, 525 (amended).

PROPERTY AND CASUALTY MODEL RATING LAW

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY MODEL RATING LAW

NAIC MEMBER	RELATED ACTIVITY
Alabama	ALA. CODE §§ 27-13-1 to 27-13-105 (1971); ALA. ADMIN. CODE r. 482-1-152.01 to 482-1-152.09 (2013); BULLETIN dated March 15, 1990 (1990).
Alaska	ALASKA STAT. §§ 21.39.010 to 21.39.070 (1966/2005); ALASKA ADMIN. CODE tit. 3, §§ 29.200 to 29.300 (1992/1993).
American Samoa	NO CURRENT ACTIVITY
Arizona	ARIZ. REV. STAT. ANN. §§ 20-341 to20-344; §§ 20-356 to 20-359 (1954/2003).
Arkansas	ARK. CODE ANN. §§ 23-67-206 to 23-67-223 (1987/2005); § 23-79-109 (1959/1999); §§ 23-67-501 to 23-67-510 (2005) (medical malpractice); 23 ARK. CODE R. (1981/1991).
California	CAL. INS. CODE §§ 1850.4 to 1851.1; § 1853.5; §§ 1853.8 to 1853.97; §§ 1855 to 1857.9; §§ 1858 to 1858. (portions of 1963 model); CAL. CODE REGS. tit. 10, §§ 2641.1 to 2647.1 (1991/2008); BULLETIN B-5.18 (2009).
Colorado	COLO. REV. STAT. §§ 10-4-401 to 10-4-418 (1979/2010); §§ 10-4-1401 to 10-4-1404 (1999); 5 COLO. CODE REGS. § 1-13 (2000/2006); § 1-10 (1991/2009).
Connecticut	CONN. GEN. STAT. §§ 38a-663 to 38a-680 (1969/1989) (commercial lines); §§ 38a-684 to 38a-694 (1982/2013) (personal risk insurance); BULLETIN PC-8 (1990).
Delaware	DEL. CODE ANN. tit. 18, §§ 2501 to 2531 (1953/2009); DEL. CODE ANN. tit. 19, §§ 2601 to 2623 (1993) (Workers' Comp.); BULLETIN 5 (1990/1992).
District of Columbia	D.C. CODE §§ 31-2701 to 31-2710 (1973/2004); BULLETIN 90-1 (1990).
Florida	FLA. STAT. §§ 627.011 to 627.381 (1982/2014); FLA. ADMIN. CODE ANN. r. 69O-170.007 (1990); Memorandum 2006-012 (2006).
Georgia	GA. CODE ANN. §§ 33-9-1 to 33-9-38 (1967/1987); DIRECTIVE NO. 90-PC-6 (1990); GA. COMP. R. & REGS. 120-2-77 (1999/2000).
Guam	GUAM GOV'T. CODE §§ 43385 to 43387 (1978).
Hawaii	HAW. REV. STAT. §§ 431:14-101 to 431:14-120 (1988/2009).
Idaho	IDAHO CODE ANN. §§ 41-1401 to 41-1441 (1969/2005).
Illinois	ILL. ADMIN. CODE tit. 50, § 754 (1970) (filing requirements).

PROPERTY AND CASUALTY MODEL RATING LAW

NAIC MEMBER	RELATED ACTIVITY
Indiana	IND. CODE §§ 27-1-22-1 to 27-1-22-24 (1967/2006); BULLETIN 67 (1991).
Iowa	IOWA CODE §§ 515F.1 to 515F.19 (1990); DIRECTIVE dated April 6, 1990 (1990).
Kansas	KAN. STAT. ANN. §§ 40-951 to 40-967 (1997/1999); KAN. ADMIN. REGS. §§ 40-3-46 to 40-3-47 (1991); BULLETIN 2010-1 (2010).
Kentucky	KY. REV. STAT. ANN. §§ 304.13-011 to 304.13-390 (1982/2006); § 304.11-020 (1970/2000).
Louisiana	LA. REV. STAT. ANN. § 22:1401 to 22:1422 (1979/2005); § 22:620 (1999); § 22:972 (1958/2010); LA. ADMIN. CODE tit. 37, §§ XIII.9001 to XIII.9021 (Regulation 72) (2000).
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 2301 to 2330 (1970/2006); § 2412-A (1999); BULLETIN 241 (1995).
Maryland	MD. CODE ANN., INS. §§ 11-101 to 11-232 (1945/2006); §§ 11-301 to 11-344 (1984/1997); MD. CODE REGS. 31.07.01.01 to 31.07.01.08 (1990/2008).
Massachusetts	MASS. GEN. LAWS ch. 174A, §§ 1 to 19; MASS. GEN. LAWS ch. 175A, §§ 1 to 20 (1947/2014); MASS. GEN. LAWS ch. 175, §§ 224 to 225 (2004); BULLETIN SRB-90-5 (1990).
Michigan	MICH. COMP. LAWS §§ 500.2301 to 500.2352 (workers' compensation); §§ 500.2400 to 500.2484 (casualty insurance rates); § 500.2603 (rate making provisions-uniformity); BULLETIN 2006-05 (2006).
Minnesota	MINN. STAT. §§ 70A.01 to 70A.23 (1969/1987).
Mississippi	MISS. CODE ANN. §§ 83-2-1 to 83-2-31 (1988/2006); §§ 83-2-21 to 83-2-31 (2006).
Missouri	MO. REV. STAT. §§ 379.316 to 379.361 (1972/2002); MO. CODE REGS. ANN. tit. 20, § 500-4.200 (1990).
Montana	MONT. CODE ANN. §§ 33-16-101 to 33-16-405 (1969/1999); MONT. ADMIN. R. 6.6.3001 to 6.6.3007 (1990).
Nebraska	NEB. REV. STAT. §§ 44-7501 to 44-7535 (2001/2010); 210 NEB. ADMIN. CODE § 73 (2001); BULLETIN CB-50 (Revised) (2001).
Nevada	NEV. REV. STAT. §§ 686B.010 to 686B.1779 (1971/2013); NEV. ADMIN. CODE §§ 686B.400 to 686B.460 (1990/2006).

PROPERTY AND CASUALTY MODEL RATING LAW

NAIC MEMBER	RELATED ACTIVITY
New Hampshire	N.H. REV. STAT. ANN. §§ 412:1 to 412:16 (2004/2014); §§ 413:1 to 413:10 (1947/2004) (rating organizations); §§ 414:1 to 414:9 (1947/2004) (fire and casualty); N.H. CODE ADMIN. R. ANN. INS. 2801.01 to 2801.07 (1990/1992).
New Jersey	N.J. REV. STAT. §§ 17:29AA-1 17:29AA-32 (1982) (commercial lines); §§ 17:29A-1 to 17:29A-32 (1944/1950); P.L. 1990 c.8 (Fair Automobile Insurance Reform Act of 1990); N.J. ADMIN. CODE §§ 11:2-2.1 to 11:2-2.7 (2002/2009); §§ 11:3-16.1 to 11:3-16.10 (1990/2009); §§ 11:13-8.1 to 11:13-8.5 (1993/2002); §§ 11:4-9.1 to 11:4-9.5 (1995/2000).
New Mexico	N.M. STAT. ANN. §§ 59A-17-1 to 59A-17-35 (1985/2003); N.M. CODE R. §§ 13.8.2.1 to 13.8.2.26 (1997/2006).
New York	N.Y. INS. LAW §§ 2301 to 2344 (1984/1990); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 161.0 to 161.9 (Regulation 129) (1986).
North Carolina	N.C. GEN. STAT. §§ 58-40-1 to 58-40-140 (1977/2013);11 N.C. ADMIN. CODE 10.1601 to 10.1604 (1991/1992).
North Dakota	N.D. CENT. CODE §§ 26.1-25-01 to 26.1-25-18 (1983/1991); BULLETIN 90-1 (1990).
Northern Marianas	NO CURRENT ACTIVITY
Ohio	OHIO REV. CODE ANN. §§ 3935.01 to 3935.99; §§ 3937.01 to 3997.99 (1947-1948/2013); BULLETIN 91-1 (1991).
Oklahoma	OKLA. STAT. tit. 36, §§ 901 to 938 (1957/2006); §§ 981 to 998 (1999/2005); OKLA. ADMIN. CODE §§ 570:10-1-3 to 570:10-1-41 (1992/2005); §§ 365:15-7-1 to 365:15-7-24 (2005/2006).
Oregon	OR. REV. STAT. §§ 737.007 to 737.560 (1967/1987); BULLETIN INS-90-4 (1990).
Pennsylvania	40 PA. CONS. STAT. §§ 65-101 to 65-119 (1947/1994); §§ 67-101 to 67-119 (1961/1994); Directive dated July 16, 1990; Statement of Policy §§ 120.1 to 120.5 (1993) (workers' comp.); §§ 66-101 to 66-119 (1998).
Puerto Rico	P.R. LAWS ANN. tit. 26, §§ 1201 to 1240 (1979).
Rhode Island	R.I. GEN. LAWS §§ 27-44-1 to 27-44-22 (1988/2005) (Use for competitive market); §§ 27-6-1 to 27-6-52; 27-9-1 to 27-9-52 (1948/2013) (use for non-competitive market); §§ 27-7.1-1 to 27-7.1-25 (1985/2005) (workers' compensation); §§ 27-65-1 to 27-65-2 (1999); BULLETIN dated April 27, 1990 (1990).

PROPERTY AND CASUALTY MODEL RATING LAW

NAIC MEMBER	RELATED ACTIVITY
South Carolina	S.C. CODE ANN. §§ 38-73-10 to 38-73-1540 (1988/2004).
South Dakota	S.D. CODIFIED LAWS §§ 58-24-1 to 58-24-74 (1966/2014); BULLETIN 94-3 (1994).
Tennessee	TENN. CODE ANN. §§ 56-5-301 to 56-5-318 (1983).
Texas	TEX. INS. CODE ANN. §§ 5.01 to 5.54 (1951/2005).
Utah	UTAH CODE ANN. §§ 31A-19a-101 to 31A-19a-210 (1986/2013); UTAH ADMIN. CODE r. 590-140 (1990/2000); BULLETIN 90-6 (1990).
Vermont	VT. STAT. ANN. tit. 8, §§ 4681 to 4708 (1984/1990); BULLETIN 99 (1990).
Virgin Islands	NO CURRENT ACTIVITY
Virginia	VA. CODE ANN. §§ 38.2-1900 to 38.2-2027 (1986/2005); ADMIN. LETTER 1990-5 (1990); ADMIN. LETTER 1993-10 (1993).
Washington	WASH. REV. CODE §§ 48.19.010 to 48.19.440 (1947/2003); WASH. ADMIN. CODE 284-24-010 to 284-24-120 (1982/2008).
West Virginia	W. VA. CODE §§ 33-20-1 to 33-20-16 (1957/1986); West Virginia Informational Letter No. 68 (1990).
Wisconsin	WIS. STAT. §§ 625.01 to 625.35 (1969/1979); BULLETIN dated June 11, 1990 (1990).
Wyoming	WYO. STAT. ANN. §§ 26-14-101 to 26-14-118 (1983/2005).

PROJECT HISTORY – 2009/2010

PROPERTY AND CASUALTYMODEL RATE AND POLICY FORM LAW GUIDELINE (#1780) - 2009
&
PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE (#1781) - 2010

1. Description of the Project, Issues Addressed, etc.

The Commercial Lines Re-engineering Working Group of the Property and Casualty Insurance (C) Committee was charged to rework the NAIC's two model rating laws for property and casualty insurance into one law, which:

1. Also regulates forms;
2. Establishes uniform non-renewal and cancellation provisions;
3. Creates waivers of form requirements for multi-state risks;
4. Establishes an exemption from rate and form requirements for large commercial policyholders; and
5. Enables the degree of regulation to vary so as to fit the needs of each marketplace.

The new model law guideline contemplates several possible approaches to rate regulation, but defaults to file and use. A prefatory drafting note to the sections relating to rate regulation conveys the context;

> The NAIC long ago concluded that competition could be an effective regulator of property/casualty insurance rates. Recent consideration of commercial lines rate regulation has led to the conclusion that commercial insurance consumers will generally be better served by less restrictive regulatory interventions—by greater reliance on competition. Consistent with these two conclusions, the rate-regulatory provisions contained in the model law guideline reflect a file and use rate-regulatory approach. It should be noted, however, that the NAIC has not taken a position respecting any particular line of insurance in any particular state. While this model law guideline "defaults" to file and use, it is expected that each state will consider whether other approaches are more appropriate for specific lines or all lines. Drafting notes contained in an appendix for sections 4 through 7 contemplate several alternative approaches, providing for greater or lesser degrees of reliance on competition, which a state may determine to be preferable.
>
> The movement of states away from prior approval of rates has been more pronounced in connection with commercial lines than personal lines. It has occurred less rapidly in connection with workers' compensation insurance than with most other commercial lines. Although many states have adopted competitive rating approaches for medical professional liability insurance, each state will want to consider the extent to which that state's marketplace for such insurance is, in fact, structured in such a way that reliance upon competition is a viable approach. Each state will also want to consider the extent to which the reverse-competitive market structures of credit property insurance, credit involuntary unemployment insurance and mortgage guaranty insurance either suggest or demand a more guarded regulatory approach than is used for other lines of insurance.

The NAIC did not have a general policy form model law prior to the inclusion of policy form standards and filing requirements in this model law guideline. Development of the standards and filing requirements was necessary to meet the charge given the group to develop appropriate relaxation of regulatory requirements for certain large commercial policyholders. In the prior law there were no regulatory requirements for policy forms. Thus, a baseline was established so that a less restrictive stance for the sophisticated commercial buyer could be implemented. A "default" of prior approval was selected for policy form filings. While this was not very popular with the insurance industry, it reflects the reality of how the regulation of policy forms is accomplished in most states today, and the importance of assuring, prior to use, that policy forms meet minimum standards.

The project also includes a companion model regulation guideline that was developed to provide guidance to states when the model law guideline directs to commissioner to establish a regulation to implement a portion of a law.

2. Name of Group Responsible for Drafting the Model and States Participating

The Commercial Lines Re-engineering Working Group of the Property and Casualty Insurance (C) Committee was responsible for revising the Property and Casualty Model Rating Law and the Property and Casualty Model Rating Law (File and Use Version). The following states were members of the working group with Texas serving as chair: Florida, Iowa,

Kentucky, Massachusetts, Maine, Missouri, Nebraska, New York, Ohio and South Dakota. Other regulators and various interested parties assisted in the process.

3. Project Authorized by What Charge and Date First Given to the Group

In 1999, the Property and Casualty Insurance (C) Committee was charged to: "Continue to discuss the feasibility of relaxing regulatory requirements for some commercial lines. Present at the 1999 Winter National Meeting the completed changes to NAIC model rating laws to implement the recommendations made by the (EX) Special Committee on Regulatory Re-engineering in its white paper on commercial lines." It appointed the Commercial Lines Re-engineering Working Group to develop the changes to the model rating laws. The charge was carried over into 2000 to provide the added time needed to meet it.

The law and regulation were adopted by the Property and Casualty Insurance (C) Committee at the 2000 Spring National Meeting, as was the NAIC *Statement of Intent: The Future of Insurance Regulation* However, the Committee also passed a motion to recommend a new charge to monitor the discussions of the then-Speed to Market (EX) Working Group relative to rate and form filings for property and casualty insurers and to revisit the model law and regulation for consistency with the recommendations of the Working Group.

In June 2000, the Executive (EX) Committee received the model law and model regulation, but instead of adopting them, referred them to the Speed to Market (EX) Working Group for further consideration. Many years passed while the Speed to Market (EX) Task Force considered the *Personal Lines Regulatory Framework* white paper and on April 16, 2009, the Speed to Market (EX) Task Force passed the following motion: "That model laws #775 and #780 and the 2000 draft model law and regulation be identified as guidelines and retained as a resource." The NAIC model law coordinator converted model laws #775 and #780 to guidelines consistent with the revised NAIC policy regarding model law development. The coordinator was unsure whether the 2000 model law and model regulation should be made a guideline without affirmative action from the Property and Casualty Insurance (C) Committee. The Property and Casualty Insurance (C) Committee was then asked to consider the model law and model regulation.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was very open as the Commercial Lines Re-engineering Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and insurance industry representatives. The Commercial Lines Re-engineering Working Group began its work in November of 1998, and adopted an initial exposure draft of the model law in March of 1999 at the NAIC Spring National Meeting. It met at all NAIC National Meetings in 1999, held an interim meeting and numerous conference calls to be certain that all issues were addressed and that all parties were given an opportunity to be heard. Because of the volume of comments and the important nature of the issues, the working group did not adopt the model law and the model regulation until March 14, 2000, having adopted a final exposure draft in December 1999. The Property and Casualty Insurance (C) Committee first adopted the model law and model regulation on March 15, 2000.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

All of the meetings of the Commercial Lines Re-engineering (C) Working Group, the Property and Casualty Insurance (C) Committee, the Personal Lines Regulatory Framework (EX) Working Group and the Speed to Market (EX) Task Force were open to all interested parties. All revised drafts of the model law were circulated for public comment. Most of the drafting was done by NAIC staff or members of the working group. There was language adopted by the working group as a result of suggestions from the American Insurance Association, the Alliance of American Insurers, the Property Casualty Insurers Association of America, the Independent Insurance Agents of America, various individual insurer representatives and law firms and the Center for Economic Justice.

On March 28, 2010, the Property and Casualty Insurance (C) Committee adopted the law and regulation as guidelines with the vote being subject to a 30-day review and comment period where Committee members can submit comments or ask for reconsideration; no comments or reconsideration request were made.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

While in the early drafting sessions, the working group's initial focus was upon relaxing regulatory requirements for large, sophisticated commercial risks, the working group also recognized that if it were to meet its assigned charge, that risks other than large commercial risks must also be addressed. As a result, the working group's main focus centered on developing a model rate and form law that would work for all risks, including personal lines.

While ensuring continued consumer protections, the working group's revision to the model law accomplishes the following:

1. provides a greater reliance on competition than the two other NAIC model rating laws;
2. "defaults" to a file and use competitive approach for rate filings with several legislative options suggested through drafting notes;
3. defaults to a prior approval approach for policy forms and other contract language;
4. suggests that the commissioner be granted authority to monitor competition and react with appropriate changes to regulatory processes through implementation of regulations, including the waiver if some or all rate filing requirements for one or more commercial lines of insurance, and a more limited degree of waivers relating to commercial policy forms;
5. addresses inefficiencies for multi-state commercial policyholders by introducing a limited form of reciprocity for insurers selling policies to risks operating in more than one state;
6. exempts from rate and form regulation sales made to "Exempt Commercial Policyholders" (state defined large, sophisticated commercial risks); and
7. promotes the use of the System for Electronic Rate and Form Filing (SERFF) through changes that make the rate and form filing process media neutral.

7. Any Other Important Information (e.g., amending an accreditation standard).

Insurers, agent associations and consumer representatives had significantly different opinions regarding the extent to which rates and forms should be subject to regulatory scrutiny. Insurers generally believe that the working group did not go far enough in granting relief from rate and form filing and approval requirements. There were disagreements on where to draw the line that separates a sophisticated commercial buyer from an unsophisticated one. It is safe to say that insurers would generally favor an approach that employs use and file, informational filings or no filings for rate and policy forms. Consumer representatives, agents and regulators were not generally supportive of these options. Insurer representatives were supportive of lower thresholds for defining what type of entity is exempt from various regulatory requirements. Agents were generally opposed to low thresholds fearing an increase in litigation about the advice they provide to clients. Regulators generally opposed low thresholds as a matter of adequate consumer protection. Consumer interests feared that low thresholds place some consumers in an unequal bargaining position when dealing with insurers. Members of the working group have taken a balanced approach that considers the interests of all parties. They are proud of their work effort and believe that they have addressed all concerns. While not everyone agrees with the outcome on every issue, all parties will agree that the working group was open to hearing their issues and concerns. Members of the insurance industry, the producer community and consumer interests believe that a reasonable model law guideline and companion model regulation guideline have been developed.

PROJECT HISTORY – 2002

PROPERTY AND CASUALTY MODEL RATING LAW (PRIOR APPROVAL VERSION)
PROPERTY AND CASUALTY MODEL RATING LAW (FILE AND USE VERSION)

1. Project Description

The NAIC currently has three alternative model rating laws that apply to property and casualty coverages. This project amends two of the three models. In particular, the Property and Casualty Model Rating Law (Prior Approval Version) and the Property and Casualty Model Rating Law (File and Use Version) have a common section that relates to the collection of statistical information to aid in determining whether rating systems comply with the rate standards set forth in the model laws. The section proved to be very controversial as insurers and consumer advocates could not agree on the level of public disclosure that should be required. Eventually the Statistical Task Force provided a recommendation to the Property and Casualty Insurance (C) Committee, however, the membership of the task force had dwindled to four states at the time—in large part because of the controversy related to this project. In its recommendation, the task force recognized that no consensus could be reached among the four states and so informed the committee. The issue proved to be no less controversial at the committee level than it was when the task force was wrestling with the issue. Eventually Commissioner José Montemayor (TX) tendered a compromise. He suggested that the real controversy lies in the issue of how insurer-specific data should be treated. In June 2001, he proposed a fairly simple resolution of the matter before the committee. He suggested that if regulators cannot agree on what to say regarding insurer-specific data, they should agree to say nothing. The effect of the silence by the committee is to leave such data open to disclosure, except to the extent protected under each state's public information laws. The committee unanimously accepted the compromise after further deliberation on the matter.

2. Group Responsible for Drafting Model and States Participating

The Statistical (EX) Task Force, later known as the Statistical (Technical) Task Force and now known as the Statistical Information (C) Task Force was originally asked to update the language in the two NAIC property and casualty model rating laws in place at that time. Over the period when the discussions were held, the following states served on the task force: Alaska, California, District of Columbia, Illinois, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Jersey, New York, North Carolina, Oregon, Texas and Virginia. When the recommendation was sent to the committee, the Statistical (Technical) Task Force was chaired by Missouri and had the District of Columbia, New York and Texas as members. When the recommendation, as amended, was finally adopted by the C Committee, the committee was chaired by South Dakota and had the following members: California, Kentucky, Missouri, New Jersey, New York, Oregon. Puerto Rico and Texas.

3. Charge Authorizing Project

In 1996 the Statistical (EX) Task Force was charged to—Review and recommend revisions to the Model Regulation to Require Statistical Reporting and (if necessary) to the model rating laws. Make final report by December 1996.

In 1997 the Statistical (Technical) Task Force was charged to—Complete consideration of the Model Regulation to Require Statistical Reporting and of statistically-related changes to the Property and Casualty Model Rating Law and the Property and Casualty Model Rating Law (File and Use Version). Make final recommendations by June 1997.

In 1998 the Statistical (Technical) Task Force was charged to—Complete the Task Force's consideration of changes to the model P&C rating laws that deal with disclosure of statistical data reported to state insurance departments. Make final recommendations to Property and Casualty Commercial Lines (D) Committee by June 1998. Cost of approximately $200.

In 1999 the Statistical (Technical) Task Force was charged to—Complete consideration of changes to the sections of the model P&C rating laws that address possible disclosure of statistical data collected pursuant to the rating law. Make final recommendation by June 1999.

The task force presented its findings to the Property and Casualty Insurance (C) Committee in March 1999 and the committee has been considering the proposal since then.

4. General Description of Drafting Process

The Statistical Task Force solicited comments from all interested parties, including interested regulators, funded consumer representatives and industry representatives. The task force also solicited key concerns from interested parties and state regulators regarding their views on collection, compilation and public disclosure of statistical data. The task force and, later, the committee received and reviewed numerous comments from interested parties. The comments varied from one extreme to the other. Those working in the insurance industry are concerned that open access to data could compromise an insurer's competitive position and they tended to favor less data collection and protection of the data as trade secret. Consumer advocates believe that Commissioner Montemayor's proposal lessens public access to insurance data when compared with the current model language and they opposed its adoption. They believe the new proposal deletes current language that provides that data compilations prepared by statistical agents for the Commissioner are public documents and establishes only that industry-aggregate data are public records.

5. Significant Issues Raised

Clearly there is no consensus that can be achieved on this issue. Insurers and advisory organizations tend to favor minimizing the amount of data collected and limiting its publication to the greatest extent possible. On the other hand, consumer advocates tend to favor robust data collection systems that grant access to the public for all or virtually all data. Insurance regulators tend to be in the middle; however, there is also no clear consensus among regulators about the level of detail that should be collected or the amount of data that should be made publicly available. Thus, the proposal by Commissioner Montemayor is viewed as the consensus position. It simply leaves the decision on what data should be collected and how much of it should be published up to each state.

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE

Table of Contents

Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to Section [insert applicable section] of the [insert state] insurance code.

Section 2. Definitions

As used in this regulation:

A. "Exempt commercial policyholder" means an entity that has sufficient insurance buying expertise to negotiate with insurers in a largely unregulated environment and that meets any two (2) of the following qualifying criteria:

(1) Net worth of over $50 million;

(2) Net revenues or sales of over $100 million;

(3) More than 500 employees per individual company or 1,000 per holding company aggregate;

(4) Procures its insurance through use of a risk manager, employed or retained;

(5) Aggregate premiums of over $500,000;

(6) Is a not for profit, or public entity with an annual budget or assets of at least $45 million, or

(7) Is a municipality with a population of over 50,000.

Drafting Note—ECP Definition: The definition of exempt commercial policyholder (ECP) included here was taken from the NAIC white paper: *The Regulatory Re-engineering of Commercial Lines Insurance.* It should be noted that in legislative sessions subsequent to the white paper, some states adopted ECP criteria similar to or the same as those in the white paper, while other states opted to enact much lower ECP criteria, in some cases with exemption applying only to filing requirements and not rate and policy form standards. It should also be noted that the criteria for ECPs may include variations. For example, lower ECP criteria might be applied in connection with rates than are applied in connection with forms.

B. "Principally located in another state" means that the commercial policyholder maintains its headquarters in another state and that its officers and senior management are physically located at its headquarters.

C. "Risk manager" means a person whose primary economic activity consists of regularly and continuously identifying and analyzing loss exposures, selecting the technique or combination of techniques to be used to handle each exposure to loss, implementing the chosen techniques and monitoring the decisions made.

Drafting Note—"Risk Manager" Definition: To the extent the definition of an ECP in Subsection A is modified, it may also be desirable to modify the definition of "risk manager" and to include language prohibiting the risk manager from having a conflicting economic interest in the policy being negotiated or procured.

Section 3. Waiver of Filing Requirements for Insurers Providing Coverages to Certain Exempt Commercial Policyholders

An insurer providing insurance coverage for an exempt commercial policyholder shall be exempt from all of the following requirements only for those policies issued to exempt commercial policyholders:

A. The rate standards specified in Section [insert appropriate reference].

B. The rate filing requirements specified in Section [insert appropriate reference].

C. The policy form standards specified in Section [insert appropriate reference].

D. The policy form filing requirements specified in Section [insert appropriate reference].

E. All laws of this state containing statutorily mandated policy language, except for those applying to workers' compensation policies or auto insurance policies.

Section 4. Record Retention Requirements Applicable to Certain Exempt Commercial Policyholders

An insurer providing insurance coverage for an exempt commercial policyholder shall maintain adequate records to document that the exempt commercial policyholder met the criteria set forth in this regulation. The insurer shall maintain the records to ascertain that the policyholder was an exempt commercial policyholder for a period of not less than three (3) years from the expiration of the policy to which the exemption applies. The commissioner may make such examination as is deemed advisable to ascertain whether the insurer is claiming exemption for policies issued to policyholders that do not meet the criteria for consideration as an exempt commercial policyholder.

Section 5. Form Approval Requirements Applying to Multistate Commercial Risks

To facilitate the ability of insurers to transact the business of insurance with commercial risks that operate in more than one state, the commissioner finds that it is appropriate to modify the requirements for filing of certain policy forms and adherence to certain laws in this state. The following requirements are modified as indicated:

A. The commissioner hereby waives the policy form filing requirements specified in Section [insert appropriate reference] for those policy forms issued to a commercial risk that operates in two (2) or more states, provided that the business of the commercial risk is principally located in another state.

B. The insurer providing coverage for a commercial risk whose business is principally located in another state is not required to comply with [insert statutory reference to cancellation, nonrenewal and notice requirements and other laws that should not apply], provided that the insurer adheres to the cancellation and nonrenewal, and other laws of the state where the commercial risk is principally located.

C. The insurer providing coverage for the commercial risk whose business is principally located in another state is required to comply with the laws of this state with regard to workers' compensation and the mandatory provisions contained in this state's automobile insurance laws. If the insurer includes a conformity to statute clause in its policies, that clause shall be interpreted to provide the workers' compensation and automobile insurance coverage required in this state.

Section 6. Severability Provision

If any section or portion of a section of this regulation or the application of this regulation to any person, business or circumstance is for any reason held to be invalid by a court, the remainder of the regulation and the application of the provision to other persons, businesses or circumstances shall not be affected.

Section 7. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2010 Proc. 2nd Quarter, Vol. I 103, 124, 129-130, 360-388, 391-395 (adopted).

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY

PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE

NAIC MEMBER	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY – 2009/2010

PROPERTY AND CASUALTYMODEL RATE AND POLICY FORM LAW GUIDELINE (#1780) - 2009
&
PROPERTY AND CASUALTY MODEL RATE AND POLICY FORM REGULATION GUIDELINE (#1781) - 2010

1. Description of the Project, Issues Addressed, etc.

The Commercial Lines Re-engineering Working Group of the Property and Casualty Insurance (C) Committee was charged to rework the NAIC's two model rating laws for property and casualty insurance into one law, which:

1. Also regulates forms;
2. Establishes uniform non-renewal and cancellation provisions;
3. Creates waivers of form requirements for multi-state risks;
4. Establishes an exemption from rate and form requirements for large commercial policyholders; and
5. Enables the degree of regulation to vary so as to fit the needs of each marketplace.

The new model law guideline contemplates several possible approaches to rate regulation, but defaults to file and use. A prefatory drafting note to the sections relating to rate regulation conveys the context;

> The NAIC long ago concluded that competition could be an effective regulator of property/casualty insurance rates. Recent consideration of commercial lines rate regulation has led to the conclusion that commercial insurance consumers will generally be better served by less restrictive regulatory interventions—by greater reliance on competition. Consistent with these two conclusions, the rate-regulatory provisions contained in the model law guideline reflect a file and use rate-regulatory approach. It should be noted, however, that the NAIC has not taken a position respecting any particular line of insurance in any particular state. While this model law guideline "defaults" to file and use, it is expected that each state will consider whether other approaches are more appropriate for specific lines or all lines. Drafting notes contained in an appendix for sections 4 through 7 contemplate several alternative approaches, providing for greater or lesser degrees of reliance on competition, which a state may determine to be preferable.
>
> The movement of states away from prior approval of rates has been more pronounced in connection with commercial lines than personal lines. It has occurred less rapidly in connection with workers' compensation insurance than with most other commercial lines. Although many states have adopted competitive rating approaches for medical professional liability insurance, each state will want to consider the extent to which that state's marketplace for such insurance is, in fact, structured in such a way that reliance upon competition is a viable approach. Each state will also want to consider the extent to which the reverse-competitive market structures of credit property insurance, credit involuntary unemployment insurance and mortgage guaranty insurance either suggest or demand a more guarded regulatory approach than is used for other lines of insurance.

The NAIC did not have a general policy form model law prior to the inclusion of policy form standards and filing requirements in this model law guideline. Development of the standards and filing requirements was necessary to meet the charge given the group to develop appropriate relaxation of regulatory requirements for certain large commercial policyholders. In the prior law there were no regulatory requirements for policy forms. Thus, a baseline was established so that a less restrictive stance for the sophisticated commercial buyer could be implemented. A "default" of prior approval was selected for policy form filings. While this was not very popular with the insurance industry, it reflects the reality of how the regulation of policy forms is accomplished in most states today, and the importance of assuring, prior to use, that policy forms meet minimum standards.

The project also includes a companion model regulation guideline that was developed to provide guidance to states when the model law guideline directs to commissioner to establish a regulation to implement a portion of a law.

2. Name of Group Responsible for Drafting the Model and States Participating

The Commercial Lines Re-engineering Working Group of the Property and Casualty Insurance (C) Committee was responsible for revising the Property and Casualty Model Rating Law and the Property and Casualty Model Rating Law (File and Use Version). The following states were members of the working group with Texas serving as chair: Florida, Iowa,

Kentucky, Massachusetts, Maine, Missouri, Nebraska, New York, Ohio and South Dakota. Other regulators and various interested parties assisted in the process.

3. Project Authorized by What Charge and Date First Given to the Group

In 1999, the Property and Casualty Insurance (C) Committee was charged to: "Continue to discuss the feasibility of relaxing regulatory requirements for some commercial lines. Present at the 1999 Winter National Meeting the completed changes to NAIC model rating laws to implement the recommendations made by the (EX) Special Committee on Regulatory Re-engineering in its white paper on commercial lines." It appointed the Commercial Lines Re-engineering Working Group to develop the changes to the model rating laws. The charge was carried over into 2000 to provide the added time needed to meet it.

The law and regulation were adopted by the Property and Casualty Insurance (C) Committee at the 2000 Spring National Meeting, as was the NAIC *Statement of Intent: The Future of Insurance Regulation* However, the Committee also passed a motion to recommend a new charge to monitor the discussions of the then-Speed to Market (EX) Working Group relative to rate and form filings for property and casualty insurers and to revisit the model law and regulation for consistency with the recommendations of the Working Group.

In June 2000, the Executive (EX) Committee received the model law and model regulation, but instead of adopting them, referred them to the Speed to Market (EX) Working Group for further consideration. Many years passed while the Speed to Market (EX) Task Force considered the *Personal Lines Regulatory Framework* white paper and on April 16, 2009, the Speed to Market (EX) Task Force passed the following motion: "That model laws #775 and #780 and the 2000 draft model law and regulation be identified as guidelines and retained as a resource." The NAIC model law coordinator converted model laws #775 and #780 to guidelines consistent with the revised NAIC policy regarding model law development. The coordinator was unsure whether the 2000 model law and model regulation should be made a guideline without affirmative action from the Property and Casualty Insurance (C) Committee. The Property and Casualty Insurance (C) Committee was then asked to consider the model law and model regulation.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting process was very open as the Commercial Lines Re-engineering Working Group solicited comments from all interested parties, including interested regulators, funded consumer representatives and insurance industry representatives. The Commercial Lines Re-engineering Working Group began its work in November of 1998, and adopted an initial exposure draft of the model law in March of 1999 at the NAIC Spring National Meeting. It met at all NAIC National Meetings in 1999, held an interim meeting and numerous conference calls to be certain that all issues were addressed and that all parties were given an opportunity to be heard. Because of the volume of comments and the important nature of the issues, the working group did not adopt the model law and the model regulation until March 14, 2000, having adopted a final exposure draft in December 1999. The Property and Casualty Insurance (C) Committee first adopted the model law and model regulation on March 15, 2000.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

All of the meetings of the Commercial Lines Re-engineering (C) Working Group, the Property and Casualty Insurance (C) Committee, the Personal Lines Regulatory Framework (EX) Working Group and the Speed to Market (EX) Task Force were open to all interested parties. All revised drafts of the model law were circulated for public comment. Most of the drafting was done by NAIC staff or members of the working group. There was language adopted by the working group as a result of suggestions from the American Insurance Association, the Alliance of American Insurers, the Property Casualty Insurers Association of America, the Independent Insurance Agents of America, various individual insurer representatives and law firms and the Center for Economic Justice.

On March 28, 2010, the Property and Casualty Insurance (C) Committee adopted the law and regulation as guidelines with the vote being subject to a 30-day review and comment period where Committee members can submit comments or ask for reconsideration; no comments or reconsideration request were made.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

While in the early drafting sessions, the working group's initial focus was upon relaxing regulatory requirements for large, sophisticated commercial risks, the working group also recognized that if it were to meet its assigned charge, that risks other than large commercial risks must also be addressed. As a result, the working group's main focus centered on developing a model rate and form law that would work for all risks, including personal lines.

While ensuring continued consumer protections, the working group's revision to the model law accomplishes the following:

1. provides a greater reliance on competition than the two other NAIC model rating laws;
2. "defaults" to a file and use competitive approach for rate filings with several legislative options suggested through drafting notes;
3. defaults to a prior approval approach for policy forms and other contract language;
4. suggests that the commissioner be granted authority to monitor competition and react with appropriate changes to regulatory processes through implementation of regulations, including the waiver if some or all rate filing requirements for one or more commercial lines of insurance, and a more limited degree of waivers relating to commercial policy forms;
5. addresses inefficiencies for multi-state commercial policyholders by introducing a limited form of reciprocity for insurers selling policies to risks operating in more than one state;
6. exempts from rate and form regulation sales made to "Exempt Commercial Policyholders" (state defined large, sophisticated commercial risks); and
7. promotes the use of the System for Electronic Rate and Form Filing (SERFF) through changes that make the rate and form filing process media neutral.

7. Any Other Important Information (e.g., amending an accreditation standard).

Insurers, agent associations and consumer representatives had significantly different opinions regarding the extent to which rates and forms should be subject to regulatory scrutiny. Insurers generally believe that the working group did not go far enough in granting relief from rate and form filing and approval requirements. There were disagreements on where to draw the line that separates a sophisticated commercial buyer from an unsophisticated one. It is safe to say that insurers would generally favor an approach that employs use and file, informational filings or no filings for rate and policy forms. Consumer representatives, agents and regulators were not generally supportive of these options. Insurer representatives were supportive of lower thresholds for defining what type of entity is exempt from various regulatory requirements. Agents were generally opposed to low thresholds fearing an increase in litigation about the advice they provide to clients. Regulators generally opposed low thresholds as a matter of adequate consumer protection. Consumer interests feared that low thresholds place some consumers in an unequal bargaining position when dealing with insurers. Members of the working group have taken a balanced approach that considers the interests of all parties. They are proud of their work effort and believe that they have addressed all concerns. While not everyone agrees with the outcome on every issue, all parties will agree that the working group was open to hearing their issues and concerns. Members of the insurance industry, the producer community and consumer interests believe that a reasonable model law guideline and companion model regulation guideline have been developed.

GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

Table of Contents

Section 1. Purpose

This guideline provides assistance to states updating laws and establishing procedures for allowing accident and health coverage to be procured in the nonadmitted market either independently or through surplus lines brokers. States considering any action to allow accident and health coverage placement with nonadmitted insurers should consider this guideline during a review of existing laws, regulations, and procedures, with particular attention to whether existing insurance laws, tax laws, or regulations expressly prohibit the export of accident and health coverage, contain restrictive definitions with a similar effect, or include substantive provisions that specifically refer in some manner to property and casualty insurance. Amending or interpreting some of these laws to permit placement of accident and health coverage while leaving other property and casualty-specific laws in place in their current form could result in conflicts or unintended consequences.

The types of accident and health coverage that some states are permitting in their nonadmitted market include, but are not limited to, the following: short term medical, international major medical, excess disability, high-risk disability and other similar coverages. It should be noted that comprehensive health plans, Medicare supplement insurance and standard disability insurance coverage are not suitable for the nonadmitted market.

Section 2. Background

The term "nonadmitted insurance" refers to coverage that is not found in the admitted insurance market and can lawfully be sold on a nonadmitted basis. Nonadmitted insurance coverage is typically utilized to insure against a loss that exceeds the maximum limits or benefits found in coverages available within the admitted market.

While nonadmitted insurance coverages are traditionally found within the property and casualty market, there is an increasing need to supplement the admitted market for certain types of accident and health coverages. The federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), passed as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act, applies only to property and casualty insurance.

Nonadmitted accident and health coverage can be utilized to fulfill the risk mitigation needs of certain potential insureds. However, as discussed in more detail in Sections 4 and 6, the greater flexibility found in the nonadmitted market involves tradeoffs with less stringent consumer protections. The following background highlights certain coverages and identifies why the coverage may not be available from admitted insurers:

- There are high-income individuals who cannot procure sufficient disability income coverage in the market as admitted carriers may only offer maximum limits that would replace a lower percentage of these individuals' income than they might require to sustain their needs in case of a disability.

- Individuals in high-risk occupations, such as sports, entertainment, and aviation, are often not eligible for adequate disability coverage in the admitted market.

- International major medical insurance is insurance coverage provided to individuals while outside of their home country. This is a specialty line that might have limited or no availability in the admitted market. Comprehensive health plans issued in the U.S. often restrict or exclude coverage for health care obtained while the covered U.S. resident is visiting another country, for a short or long duration. Also, a foreign national visiting the U.S. may not be eligible for medical coverage from U.S. insurers. In either case, an individual's medical insurance from his or her home jurisdiction may not provide coverage in other countries.

- International travel insurance is designed to provide coverage to U.S. residents traveling abroad where domestic insurers do not provide coverage. It should be noted that this insurance may be subject to coverage requirements of the laws of the jurisdiction where it is effective (i.e., destination country) that may differ from the U.S. These policies contemplate the unique risks involved in travel and can be tailored to fit a particular destination or activity: (e.g., a traveler backpacking in several European countries or a student participating in a study abroad program). In addition, this coverage may be purchased to satisfy insurance requirements for entry into a destination country or to qualify for a student visa.

States have already established laws and processes to which carriers and brokers of surplus lines insurance must adhere. There are jurisdictions that have created a list of types of coverages that may be exported to the nonadmitted market, or that specifically prohibit certain coverage types from being exported to a surplus lines insurer. Additional requirements also apply, such as the obligation to exercise due diligence before a surplus lines broker can place coverage, which may be subject to specific procedures in some states.

Section 3. Definition

Some states have enacted laws that recognize the types of insurance that are eligible for placement with nonadmitted insurers. The NAIC *Nonadmitted Insurance Model Act* (#870), states in part:

> "Surplus lines insurance means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance…."

A state's definition of "Surplus Lines Insurance" or "Nonadmitted Insurance" will often specify the types of insurance permitted by law. A state could elect to expand these definitions to include accident and health coverages. For states that identify specific coverages within their definitions of surplus lines or nonadmitted insurance, this list could be revised to describe the types of accident and health coverage the state has chosen to permit or prohibit.

Section 4. Consumer Protection

The admitted market is closely regulated and features strong, prescriptive consumer protection measures. States should take into consideration the differences between these regulatory philosophies when deciding which types of accident and health coverages may be offered in the nonadmitted market. Steps to ensure consumer protection can be implemented at a statutory level (slowly expanding a restrictive list of allowed coverage in nonadmitted markets) or at a consumer level by requiring disclosures that the coverage is issued by a nonadmitted insurer and what that means for the consumer. These disclosures are particularly important for types of coverage that might be marketed as alternatives to comprehensive health plans, where consumers may expect a high level of consumer protection. This is the tradeoff states should address if they are considering allowing coverage such as short-term medical plans, limited-benefit medical plans, or stop-loss insurance to be offered in the nonadmitted market.

Section 5. Eligibility Criteria for Nonadmitted Insurers

States should review their laws and regulations that set forth eligibility requirements for nonadmitted insurers domiciled in United States jurisdictions to ascertain whether the state's thresholds are adequate for accident and health coverage. Although nonadmitted alien insurers may be eligible on an individual state basis, the NRRA mandates that inclusion on the NAIC's *Quarterly Listing of Alien Insurers* provides eligibility across all jurisdictions for nonadmitted property and casualty insurance. Many states have incorporated this provision into state law. States that maintain an eligibility listing of nonadmitted insurers should consider whether these procedures should be modified to address accident and health insurers.

Section 6. Lines Open for Export; Export Lists

In some states, current law provides broad authority for the Commissioner to designate a particular type of coverage to be eligible for export without compliance with certain conditions, such as satisfying a diligent search requirement. In some states, these laws could permit accident and health coverages to be included on the export list. But other states have explicit prohibitions against exporting accident and health coverage or other provisions that might operate to limit the scope of their export list laws.

Section 7. Exemption from Filing Rates and Forms; Policy Language

Existing state laws establish a regulatory system for transacting nonadmitted insurance. Fundamental to the nature of this business is the exemption from rate and form filings for all types of nonadmitted insurance. Many states have specific provisions that are required or prohibited in some or all nonadmitted policies, but the mechanism for enforcing these requirements is not through a mandatory rate and form review procedure. Some types of accident and health insurance, by contrast, are subject to specific rate and form filing requirements, in some cases mandated by federal laws or regulations. States need to determine how to accommodate these requirements if they are considering allowing these types of coverage to be offered in the nonadmitted market.

Section 8. Licensing of Producers and Surplus Lines Brokers

States need to assess licensing requirements for producers and surplus lines brokers for placement of accident and health coverage. Existing laws might specifically require property and casualty authority as a necessary prerequisite for surplus lines authority.

Section 9. Requirements for Placement

States should review any statutory and regulatory requirements for a diligent search in the admitted market by a producer or surplus lines broker for the type of coverage the customer has requested. Some states may have further restrictions on eligibility for export, such as limitations on the amount of insurance that is procurable over the amount available from admitted insurers. Furthermore, some states do not allow export for the purpose of securing certain advantages, such as lower premium rates or more favorable terms of the insurance policy.

Section 10. Premium Taxes and Reporting Requirements

States should review their existing laws regarding nonadmitted insurance premium tax and consider applying the same tax rate for the calculation and reporting of premium taxes for all nonadmitted insurance. Otherwise, states should amend those laws with specific provisions for the calculation of premium tax for accident and health insurance.

State laws and procedures for consumer notices, reporting policy transactions, premium tax payments, filing affidavits, reports, and other required documents could be expanded to apply to accident and health coverages.

Section 11. Home State Regulation

The NRRA enacts a federal definition of "home state" and provides that the placement of nonadmitted insurance is subject solely to the statutory and regulatory requirements of the insured's home state. This provides for a consistent method of determining jurisdiction for the regulation of nonadmitted insurance. Many states have incorporated this framework into state law. States should consider applying it to nonadmitted accident and health coverages.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2019 Proc. 1st Quarter (adopted).

GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

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GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	ALASKA STAT. ANN. § 21.34.035 (2004/2016).
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	DEL. CODE ANN. tit. 18, § 1915 (2011).
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	KY. REV. STAT. ANN. § 304.10-030 (1970/2018).
Louisiana	LA. STAT. ANN. §§ 22:46(17) to 22:46(17.1) (2018); § 22:433(A) (2018); § 22:438(A)(3) (2018); § 22:446 (2018); § 22:1542(18) (2018); § 22:1547(I) (2018).
Maine	BULLETIN 378 (2011).

GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

NAIC MEMBER	RELATED ACTIVITY
Maryland	MD. CODE ANN. § 3-306.2 (2015/2017).
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY

GUIDELINE ON NONADMITTED ACCIDENT AND HEALTH COVERAGES

NAIC MEMBER	RELATED ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2019

NONADMITTED ACCIDENT AND HEALTH COVERAGES GUIDELINE (#1860)

1. Description of the Project, Issues Addressed, etc.

This guideline will provide assistance to states updating laws and establishing procedures for allowing accident and health (A&H) coverage to be procured in the nonadmitted market either independently or through surplus lines brokers. Due to current market demands, the types of A&H coverage that some states are permitting in their nonadmitted market include, but are not limited to, the following: short-term medical, international major medical, excess disability, high-risk disability and other similar coverages. States considering any action to allow A&H coverage placement with nonadmitted insurers should consider this guideline during a review of existing laws, regulations and procedures.

2. Name of Group Responsible for Drafting the Model and States Participating

The Surplus Lines (C) Task Force formed the Nonadmitted A&H Drafting Group, which consisted of Colorado, Louisiana, Maine, Maryland and Wyoming.

3. Project Authorized by What Charge and Date First Given to the Group

The Surplus Lines (C) Task Force charge indicates that the group is to, "Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The guideline was drafted by the members of the Drafting Group through a series of conference calls and a webinar from October 2017 through September 2018. Each member of the Drafting Group was responsible for research and drafting responsibilities. Following an initial draft of the guideline, the Drafting Group members each proofed the document, and a subsequent conference call was held to discuss modifications.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Guideline was discussed within an open forum during the Surplus Lines (C) Task Force meetings during the 2017 Summer National Meeting and 2017 Fall National Meeting, during an open conference call in February 2018, during the 2018 Spring National Meeting and 2018 Summer National Meeting, and during a conference call in December 2018. During this time period, there were two open exposures of the guideline.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Although comments were addressed from several state insurance regulators and interested parties, there were no issues that would rise to the level of "significant." All comments received during the exposure periods were addressed, and where appropriate, textual revisions were made to the guideline.

7. Any Other Important Information (e.g., amending an accreditation standard)

Not applicable.

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

Table of Contents

Executive Summary

This Implementation Commentary is designed to assist states, PEOs, and the insurance industry to implement a regulatory framework consistent with the *Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements* (#1950) adopted by the NAIC in 2007, which are attached as Appendix A. The Commentary provides a framework for considering the Guidelines and provides additional information concerning:

- The historical background of the Guidelines, including an overview of professional employer organization (PEO) arrangements;
- Differences between the Guidelines and earlier regulatory approaches;
- Statutory and structural considerations for implementation; and
- Key issues that might be essential for successful implementation.

The PEO business model for employment services outsourcing has continued to expand nationwide.[1] While employment services outsourcing and the concept of co-employment involve a number of issues for the states, one significant issue is how state workers' compensation systems adapt to address the requirements of this method of doing business. Presently, there is a broad disparity among the states as to how these and other types of outsourcing arrangements are regulated. The existing statutory frameworks in some states might not directly or adequately address issues related to workers' compensation, while other states are devoid of any significant statutory provisions.

The Guidelines are designed to provide the states with a possible regulatory framework for addressing the most significant workers' compensation issues that have arisen to date in PEO relationships, with an emphasis on a clear allocation of the respective rights and responsibilities of PEOs, clients, and insurers. In some cases, the Guidelines seek to clarify or codify current best practices, while in others, they mandate some significant changes from the status quo. The purpose of this commentary is to provide additional insight from the working group that developed the Guidelines.

I. Historical Background of the Guidelines

The Guidelines are the culmination of more than 18 years of experience, effort, and deliberation by the NAIC, with input from the International Association of Industrial Accident Boards and Commissions (IAIABC). The Guidelines, as adopted in 2007, are the successor to a model statute and regulation, of far more limited scope, adopted by the NAIC in 1991. The Guidelines draw heavily upon the 2002 *Report on Employee Leasing and Professional Employer Organizations* produced by the NAIC/IAIABC Joint (C) Working Group, on input from that Joint Working Group, and on more than three years of deliberation and work by the NAIC Professional Employer Organization Model Law (C) Working Group of the NAIC Workers' Compensation (C) Task Force.

This historical overview is designed to provide a context for those who are seeking to use the Guidelines as a basis for statutory and regulatory actions. While the Guidelines pertain only to the issue of workers' compensation in PEO situations, an understanding of the broader context of the evolution of PEOs and of these Guidelines should assist those using them.

A. Origins of the PEO Industry and the Initial Regulatory Responses

The PEO industry began its evolution in the 1970s as the employee leasing industry. Initially, it involved a client terminating its entire workforce, a leasing company employing that workforce, and then the leasing company providing that same workforce back to the client as leased employees. The idea was for the leasing company to be "the employer" or general employer of the workers, who would be working for the client company as "borrowed servants." Unlike traditional staffing entities that would provide additional temporary workers to a client for specific needs, such as seasonal work or filling in for absences, and then reassign those workers to another client when the need was over, this new concept involved entire workforces on a long-term basis.

[1] The National Association of Professional Employer Organizations (NAPEO) estimates that the PEO industry has grown to $68 billion in gross revenues in 2008. One source for information about the PEO industry is the NAPEO Web site, *www.napeo.org*.

The concept was designed to allow the client to focus on the core business of its enterprise and to leave the employment-related issues to the leasing company, which could save costs through economies and efficiencies of scale usually only available to larger enterprises. The leasing company maintained that, as the employer of the leased workers, it was both able to and required to secure workers' compensation for the worksite employees leased to a client. However, the concept was also susceptible to abuse. As the 2002 NAIC/IAIABC report stated:

There are many reasons for entering into employment services outsourcing agreements. Many businesses become employment services outsourcing clients because they find it to be an efficient way to obtain high quality administrative services, and many of these outsourcing companies have worked hard to develop professional standards for the industry. However, other employment services outsourcing arrangements have been motivated by factors ranging from exploitation of loopholes in rating rules to outright fraud.

In particular, a widespread abuse observed by regulators was the use of employee leasing arrangements for "mod laundering" — that is, the employee leasing company would claim that, as a brand-new employer, its workers' compensation premium should not be affected by the accident experience of its clients before they had joined the employee leasing arrangement. The opaque, poorly documented nature of some employee leasing arrangements also fostered "shell games," in which workers and worksites fell into gaps where neither the client nor the leasing company was paying the premium for the exposure. Occasionally, the leasing company simply charged its clients for insurance it never bought.

Over time, it was generally agreed that "employee leasing" was a misnomer for what factually transpired in the service relationship. From the employees' perspective, their boss was still the client, which continued essentially the same employment relationship with the employees as before. On the other hand, most states recognized that the service firm did also enter into an employment relationship with the employees. Thus, both businesses had employment duties, which were shared and allocated according to the terms of the service contract between the service firm and the client.

Because of these facts, the initial "fire and lease back" concept of employee leasing has largely been abandoned and replaced by the "co-employment" relationship used by today's PEOs. Under this concept, employer responsibilities are shared or allocated between the client and the PEO by contract (and, in some states, by law). Most states now recognize both the PEO and the client as having employer responsibilities with regard to a worksite employee.

Nonetheless, the movement of workers' compensation responsibilities for these employees from client to a leasing company and back, or from leasing company to leasing company, had a major impact on the experience rating system.

Under traditional rating rules, a client customarily lost its experience factor because its entire workforce was absorbed into the leasing company's larger workforce and became insured under a master policy covering the leasing company. As noted earlier, this system allowed unscrupulous leasing companies to offer high-risk, high-experience-factor clients a lower premium by moving the workforce into a leasing company with a lower experience modifier, often a recently organized (or reorganized)[2] company with a "unity" modifier, meaning no adjustment for experience. Experience rating concerns were the principal focus of the 1991 NAIC model act and regulation, which mandated that:

1. Leasing companies must be registered with any state where they did business;

2. A leasing company must use a multiple coordinated policy arrangement in the residual market instead of a master policy; and

3. An insurer in a master policy arrangement must be able to generate the information necessary to establish an accurate experience factor for a client that left a leasing arrangement.

[2] Although the rating rules are designed to prevent employers from reorganizing with a clean slate whenever adverse experience develops, through provisions that combine the experience of predecessor and successor employers, the complexities in the employee leasing relationship and the structure of employee leasing companies as service providers (rather than "bricks and mortar" businesses) provided more opportunities for employee leasing companies and their clients to evade these rules by disguising continuity of operations.

B. Development and Objectives of the Guidelines

As the leasing industry grew and evolved into the PEO industry,[3] the initial NAIC models proved inadequate. Experience rating issues continued to be a problem and additional regulatory concerns were identified. As a result, a second study was undertaken by the NAIC/IAIABC Joint Working Group, the NAIC rescinded the 1991 models, and the present Guidelines were developed.

Several fundamental decisions were made by the Joint Working Group at the outset, which guided development of the Guidelines:

1. Limited Scope – While the Joint Working Group recognized that there are multiple state law and regulatory issues related to PEOs (including other insurance issues, such as health benefits), the Guidelines would be limited solely to the issues of workers' compensation.

2. Multiple Options – The group recognized that there was significant variation across the states with regard to workers' compensation in PEO arrangements. Some states had adopted the initial NAIC models (or a variant of those models), some states required PEOs to use multiple coordinated policies in both the residual and voluntary markets, and other states allowed master policy arrangements in the name of the PEO or leasing company. The Joint Working Group decided to provide guidance that could be adapted and used for any or all of these situations.

3. Voluntary vs. Residual Markets – The Joint Working Group, recognizing the peculiar responsibilities of the residual market, opted to maintain the requirement of a multiple coordinated policy or client-based policy in the residual market. Greater flexibility is allowed under the Guidelines for insurers and insureds in the voluntary market, as long as essential requirements for coverage, experience, and notice are met.

4. Implementation Commentary – Because of the complexity of the Guidelines, the need to address a number of issues legislatively, and the fact that the Guidelines address only the workers' compensation aspects of PEO arrangements, it was decided to issue a companion paper to the Guidelines to give state insurance regulators and legislators additional context for implementation.

Significant changes occurred in the PEO industry and in state-based insurance regulation between the development of the first NAIC model rule and act in 1989–1991 and the efforts of the Professional Employer Organization Model Law (C) Working Group in 2003–2007. In 1991, only four states[4] had any kind of statutory scheme to regulate the PEO (then employee leasing) industry. By the NAIC adoption of the Guidelines in 2007, 32 states[5] had enacted some form of registration or licensing legislation for the industry. While some of these statutes are limited in scope, most of the more recent statutes are more comprehensive and provide significant legislative guidance as to the definition and treatment of the PEO industry. Some specifically address workers' compensation issues and nearly all recognize a PEO as an employer for purposes of workers' compensation.

As work on the Guidelines proceeded, the Working Group recognized the importance of looking, from the ground up, at the tripartite relationship among the PEO, the client, and the insurer, and carefully considering the contractual and financial obligations that each of them has toward each of the other two. As a result, the Guidelines have addressed several areas where the Working Group determined that existing laws and practices needed to be changed, or where vague situations needed to be clarified, including:

[3] Over time, this type of arrangement has become known as a professional employer organization (PEO) co-employment arrangement, where both the PEO and the client have certain employer obligations.

[4] Arkansas, Florida, Maine, and Utah.

[5] Alabama, Arizona, Arkansas, California, Colorado, Florida, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, and West Virginia.

- A formal, documented obligation by the insurer to the client.

- Termination of one co-employer's coverage does not automatically terminate the other co-employer's coverage, especially when there has not been sufficient notice.

- Clear recognition of a payment structure under which the client's obligation is to pay fees to the PEO and the PEO's obligation is to pay premium to the insurer.

- Coverage issued through a PEO must cover the client's full workforce, unless the client has other coverage that provides full "catch-all" protection for any employees who are not co-employed by the PEO.

- Experience must be reported at the client level on an ongoing basis, not just when the client leaves the PEO.

- An experience modification factor will be calculated for all experience-rated clients, even in situations where the insurer and PEO choose to calculate premium on the basis of the PEO's experience.

- Disclosure requirements so that clients clearly understand their rights and responsibilities.

II. Some Legal Issues Relating to Implementation

- **Existing Law**

One of the first issues for a state to consider, when seeking to use or implement the Guidelines, is to assess the status of current state law with regard to PEOs and employer status. The Guidelines are structured as a regulation, but state law must provide a proper statutory foundation in order to be able to adopt all or part of the Guidelines as a regulation. In many states, certain provisions contained in the Guidelines might be more cleanly adopted as statutes, while other states might have concerns about delegation of too much authority to an administrative agency. In addition, some provisions go beyond the traditional bounds of insurance regulation, such as the requirement for a PEO to provide clear and conspicuous written notice to clients if the PEO is not assuming responsibility for workers' compensation coverage. Although providing PEO services without workers' compensation coverage is not the norm, it is not an insurance transaction; it is the absence of an insurance transaction. Thus, unless the insurance regulator has already been given general regulatory authority over PEOs, or the Legislature has otherwise specifically addressed the issue, it would not ordinarily trigger the jurisdiction of the insurance regulator.

For these reasons, it is necessary for each state to analyze its individual situation to determine which provisions contained in the Guidelines are best addressed by directly making those changes to state law, and which provisions are best addressed through enabling language so that the state can adopt the Guidelines provisions through rulemaking.[6] It is important to consider these issues carefully, with due regard for possible unintended consequences. For example, some states, when implementing the 1991 recommendation to prohibit master policies in the residual market, phrased their laws in the form "a master policy shall be issued in the voluntary market," which would appear to prohibit the issuance of multiple coordinated policies in the voluntary market.

In states where "delegation of authority" issues are not substantial, one possible approach is to adopt broad enabling language, such as the following:

[6] As the Drafting Note to Section 1 explains: "These guidelines are presented in the form of a regulation; however, some provisions may be more appropriately enacted as legislation in some states. Agencies promulgating regulations based upon these guidelines should ensure that statutes regulating PEOs or employee leasing arrangements, statutes regulating workers' compensation insurance, or other applicable law grant them adequate rulemaking authority. In states where another agency has regulatory jurisdiction over PEOs, the commissioner should consider jointly promulgating regulations with that agency. Agencies promulgating regulations or drafting legislation based upon these guidelines should also ensure that insurers, PEOs and regulators have adequate resources and infrastructure in place to make compliance feasible, including but not limited to the necessary information systems and the necessary reporting mechanisms for data and proof of coverage."

The Commissioner may adopt regulations establishing the terms and conditions governing the provision of workers' compensation insurance coverage for workers in a professional employer organization arrangement.

An informal survey of state insurance department counsel indicates that most states believe they would have the legal authority to take such an approach. However, some state constitutions or administrative procedure acts would require a more detailed delegation of authority, and states might also have public policy reasons for wanting to address some aspects of the Guidelines more explicitly by statute. There are also additional questions that each state must address:

- Is there an existing registration or licensing system that can be used for (or must be considered when adopting) the registration and reporting requirements?
- Are there existing definitions of PEOs or leasing companies that should or must be used, or that ought to be changed?
- How do existing statutes, regulations, and rating rules governing all employers apply to employers involved in "co-employment" relationships?
- Must statutory provisions be added or modified in order to allow for the Guidelines to be promulgated as a regulation or to make the regulatory approach effective?

The provisions for the exclusivity of the workers' compensation system for workplace injuries is a classic example of the last point, where changes in law might be needed and cannot be accomplished by regulation alone. Traditional statutes do not address employee leasing or PEOs from an exclusive remedy standpoint. Failure to address this by statute could lead to circumvention of the exclusive remedy and breed the types of litigation that workers' compensation was designed to prevent.

- **Key Issues Beyond the Scope of the Guidelines**

The Guidelines relate only to workers' compensation insurance issues. A state considering updating its regulation of PEOs through adoption of the Guidelines should consider whether or not it wishes to approach this area through a comprehensive statute addressing the regulation of the PEO industry, or a global effort to ensure that existing pieces of legislation are consistent with one another and gathering them into a single regulatory scheme, rather than piecemeal rulemaking addressing a limited set of issues against the background of existing law.[7] This is a policy decision that should be addressed with the state Legislature, and should depend in part on how recent and how thoroughly integrated the existing regulatory framework is.

As a part of this process, states should consider how well their existing laws address issues that were identified by the Working Group as being beyond the scope of the Guidelines. These include:

- Concerns raised by cross-ownership of insurers and PEOs.
- Whether adjustments need to be made in existing state law for taxes and assessments when large-deductible policies are issued to PEOs.
- Whether compulsory coverage laws and proof-of-coverage laws need to be amended to clarify the status of PEOs and their clients.
- Whether laws need to be amended to address the employee status and opt-out rights of the owners of client businesses when those owners become PEO co-employees (what one regulator has called the "auto-leasing" problem).

[7] NAPEO, the largest trade association of the PEO industry, has actively promoted registration of PEOs and regulation of the industry. It has developed a model act that contains a comprehensive registration scheme, but its workers' compensation provisions are limited and address only a part of the Guidelines.

III. Specific Issues Related to the Guidelines

Rather than presenting a detailed section-by-section analysis of the Guidelines, this paper focuses on the issues that the authors of the Guidelines identified and how the Guidelines need to be applied in addressing those issues.

A. Statutory-Regulatory Framework for PEOs

A PEO performs a wide range of employment-related services, some of which involve significant amounts of money. These services are relied on by its clients, by employees, by insurers, and by government agencies — and the impact can be devastating if a large PEO becomes insolvent, fails to meet its obligations, or buys insurance and pays taxes based on incorrect information. For these reasons, there is a broad consensus among all interests involved, including leading PEO representatives, that PEO services should be a regulated industry.

There is no consensus, however, as to what form this regulation should take. Should PEOs be licensed or should they be required only to register? Should there be financial requirements and supervision and, if so, what should the requirements be? Almost any regulatory option one could imagine has been used by at least one state.[8] As noted earlier, one of the first and most fundamental questions the Working Group addressed was whether to propose a regulatory framework for PEOs. As important as the issue is, the Working Group concluded that it was not the appropriate body to set comprehensive standards, as its jurisdiction and subject-matter expertise was limited to workers' compensation. The former NAIC model act, adopted in 1991, set up a limited-purpose registration process, requiring a PEO to be registered in order to be issued a master workers' compensation policy or be covered under multiple coordinated policies. However, there was a strong consensus that such a piecemeal arrangement was not desirable, but rather that regulation of PEOs should be comprehensive in scope, involving not only workers' compensation insurance but also other areas, including substantive workers' compensation law, health insurance, unemployment compensation, taxation, and solvency.

Some of these issues are within the purview of other NAIC committees or the IAIABC, and the NAIC/IAIABC Joint Working Group has briefed those bodies and encouraged them to stay involved in these matters. Other essential elements of comprehensive PEO oversight are beyond the jurisdiction of both insurance and workers' compensation regulators. Therefore, the Guidelines are based on the premise that some sort of legislation already exists — as it does in most states — that defines what a PEO is, requires PEOs to be registered or licensed by the state, and recognizes some form of co-employment relationship (either by statute or case law). Section 4 of the Guidelines then provides that workers' compensation coverage may only be provided through a PEO arrangement if the PEO is properly registered (insurers are prohibited from issuing master policies to unregistered PEOs or entering into multiple coordinated policy agreements with them) and Section 15 provides for administrative enforcement by the insurance commissioner.

The Guidelines attempt to recognize the diversity of state laws currently regulating PEOs, and include a number of drafting notes to provide guidance. Drafting notes to Sections 1 and 15 suggest that if a different state agency has regulatory jurisdiction over PEOs, the regulations implementing the Guidelines should be promulgated jointly by that agency and the insurance commissioner. If a state does not currently register or license PEOs, and does not enact such a requirement at the time it implements the Guidelines, a drafting note to Section 4 suggests that as a fallback, the regulation could require a limited-purpose registration similar to the 1991 model act. Similarly, Subsection 3H appears in two versions, one for use in the states that already have a statutory definition of "PEO," incorporating the statutory definition by reference, the other version spelling out an explicit definition for use in the states that need one.

[8] Currently, the most common state regulators of PEOs or employee leasing companies are insurance departments (Arkansas, Illinois, Indiana, Louisiana, Maine, North Carolina, Oklahoma, and West Virginia); labor departments (Colorado, Connecticut, Montana, New Hampshire, New Jersey, New York, and Vermont); or the industrial or workers' compensation commissions (Alabama, Kentucky, Nevada, Ohio, Oregon, and Virginia).

Other potential inconsistencies between current state laws and the Guidelines are less likely to have a substantive impact on the Guidelines, but still need to be addressed in some manner.[9] Implementation of the Guidelines is a good occasion for the states to review their current regulatory frameworks for PEOs to see if changes should be made and to evaluate how the Guidelines best fit. As recognized in various drafting notes, changes to the Guidelines to adapt to the state's structure and terminology might be necessary. In particular, references to "registration" of PEOs need to be changed to "licensing" in states that require licensure, the term "PEO" needs to be modified if the state uses some other terminology such as "employee leasing," and references to "co-employees" need to be changed in the states that do not recognize co-employment.

B. Master Policies and Client-Level Experience Rating

As indicated above, the issue that originally prompted the concern of insurance regulators and workers' compensation regulators related to the inability of experience rating systems to track experience of individual employers when they became clients of employee leasing firms (later PEOs). Much of this concern is eliminated with multiple coordinated policies, because current insurance statistical and data handling structures have the ability to track experience from separate coordinated policies and to produce experience ratings using all of the client employers' past experience. The fundamental challenge has been "master policies," where multiple client employers are covered under a single policy issued in the name of the PEO.

For this reason, the Working Group gave serious consideration to recommending that master policies be prohibited entirely. However, because of the potential efficiencies that could be realized from the master policy model, representatives of the PEO and insurance industries strongly urged the Working Group to consider whether there was a way to permit master policies that could satisfy regulatory concerns. The Working Group, therefore, took as its starting point the recommendation in the 2002 NAIC/IAIABC Joint Working Group report that the only acceptable alternative to prohibiting master policies would be:

… allowing master policies but with client-specific notice requirements and payroll, loss and other data reporting requirements that would give the client a status similar to that of an individual insured under a group policy.

If the latter approach is taken, careful attention must be paid to the need to guarantee that coverage cannot be terminated or materially altered by the insurer or by the employment services outsourcing company without reasonable advance notice to the client. It is also important to maintain and report accurate and up-to-date information in sufficient detail to permit the calculation of meaningful client-specific experience ratings and verification of proof-of-coverage on the client level. In practice, this may be a moot point, since insurers and employment services outsourcing companies may not consider the master policy a worthwhile option if client-by-client recordkeeping and reporting are unavoidable.[10]

Despite the skepticism that had been expressed, the Working Group and the interested persons were able to reach consensus on a regulatory framework for master policies. In particular, the Guidelines require experience reporting at the client level and the production of experience ratings on an ongoing basis for every client of sufficient size to be eligible for experience rating. This requires two essential enhancements to the current system. One is the ability to identify each client workforce as a discrete unit of coverage, even if coverage is provided to the PEO on a master policy and the client does not purchase a separate policy.[11] This is primarily a regulatory issue, and is one of a number of reasons the Guidelines have adopted a "certificate of coverage" requirement, under which each client is issued a coverage document outlining its rights and obligations under the master policy and clearly establishing both the identity and

[9] A majority of the states have existing provisions addressing workers' compensation in PEO arrangements (some using the older "employee leasing" terminology).

[10] NAIC/IAIABC Joint Working Group *Report on Employee Leasing and Professional Employer Organizations* at 32.

[11] Section 11 of the Guidelines requires that all loss reporting be conducted in a manner that will allow for the experience rating of the client to be maintained on a stand-alone basis.

status of the client and the inception and termination dates of coverage.[12] This has occasionally been a source of misunderstanding because of the traditional usage of the term "certificate of insurance" in the context of the property/casualty insurance industry. Like the certificates issued by insurers under group life and health policies, this is a legally binding coverage document, not just a representation of the status of coverage at some point in time, and has the effect of making the client an additional insured under the policy.[13]

The other essential element of an improved experience rating system is an effective data reporting infrastructure. This is also necessary to make proof of coverage (POC) function effectively at the client level, but it is not something that can be established simply by legislative or regulatory decree. What is mandated must actually be feasible, and those implementation issues are discussed below in "Data Reporting."

Although the Guidelines require the maintenance of separate experience modification factors for each client that is subject to experience rating, they do not mandate the use of those factors when setting premium rates for PEO coverage in the voluntary market. Although a prudent insurer could be expected to consider this information, the Guidelines leave the ultimate decision to the agreement of the parties. One reason for providing this flexibility is that, in some situations, if a PEO has a relatively stable or homogeneous client base, the PEO's aggregate experience might provide meaningful information that client-level experience does not provide. This is because the individual client experience will likely be more volatile and less credible, especially for smaller clients, some of which might be too small to be subject to experience rating at all. Another reason a PEO is not necessarily merely the sum of its clients is that the PEO's risk-management activities might also have an impact on anticipated losses, hopefully for the better. The enhanced data-reporting requirements under the Guidelines can help carriers evaluate whether a PEO is providing effective loss-control services.

The Guidelines also make provision for experience rating in split workforce situations, because the PEO co-employees and the client's direct hire employees will, according to the Guidelines, have the same experience modification factor, but they might have very different risks, especially if the PEO takes on only the safest or most hazardous work units. In these situations — especially if separate experience modification factors cannot be calculated with reasonable accuracy — insurers are allowed to use their reasoned underwriting judgment.[14] The Guidelines also prohibit splitting a client's risk between the residual and voluntary market, an arrangement that has caused problems in the past.[15]

In order to implement an experience rating plan that complies with the Guidelines, adoption of regulations might not be all that needs to be done. It will be necessary to ensure that the state's workers' compensation advisory or rating organization has submitted a compatible experience rating plan, and it also will be necessary to review the experience rating statutes for possible inconsistencies. In particular, any provision that might be construed as mandating the treatment of the PEO as "the employer" for experience rating purposes will need to be revised, and if the state chooses to adopt the provisions allowing the parties to choose an alternative experience rating methodology in the voluntary market, the mandatory experience rating provisions need to accommodate that flexibility by giving the Commissioner sufficient authority through the rulemaking process or the rating plan approval process.

[12] Specifically, the certificate must: 1) specify the effective date of the client's coverage and the expiration date of the underlying master policy (with a renewal certificate issued when the master policy is renewed); 2) provide that coverage shall continue as long as the master policy and the PEO agreement between the PEO and the client both remain in force, spelling out any exceptions; and 3) provide that termination of coverage without replacement requires 30 days' advance notice to the client. Subsection 7D.

[13] Subsection 7B.

[14] Subsection 12B.

[15] Subsection 6D.

C. Lack of Coverage, Gaps in Coverage, and Proof of Coverage

Coverage gaps and omissions are anathema to the workers' compensation ethic. Insurance regulators and workers' compensation administrators agree that the structure of the workers' compensation system should make gaps and omissions in coverage nearly impossible. A well-designed POC system is one essential tool in preventing coverage failures, which should rarely occur once a business has been identified by the system as having employees.

One of the Working Group's most pressing concerns, as it developed the Guidelines, was the awareness that the traditional approach to coverage for PEO arrangements has given rise to several sources of coverage failures:

- Tracking a client in and out of a PEO arrangement: Traditionally, coverage has been reported in the name of the policyholder, which is always the PEO in the case of a master policy and is often the PEO in the case of a multiple coordinated policy arrangement. Unless the POC system also tracks coverage at the client level, it will lose track of an employer when it becomes the client of a PEO and will be unaware of the existence of a new business that becomes a client of a PEO immediately upon its creation. While this might be unimportant when the employer remains a fully covered client of the PEO, it can become a problem when the PEO-client relationship comes to an end while the client's business continues. At that point, a POC system that has not been tracking the client will have no way to know that there is an active, operating employer whose workers' compensation coverage has terminated, unless and until the former client obtains replacement coverage.

- Disputes over client status: If a master policy provides generic coverage to all the unnamed clients of the PEO, it might be unclear and open to dispute whether a particular employer was a covered client. Even when there are clear records demonstrating that a PEO-client relationship existed, they might not be sufficient to establish conclusively when the relationship began, when it ended, or whether it was in place at the time of the accident.

- Split-workforce arrangements: A client employer may choose to engage a PEO for only a specified segment of its entire workforce. Ordinarily, all of an employer's employees within the state are covered under a single policy, but the split-employment arrangement results in split coverage when some work units are covered through the PEO and others are not. This can give rise to coverage disputes if the status of a particular employee is not clear. There is also the danger that the state's compensation administrator will receive a POC report from the PEO's insurer, but not realize that the coverage is only for some of the client's employees, and thus allow the client to operate with the rest of its workforce uninsured. Therefore, when split workforce coverage is permitted, the POC system must not only track the coverage at the client level, but also must identify which work units are covered under the policy and whether that coverage is partial or complete.

- "Orphan" employees: One of the most common and dangerous types of split-workforce arrangements is unintentional (or at least is not the stated and acknowledged intent of the parties). The parties intend for all of the client's employees to be co-employed by the PEO so, in theory, there is full coverage even if the policy's terms limit coverage to the PEO's co-employees. However, because there is only one policy, if there is anyone who is not covered through the PEO, then that employee is not covered at all. The most common danger here is the employee who is not treated as an employee, and whose existence might even be unknown to the PEO and/or its insurer — this might be someone who is held out by the client (often in good faith) to be an independent contractor, or someone who is employed by an uninsured subcontractor of the client. If the policy were issued directly to the client, it would clearly cover all employees of the client, whether or not disclosed to the insurer. However, if the policy is issued to the PEO, these employees risk falling through the cracks because they were never employed by the policyholder. There also are cases where there is no dispute that the worker was employed by the client, but the PEO's insurer disputes whether the necessary steps were taken for the worker to be hired by the PEO, especially in the case of casual employees, such as day laborers who might not have been placed on the PEO's payroll.

- Insolvency: Another factor that increases the risk of coverage disputes is the insolvency of the PEO, the client, or an insurer. If the PEO becomes insolvent, its insurer might use the PEO's failure to comply with its obligations as a basis for contesting coverage. Often, in these cases, the situation is made worse because existing law generally gives the PEO the responsibility of notifying individual clients. When the PEO is already out of business, or generally defaulting on all of its other obligations, the clients are unlikely to be receiving the notice to which they are entitled. If the insurer becomes insolvent, the receiver or the guaranty fund might take a fresh look at the validity of categories of claims the insurer had been paying routinely, especially if PEO losses are perceived as a contributing factor in the insolvency. The receiver also will be cancelling coverage, and clients might not receive this notice in a timely manner when the PEO is the named insured. And, in split-workforce arrangements, the coverage difficulties already noted earlier are complicated, not only by the increased likelihood that any claim that can possibly be contested will be contested, but also by the possibility of additional grounds for disputing a claim. In particular, when there is a solvent insurer on the same risk — even if the insolvent insurer would clearly have had primary responsibility for the claim in the ordinary course of operations — a guaranty fund could argue that the other insurer must pay before the guaranty fund despite providing only secondary coverage.

The Guidelines provide regulatory language (or statutory language in states that enact these provisions by statute) to respond comprehensively to these potential sources of gaps or omissions. It must be emphasized, however, that these protections are incomplete unless the state's POC laws and the advisory organization's POC data system provide a mechanism that effectively tracks coverage at the client level. In addition, there must be an effective mechanism for verifying that PEOs doing business in the state are properly insured, which can be accomplished through either the PEO registration process, some type of two-tier POC system for PEO arrangements that simultaneously tracks worksite employers and a separate PEO category, or a combination of the two approaches. Currently, many states with a comprehensive regulatory framework for PEOs mandate separate reporting by a PEO of incoming and exiting clients. This might be considered as a part of, or supplement to, the present POC system.

Two important new safeguards against coverage failures established by the Guidelines are:

- The certificate of coverage mechanism discussed earlier, which — when properly implemented by insurers and regulators — ensures that even under a master policy, each client's coverage has a clearly established inception and termination date, with adequate advance notice to both the client and the POC system before a client's coverage can be terminated or replaced.[16]

- A presumption that a PEO's policy ordinarily provides full workforce coverage to all covered clients, meaning that coverage during the relationship is equivalent to the coverage a client would have under a stand-alone policy.[17] The PEO's insurer does have the right to issue a policy that limits the scope of coverage to PEO co-employees, but only a full-workforce policy can be used to satisfy the clients' coverage obligations,[18] so there is an expectation that PEOs and their clients will only be interested in non-full-workforce coverage, when they intend from the outset that the PEO arrangement will only cover a portion of the client's workforce.[19]

[16] West Virginia took a different approach in its new PEO law. Under the Guidelines, an insurer issuing a master policy has no responsibility to a client if no certificate of coverage or its equivalent was ever issued by or on behalf of the insurer, unless the insurer is in some way responsible for the failure to issue the certificate. The PEO is obligated to give clear written notice to the client if it provides PEO services without providing workers' compensation coverage, Paragraph 4C, but if the PEO fails to comply, it is the PEO that bears the liability to the client, not the insurer that did not provide the coverage. By contrast, under West Virginia's "stopgap" provision, the PEO's insurer is responsible if the client has no other coverage. *See* W. Va. Code St. R. § 85-31-6.1. These provisions do not bar the insurer from pursuing indemnification from any solvent party that may be at fault.

[17] Paragraph 7A(1): "If the PEO agreement with a covered client is a full workforce PEO agreement [as defined in Subsection 2(E)], the policy or certificate shall cover all PEO co-employees and shall also cover any other obligations of the client under [insert appropriate statutory reference] to the same extent as if the client had obtained a direct purchase policy in this state."

[18] Subparagraph 7A(2)(b), which also makes an exclusion for the client's direct hire employees unenforceable if the insurer has reported the policy to the POC system. A drafting note advises states to allow non-full-workforce policies to be reported as secondary coverage if a state's POC system tracks both primary and secondary coverage.

[19] The Guidelines contain a drafting note allowing for a "Designated Workplaces Exclusion Endorsement" in this situation where allowable under existing law and regulation. However, under such an exclusion, the client must maintain separate coverage for the workplace in question.

The provision making full-workforce coverage the norm and more limited coverage the exception was one of the most controversial decisions made by the Working Group. Insurers objected that making them cover any unknown employees of a PEO's clients would undermine the certainty they seek when they deal with the PEO. Regulators acknowledged this point, but ultimately decided that an essential feature of the workers' compensation system is that somebody must take responsibility for ensuring that there are no orphan employees. If it is not the PEO's insurer, then it must be the client's insurer, and reasonable steps must be taken to verify that the client does indeed have an insurer that provides the same all-inclusive coverage that any traditional statutory workers' compensation policy provides for all employees, whether or not listed on the employer's payroll.[20] The client's representation that it has no direct-hire employees is not sufficient; after all, if it were sufficient, the PEO's insurer would have no qualms about writing full-workforce coverage in the first place.[21]

Moreover, even if it issues a limited policy, a PEO carrier becomes liable under the Guidelines for full-workforce coverage if it does not promptly issue notice of termination after learning that the client's coverage has been cancelled or is otherwise not in effect. This provision does not address every potential gap in coverage, however, because it does not apply in a situation where the PEO carrier is not aware of the cancellation or termination of a client's policy. After considerable debate and consideration of input from carriers, the drafters of the Guidelines concluded that a cross-notice provision they had originally proposed was unfeasible, and that the offending client would have to bear the consequences of being treated as an uninsured employer.[22] The Guidelines also include provisions for the uninterrupted payment of benefits if the insurers dispute who is responsible for a claim (the client's insurer is provisionally responsible, subject to reimbursement by the PEO's insurer if the dispute is resolved in favor of the client's insurer),[23] and for situations where a PEO agreement is terminated but the workers covered by the PEO continue as employees of the client[24] or where there are two insurers and one becomes insolvent.[25]

D. Notice and Cancellation of Coverage for PEOs and Clients

Workers' compensation coverage is a mandatory requirement for almost every business in almost every state in the United States. It is essential, therefore, that employers who are clients of PEOs receive timely notice before their coverage is terminated without their consent. In a PEO arrangement, the client usually relies on coverage purchased by a third party (the PEO). Because the client remains fully responsible for workers' compensation benefits for its employees, the consequences for the client can be disastrous if that coverage can be terminated without the client's advance knowledge.

This is especially true in PEO relationships, because if a PEO should terminate its co-employment of the client's employees, the client would almost certainly continue its operations as the sole employer of its workers. Doing so without coverage would violate state workers' compensation requirements and be illegal. As a result, the client would be exposed to penalties for operating without insurance, possibly including closure of the business, and exposure to both workers' compensation and tort liability for workplace accidents. Recovery of any resulting losses or penalties from the PEO is likely to be uncertain, slow, and difficult at best. In fact, there would be no prospect of meaningful recovery in situations where the PEO itself has failed and there is no one left to pay a judgment, which unfortunately is one of the situations where the normal communication procedures are at the greatest risk of breaking down.

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[20] Subparagraph 7A(2)(a): "A PEO's insurer may not issue or renew coverage with a direct hire exclusion unless it obtains satisfactory evidence demonstrating that the client has coverage for all of its other workers' compensation liabilities."

[21] Subparagraph 7A(2)(e).

[22] It should be noted that this approach also creates a risk of exposure for the uninsured employer fund, in states that have them. West Virginia has decided that concerns such as these outweigh the burden of holding the PEO's insurer responsible for the ongoing verification of client coverage.

[23] Subparagraph 7A(2)(d). In West Virginia, on the other hand, the PEO's insurer is responsible in these situations. *See* W. Va. Code St. R. §§ 85-31-6.1 & -6.2.

[24] Subparagraph 7A(2)(f).

[25] Subparagraph 7A(2)(g).

The 1991 NAIC *Employee Leasing Model Regulation* (#936) tried to address this issue by requiring the PEO to notify all of its clients within 15 days after receiving notice that its workers' compensation policy would be cancelled or nonrenewed. However, this left PEO clients with seriously diminished rights, as compared to employers who purchased coverage directly. It also left unaddressed the issue of termination of the PEO arrangement and placed notice issue in the hands of the PEO rather than the carrier.

Under standard workers' compensation policies and practice, and typical state insurance laws, if an insurer fails to give its policyholder timely notice of cancellation or nonrenewal, the termination is invalid and the policyholder remains fully insured. However, where the policyholder is the PEO, or even if the policyholder is the client but its address of record is "care of the PEO," the insurer can comply with its own legal obligations without any guarantee that any notice will actually get to the client. Furthermore, under some scenarios, the client could already be without coverage before the PEO was required to give notice under the 1991 model.

An essential element of the Guidelines is to address what should be one of the client's most valuable rights: continued coverage until adequate notice of cancellation is provided.

The Working Group concluded that the insurer must be responsible for notice in every case where the client is dependent upon receiving timely notice in order to maintain coverage.[26] The insurer can still delegate this function to the PEO, but if that process breaks down, then the insurer must provide extended coverage to the client, subject to applicable premium charges, for the duration of the statutory notice period. Nothing in the Guidelines prevents the insurer from holding the PEO responsible for any failure to comply with its contractual duties, nor from requiring the PEO to post security for the performance of its obligations, but the insurer may not seek recourse from the client for the PEO's default.

For these reasons, cancellation or nonrenewal of a client's coverage is not valid unless either:

- Thirty (30) days' advance notice has been delivered to both the client and the POC system. If termination is initiated by the PEO, this notice may be delivered by the PEO (with notice to the insurer);

- The client initiates or affirmatively consents to the termination. However, the Guidelines expressly prohibit circumventing restrictions on involuntary termination through such devices as documents authorizing the PEO to cancel coverage "voluntarily" on the client's behalf;[27] or

- The PEO has replaced coverage with no break in coverage and provided advance notice to the insurer, the client, and the POC system. This exception only applies if valid replacement coverage has actually been obtained. In that case, any dispute over the cost or other terms of the replacement may be sorted out between the actual parties to the dispute without worrying that the client might go bare.

The relationship between the PEO and the insurer, on the other hand, is closer to the traditional insurer-policyholder relationship and, therefore, raises fewer unique issues that need to be addressed in the Guidelines. Accordingly, the Guidelines explicitly provide that, "A master policy or a coordinated policy may be cancelled or nonrenewed by the insurer on the same grounds and subject to the same conditions as any other workers' compensation insurance policy." It is important to keep in mind, however, that for the reasons discussed earlier, even though the PEO's default on its obligations may result in loss of coverage for the clients, there must be timely notice before that loss of coverage can be effective, and notice to the PEO can never substitute for notice to the clients. Indeed, if the client's coverage must be terminated for reasons beyond the client's control, it is all the more important that the client be given ample time to obtain appropriate replacement coverage.

[26] Section 10.

[27] Subsection 10E.

The Guidelines, therefore, expressly contemplate that even after cancellation or nonrenewal has taken effect as between the insurer and the PEO, the insurer might still have a continuing obligation to cover the client. If that happens, the insurer must implement some other mechanism for providing coverage to the client, and may bill the client directly for that coverage. This situation is especially likely to arise in states that allow expedited cancellation of workers' compensation policies for nonpayment.

A drafting note to the Guidelines advises that, "If applicable state law permits involuntary termination of workers' compensation coverage upon shorter notice in some or all situations, states may consider modifying this provision accordingly." The statutory basis for expedited cancellation of a policy is usually nonpayment of premium. However, states should recognize that nonpayment by the PEO to the insurer does not constitute fault on the part of the client, which might be having similar difficulties of its own if the PEO has stopped performing its obligations. The Guidelines make clear that a client's failure to pay fees when due to the PEO does not constitute nonpayment of premium.[28]

This raises another important issue not adequately addressed by the 1991 model; i.e., responsibility for premium payment. The essence of the PEO coverage model, whether it is implemented through a master policy or multiple coordinated policies, is that the PEO is responsible for paying the premium to the insurer. In turn, the PEO charges fees to its clients that are intended to be sufficient to cover its cost of workers' compensation insurance and all other services provided by the PEO. When the insurer has accepted that the PEO is serving this role, the client is entitled to rely on that acceptance unless and until the insurer has notified the client that any future bills must be paid directly to the insurer. Therefore, the Guidelines provide that, for coverage provided under a master policy or multiple coordinated policy agreement, the insurer's only recourse is against the PEO; i.e., if the PEO defaults on its obligations, the client is protected against being billed a second time for workers' compensation coverage after it has already paid the PEO in full. The need for the insurer to pursue recovery from the PEO might pose difficulties for the insurer, but these can often be mitigated by obtaining adequate security in advance.

But what if the client has not paid the PEO in full? The client's obligation to the PEO is important, but it is a contractual matter between the PEO and the client. Because of the broad and varied scope of PEO services, which extend to matters well outside the scope of an insurance department, the Working Group did not support the regulation of PEO fees. The Working Group considered, but did not favor, a proposal to treat the PEO as a payment intermediary with workers' compensation premiums itemized and billed separately. As a result, fee regulation under the Guidelines is limited to disclosure requirements and prohibitions against insurance-related misrepresentation (See "Pricing" below).

This means that fee disputes and termination disputes between clients and PEOs cannot be resolved through the insurance department's administrative processes. The nature of the PEO-client relationship makes it unrealistic to require good cause for termination, let alone to require the PEO to maintain a client against the PEO's will if good cause is lacking.[29] And without regulated fees or pass-through billing of insurance premium, the complexity of the claims and counterclaims that might occur makes it inappropriate to treat fee disputes as similar to premium disputes. Accordingly, the Working Group did not adopt the PEO industry's request to allow expedited cancellation for nonpayment of PEO fees, in those states that allow expedited cancellation for nonpayment of premium. However, some states allow expedited cancellation for fraud, and those states should consider whether cases involving fraud committed by the client would be within the scope of the Drafting Note on expedited cancellation.

Another termination issue that the 1991 model does not address is the nature of the insurer-employer relationship under a multiple coordinated policy arrangement. Should the client have the right to convert its policy to a direct purchase policy if it leaves the PEO, or should leaving the PEO be a valid ground for terminating the client's coordinated policy? Some regulators felt that an insurer ought to make the same full-year commitment when it issues a coordinated policy covering a business as it does when it issues a direct-purchase policy. However, insurers replied that in the voluntary market, participation in a multiple

[28] Subsection 8A.

[29] Although the Guidelines prohibit the cancellation of workers' compensation coverage until adequate notice has been provided, they expressly acknowledge that other PEO services may cease immediately upon termination of the PEO agreement to the extent permitted by law, and require this to be disclosed to the client. Paragraph 4D(3).

coordinated policy arrangement through a PEO is often an essential condition for their acceptance of the risk, and termination of that arrangement represents a material change in circumstances that justifies termination of coverage. The insurer might not even have an applicable rating plan for direct-purchase coverage for that class of business. Based on those considerations, the Guidelines provide that the client should not have a legal right to convert to direct-purchase coverage if the PEO relationship terminates. The insurer has the option to allow this, but it also should have the option to terminate coverage once adequate notice can be provided. This means that if the PEO relationship is terminable at will at any time, then the insurance policy might be as well, but the insurer's obligation to provide full statutory notice means the client is left with time to shop for replacement coverage and is in essentially the same position as if it had not joined the PEO in the first place. It should be noted that, because cancellation of coverage must be initiated by the insurer, the process depends on the PEO giving timely notice to the insurer. Until this happens, the client continues to be covered and the PEO continues to be responsible for the premium.

Of course, if the Guidelines conflict with applicable cancellation statutes, then the statute must prevail. If termination of the PEO relationship is not considered a breach of a valid contractual condition or a sufficiently material change to justify cancellation under applicable state law, a drafting note to the Guidelines recognizes that those states must either amend the statute to provide a new permitted ground for cancellation, or revise their regulation to conform to the statute by mandating conversion to direct-purchase coverage in lieu of cancellation.

E. Policy Forms

As we have seen, the Guidelines require a number of changes in the terms of the insurer-insured relationship, and also in how some of the existing terms are documented. This will require changes to the policy forms, and careful review by regulators. In addition, many of the existing standardized forms and endorsements developed by advisory organizations have been in place in substantially similar form for many years and, in some cases, the language reflects terminology, such as "employee leasing," that is no longer in widespread use. If a significant number of states adopt an approach substantially similar to the Guidelines, the use of standard language will be helpful to all stakeholders, especially insurers, PEOs, and clients that do business on an interstate basis. This means the standardized endorsement language currently in place will need to be updated, and new standard forms will need to be developed: in particular, multiple coordinated policy agreements and master policy certificates of coverage. Insurers, PEOs, producers, clients, and regulators should all be working with the advisory organizations in this process.

F. Data Reporting

In order for workers' compensation administrators and insurance regulators to maintain the experience rating and POC systems discussed in the previous sections, both they and the rating agencies or advisory organizations must have the statistical data essential to enforce and monitor the workers' compensation system. The statistical data must be sufficient to enable the state's compliance administrator to identify efficiently whether an employer within the state has the coverage required by law, and track the employer's claims experience and benefit payments. The method of coverage chosen by an employer must be reported to the compliance administrator as proof that the protection exists on that job site, and subsequent changes to that method must also be reported. For experience rating, Subsection 11A of the Guidelines requires all loss and payroll reporting to be "conducted in a manner that identifies both the PEO and the client, and enables the calculation of experience modification factors" at the client level.

It was generally acknowledged during the development of the Guidelines that data reporting is not a significant issue where coverage is client-based (i.e., either through a stand-alone client-based policy or through a multiple coordinated policy arrangement where each client is identified on a separate policy). The main data issues appear to relate to master policies, or to multiple coordinated policies that are in the name of the PEO and do not adequately identify the individual client or do not adequately enable the reporting of client-level data needed for experience rating and POC systems. Concerns also have been expressed about the reporting of multiple coordinated policies when the policies are issued with the PEO, rather than the client, as the principal named insured, which is an option expressly permitted by the Guidelines as long as it is done "in a manner that clearly specifies the identities of the PEO and client and clearly describes the scope of coverage."[30] Subsection 11A of the Guidelines mandates that all such data be

[30] Subsection 7E.

maintained and reported by carriers at the client level, regardless of whether coverage involves a multiple coordinated policy arrangement or a master policy,[31] but does not dictate how this is to be done.

There was significant debate as to the nature of the data-reporting issue, who was responsible, and how to resolve the difficulty. Various carriers said they were able (or were not able) to provide client-based data, rating agencies said they were (or were not) able to handle the data in PEO arrangements, and the states indicated varying levels of sophistication with regard to data collection and/or use. These technical issues are important, but establishing the necessary technical infrastructure is beyond the scope of the Guidelines. Instead, an effort was made to identify the goals of the Guidelines based on an assumption that the technical issues could be resolved.

The root of these technical issues is that present industry standards for the reporting and collection of data are based on separate policies for each employer. These standards support the constant exchange and use of data from carriers' systems to data-collection organizations and, subsequently, to many states' compliance systems. While some industry standards have changed to assist in the complex reporting of PEO-related data, the ability to make significant changes has been limited both by cost considerations and the need to be careful about preserving current capabilities for exchanging data. Additional requirements or changes to industry standards are meaningful responses only if compliance is technically feasible. A significant challenge with reporting and tracking client-level data is that clients can be added or terminated during the policy period, or move from one PEO relationship to another. These activities make it challenging to report and track individual client experience and coverage without separate policies and without substantial changes to industry standards and major costs.

The Workers *[sic]* Compensation Policy Reporting Specifications (WCPOLS) system, the electronic data-entry system jointly created by the nation's rating agencies, has for many years included a functionality that can identify whether a workers' compensation policy is related to a PEO arrangement. Similarly, the National Council on Compensation Insurance (NCCI), the country's largest advisory and rating organization and POC provider, has developed and implemented an MCP model that is widely used in the residual market. However, issues still remain as to how information on voluntary market policies is provided to and processed by rating agencies and users. For example, it is reported that the "PEO-related policy" flag is not used consistently, for example, and this information is not sufficient by itself to allow client-level data to be tracked effectively.

According to NCCI, a number of issues continue to be significant when determining how compliance requirements can be met and addressed. Under the 1991 model, the delivery methodology chosen for creation of an experience modification for a company leaving what was then called an employee leasing arrangement was the filing of a paper report and a manual calculation. Time has proven that to be both unreliable and inefficient.

Currently, an increasing majority of states statutorily recognize both a PEO and its clients as employers for purposes of workers' compensation. The Guidelines themselves provide the potential for multiple means of providing coverage in a PEO arrangement.[32]

One solution might be to develop some form of system for master policy situations that parallels the multiple coordinated policy framework for reporting data. This would require both carriers and rating agencies to be able to segregate data for clients of PEOs as if each had an individual policy. Carriers that are engaged in PEO coverage indicate a willingness to provide this client-level data, as do the PEOs themselves. NCCI has provided a technical supplement outlining various alternative mechanisms for reporting and compiling this information.[33] However, NCCI has warned that any option requiring significant changes to industry standards, including operating and reporting systems, would be difficult to implement and costly to the industry.

[31] Subsection 7J; *see also* Sections 11 and 12.

[32] Section 3.

[33] See Appendix B.

While insurers and rating agencies have historically managed their data systems to respond to both regulatory and industry needs, it is the states' ultimate responsibility to determine what data they need and what they will require rating agencies to do. Where possible, the Guidelines have attempted to generate greater, rather than less, flexibility, providing a clear mandate to provide both the states and the rating agencies the data that will allow experience rating programs and POC systems to operate at the client level, but without micromanaging the details of system design. There is, nevertheless, certain basic information that must be collected for both the PEO and its clients:

- Employer Identification – This includes the name of the employer and any Federal Employer Identification Number (FEIN) or Social Security Number (SSN) associated with the employer.

- Location – This includes the actual address of the client, and not just the mailing address of the PEO.

- Payrolls and Classifications – Payrolls must be assigned to appropriate class codes on a client-by-client basis, with the ability to identify the PEO that is involved.

- Loss Data – The same loss data that is required for all other policyholders, in a form that can be attributable to both the client and the PEO.

- Coverage Information – This includes policy dates, the nature of the policy, states that are covered, etc.

Regulators, and many within the industry, contend that this is information a well-managed insurer would want to collect anyway and, therefore, ought to be the wave of the future. One current impediment — the fact that some carriers issuing master policies simply do not track coverage at the client level in the first place — should vanish once the Guidelines' certificate-of-coverage requirements are in force. Carriers also must recognize that issuing coverage on a master policy basis is an option, not a necessity, and if they are unable to issue master policies in compliance with state laws and regulations consistent with the Guidelines, then they can switch to multiple coordinated policies, as some states currently require.[34]

Given that a large majority of states now statutorily recognize PEOs as employers for workers' compensation (and that number is growing rather than shrinking) and that the PEO concept of co-employment is likely to continue, the states and the requisite stakeholders (workers' compensation administrators, rating agencies, carriers, and PEOs) will need to work cooperatively to address system issues. In particular, this includes a nationwide effort to coordinate the evolution of data collection and processing in a consistent and cost-effective manner. At least for a period of time, those states seeking to adopt laws and regulations consistent with the Guidelines might find themselves having to deny carriers the ability to write PEO coverage on a master policy basis until they can have sufficient assurance that client-specific data to support POC and experience rating systems will be reported.

G. Exclusive Remedy

Workers' compensation was designed as a mandatory (in most states) no-fault system to guarantee compensation to a worker injured on the job and, in return, protect the employer from protracted litigation or extraordinary liability for normal worksite injuries. Employers are required to buy workers' compensation coverage (or, in the case of self-insurance, provide it themselves under regulatory oversight), and the insurance or self-insurance is required to cover all worksite injuries. The worker gains certainty of coverage for worksite injury but (except in certain egregious situations) gives up the right to sue in tort for those injuries. The workers' compensation system has become the "exclusive remedy" for recovery if the employer complies with its obligation to maintain coverage.

[34] *See, e.g.,* N.J. Admin. Code, Title 12, § 16-24.6.

In most states (either by law or by interpretation), this exclusive remedy has been extended to protect employers that borrow workers from liability, if the employer supplying the workers provides workers' compensation insurance.[35] However, it is not always clear that this applies in the case of a "co-employment" relationship. Such clarification is necessary, because allowing the worker the option to collect the statutory workers' compensation benefits from the co-employer whose name is on the insurance policy or to sue the other co-employer for the same incident and injury would defeat the nature of the no-fault system. Both co-employers have agreed upon an arrangement that guarantees the availability of workers' compensation benefits, so both deserve the benefit of the exclusive remedy.

In implementing the Guidelines, it is recommended that a state review its workers' compensation provisions to ensure that the exclusive remedy provision will prevent "double-dipping" or create an incentive for more litigation that could undermine the purpose of exclusive remedy. The Working Group, when drafting the Guidelines, recognized that this was a statutory, rather than regulatory, issue, and that the applicable statutes are generally found in the workers' compensation laws, rather than the insurance laws.

In the case of a PEO relationship (or co-employment model), does state law clearly provide that both the PEO and PEO client are entitled to exclusive remedy protection?[36] Or is the exclusive remedy only extended to the party obtaining insurance coverage? Absent a provision clarifying the entitlement of both co-employers to the exclusive remedy, a state runs the risk that a business that chooses to avail itself of PEO services will, thereby, expose itself to tort lawsuits for workplace injuries, even though the business has been careful to make sure that full workers' compensation protection is available through the PEO. In the worst case, the client might be exposed to a "double-dip" lawsuit after the injured worker has already received workers' compensation benefits! (Or, conversely, a PEO that does not provide workers' compensation coverage could expose itself to tort liability for its clients' workplace injuries, even though it has provided only administrative services to its clients.)

States with more comprehensive PEO acts have routinely dealt with this issue when enacting that legislation.[37] If such a provision is not already in place, it should be added to the state's workers' compensation statute. This might require a cooperative effort of the insurance department with a state workers' compensation commission or labor department, depending on which agency is responsible for administering the state's workers' compensation system.

H. Residual Market Issues

What should be the recourse if a PEO is unable to obtain voluntary coverage, either for its own employees or for those workers that it co-employs with its clients? At first glance, it might seem obvious that the PEO should be entitled to coverage in the residual market. However, the Working Group recognized that this is not the only way coverage can be issued. The PEO needs to be able to purchase coverage for its own home office employees on the same basis as any other employer — but as long as each client retains the right to purchase its own residual market coverage, the PEO does not absolutely need the right to buy coverage for all of its clients.

Therefore, the Working Group concluded that it is appropriate to allow the residual market to impose some minimum standards on PEOs that could not be applied to other employers. If a PEO is in good standing, it has the right to purchase residual market coverage on a multiple coordinated policy basis, just as it can under the 1991 model regulation and existing residual market plans. However, Section 6 of the Guidelines

[35] Under this protection, for example, a client using temporary staff personnel would be afforded the exclusive remedy protection of the temporary employment service's workers' compensation coverage for injuries sustained during a temporary worker's assignment to the client.

[36] The Indiana Code, for example, provides, at IC 27-16-9-2: "The protection of the exclusive remedy provisions of IC 22-3-2-6 and IC 22-3-7-6 apply to the PEO, the client, and each covered employee and other employee of the client regardless of whether the PEO or the client is responsible to obtain the worker's compensation coverage for the covered employees under the professional employer agreement."

[37] For example, the New York Professional Employer Act provides: "Both the client and the professional employer organization shall be considered the employer for the purpose of coverage under the workers' compensation law and both the professional employer organization and its client shall be entitled to protection of the exclusive remedy provision of the workers' compensation law irrespective of which entity secures and provides such workers' compensation coverage." New York Labor Code, Article 31, § 922 at paragraph 4.

includes provisions under which the residual market may determine (subject to the PEO's right to appeal to the Commissioner) that a PEO is not in good standing and coverage for the clients' workforces must be purchased by the clients themselves:

- If the PEO or an affiliate owes past-due premium or otherwise does not meet the general qualifications for residual market coverage;

- If the PEO is unable to demonstrate the financial capacity to comply with its obligations under the multiple coordinated policy agreement; or

- If the PEO has been barred by regulators or found to have unfit management or ownership.

In addition, as discussed above in "Experience Rating," an unimpaired ability to enter into split-workforce PEO arrangements might give the PEO and clients an incentive to "dump" the riskiest components of the clients' workforces into the residual market, or for a PEO to buy voluntary market coverage for its best clients and "dump" the others. Therefore, Subsection 6D of the Guidelines makes split-workforce arrangements ineligible for residual market coverage, and gives the residual market the authority to deny or surcharge coverage if a PEO splits its client base.

A final issue that needed to be addressed in order to construct a nationwide model is that different states make residual market coverage available in different ways. Therefore, the Guidelines include two different versions of Section 6: one to be used in states with an assigned risk/servicing carrier program; the other to be used in states with a single statutory carrier of last resort. The Guidelines presume that such a carrier also has the authority to write voluntary market coverage, so states with a single carrier that only provides involuntary coverage should adjust the language accordingly.

I. Pricing

The Guidelines impose no requirement that the PEO itemize the workers' compensation portion of its billings to its clients.[38] Paragraph 4D(2)[39] requires the PEO to provide specific notice that the premium obligation of coverage provided through the PEO is that of the PEO alone, and not the client.

Although itemized charges for workers' compensation are not required, the PEO may choose to provide them. In that case, the PEO has the obligation to be fair and accurate. It cannot, for example, advertise below-market workers' compensation coverage if its true costs are higher and it conceals the difference elsewhere in its bill. Subsection 4F of the Guidelines requires that a PEO "not make any materially inaccurate, knowingly or recklessly misleading, or fraudulent representations to the client of the cost of workers' compensation coverage."

[38] As discussed earlier, the Guideline drafters considered, but rejected, a proposal to require pass-through billing of premium. There was significant sentiment that amounts charged to clients for the workers' compensation services elements of PEO services should be reflective of the costs of workers' compensation coverage, but the ultimate agreement was that this is a commercial and market issue.

[39] "The PEO shall have a written agreement with the client, signed by the client before coverage becomes effective, including clear and conspicuous provisions … Explaining that while the coordinated policy or certificate of coverage is in force, the PEO will be responsible for paying all premium obligations, including any audit adjustments and policyholder assessments, and will be entitled to any premium refunds. The written agreement shall further explain that although the PEO will charge fees to the client that reflect or include the cost of coverage, these fees are not considered insurance premium obligations of the client. If there is a policy deductible, the written agreement shall further explain that the PEO is responsible for reimbursing the insurer for the deductible and may not seek recovery from the client."

In situations where a PEO itemizes the costs of workers' compensation, Subsection 4F requires that any such statement of costs be within defined bounds unless otherwise approved by the Commissioner.[40] This is of particular concern when the PEO assumes responsibility for most or all of the claims cost under a large-deductible or retrospectively rated policy and adopts its own "rating" methodology for recovering those claims costs from its clients. In some states, legislation might be necessary in order to give the Commissioner the authority to impose such restrictions, because they could be viewed as direct regulation of PEO fees and, thus, beyond the jurisdiction of insurance regulators. If a statutory amendment is proposed, it might logically be included in either the state's insurance rate regulatory act or its PEO act. Including the language in the PEO act allows the imposition of sanctions on a noncompliant PEO and, depending on the structure of laws already on the books, Section 4 of the Guidelines can essentially be "lifted" from the regulation and placed in the state's PEO act substantially intact. The state's rating law might be a less appropriate place for these provisions, as the PEO is not an insurance company; nevertheless, a cross-reference in the insurance laws might be necessary in order to give the Commissioner the necessary rulemaking authority.

J. Improper Extensions of Coverage (Piggybacking)

Subsection 7C of the Guidelines is designed to limit coverage of a master policy to only one PEO or one PEO group. It also prohibits extension of coverage under a master or coordinated policy to another PEO, employee leasing company, temporary service agency, or other entity in the business of employment services outsourcing. This provision is designed to prevent "piggybacking" and provides an additional argument for a comprehensive legislative/regulatory approach to PEOs in any given state. It addresses an issue raised by the 2002 NAIC/IAIABC Joint Working Group report.

The classic "piggybacking" scenario occurs when PEO A, which has a master policy, then co-employs all of the employees and worksite co-employees of PEO B, thus seeking to extend coverage to PEO B's co-employees and clients. This represents a significant increase in the insurer's exposure, without any new underwriting by the insurer — and possibly without even the payment of additional premium. There are variations on this scheme, but the purpose is the same: to extend the insurance coverage beyond that for which it was originally intended or contracted. In one common variant, PEO A claims to have acquired PEO B, and asks its insurer to add PEO B to the policy, when the "purchase" is a sham transaction that does not really transfer actual ownership and control.

The drafters designed this provision not only to address piggybacking, but also to prevent a PEO contract with a client temporary staffing agency that, in turn, provides employees on a temporary basis to other clients. It was determined that having the on-site client employer more than one level removed from the employer securing coverage was too problematic.

On the other hand, this provision is not intended to prohibit: 1) a legitimate acquisition of one PEO by another; 2) a PEO providing services to an HR consulting or other entity that does not provide workers or W-2 co-employment services to client companies; or 3) a commonly owned PEO group procuring common coverage. However, pursuant to Subsection 7C, "For a master policy to be issued to a PEO group, all covered PEOs must be combinable for experience rating purposes, each member of the group shall execute a cross-guarantee of the premium payment obligations of the other members, and each covered PEO shall be expressly named as an insured PEO before the effective date of coverage."

The effectiveness of Subsection 7C is enhanced by a state's adoption of the Guidelines' recommendation for registration or regulation of PEOs generally. Once a state has a requirement for registration or licensing of PEOs doing business in the state, it is easier to identify PEOs, know their insurance relationships, and to prevent these types of improper extensions of coverage.

[40] "If the PEO charges the client an itemized amount for workers' compensation coverage, the PEO shall provide the client with a good faith estimate of the actual cost of coverage and an accurate and concise description of the basis upon which it was calculated and the services that are included. Without the prior approval of the commissioner, a PEO may not charge a client an itemized amount for workers' compensation coverage that is:

(1) Materially inconsistent with the actual amounts charged by the insurer or reasonably anticipated loss-sensitive charges;
(2) In conflict with the terms of the uniform classification system; or
(3) Materially in conflict with the terms of the uniform experience rating plan."

K. Self-Insurance

One fundamental question that arises, if a state recognizes a PEO as an employer, is whether the PEO should be allowed to self-insure its workers' compensation exposure on the same basis as other employers. Currently, some states permit self-insurance by PEOs and others do not.

The Working Group was concerned that a PEO self-insurance program is not true "self-insurance," as that term is commonly understood. In effect, a self-insured PEO is really insuring its clients, and allowing a PEO to self-insure would leave the clients and workers with no other recourse if the PEO failed, or would create unacceptable risk for the self-insurance guaranty fund in states that have such a fund. Therefore, the Working Group decided not to propose self-insurance by PEOs as one of the options for coverage in Section 3. Subsection 3B contemplates the possibility that a client might be allowed to self-insure (because not all PEO arrangements give the PEO responsibility for workers' compensation coverage), but not a PEO.

A drafting note to Section 3 acknowledges that some states permit self-insurance by PEOs and that states desiring to maintain such coverage will need to modify the Guidelines accordingly. However, a drafting note suggests that any states considering self-insurance:

… should seriously consider basing such authorization upon licensure as an alternative risk-bearing entity, similar to laws allowing licensure for multiple-employer welfare arrangements and group self-insurance pools, and upon compliance with standards substantially similar to those established by these guidelines for insurers issuing master policies.

L. Loss-Sensitive Coverage

The self-insurance question involved extensive discussions among the Working Group and interested parties concerning the nature of the risk assumed by a PEO with regard to workers' compensation. This risk differs from the risk ordinarily assumed by the employer that self-insures or has a loss-sensitive coverage plan. For a traditional employer, the workers' compensation risk is inherent in its operations, while for a PEO, the risk is assumed from its clients by contract (along with other employment-related risks). The client remains the owner of the operating business where the injury would occur. If a traditional employer self-insures or has a loss-sensitive arrangement, the self-insurance program is pure expense. Self-insurance "pays off" if it is cheaper than buying standard insurance, but the employer can never actually make a profit, only reduce the expense or suffer a loss.

By contrast, a PEO in a loss-sensitive arrangement must estimate its clients' likely workers' compensation losses, and collect payments from the clients that are sufficient to cover the expected losses and the expenses of operating the program. If the PEO manages the workers' compensation elements of its contract successfully and the losses are better than expected, the PEO makes a profit. If losses and expenses (adjusted to present value) are equal to the payments collected, this element of the PEO's operations break even. And if the clients' losses are significantly worse than expected, the PEO will incur a loss.

This analysis initially led some of the regulators on the Working Group to oppose any arrangement in which the PEO was involved in its clients' coverage on any other basis than as a pure intermediary between the clients and a licensed insurer. The industry's response, and that of some carriers, was that it was healthy for a PEO to assume some or all of its clients' risk, because that gave the PEO an economic incentive to operate good risk-management programs, so that a PEO was not simply financing coverage but actually improving the operations of its clients' workplaces. In this regard, the industry argued that the PEO's position was not that of an insurer, but that — as a co-employer with multiple touch points with the workforce (payroll, human resources, benefits, health, and compliance) — it had far greater abilities to invest in and manage risk than a client would have. A PEO, it was argued, was in a better position than the traditional insurer to improve safety, manage return to work, identify fraudulent claims, and address workers' compensation issues.

A consensus emerged on the Working Group that it should be permissible for a PEO to take on some degree of insurance risk. It was noted that the states already allow fronting arrangements in which unlicensed entities can assume insurance risk — as long as a licensed insurer assumes responsibility by issuing the primary policy, the insurer is then permitted to cede the risk to an unlicensed reinsurer, subject to reporting requirements and rules against taking accounting credit for unsecured reinsurance.

Regulators recognized that the rationale for prohibiting self-insurance does not necessarily apply to loss-sensitive coverage, because there is a significant difference between the risk that a PEO assumes under a large-deductible or retrospectively rated policy issued by a licensed insurer and the risk that a PEO assumes under a self-insurance program. With loss-sensitive insurance coverage, a licensed insurer has assumed full responsibility for all payments due under the policy, whether or not the PEO is willing and able to fulfill its obligations to the insurer, in the same manner as a fronting insurer that passes the risk to an unlicensed reinsurer.

Therefore, the Working Group determined that loss-sensitive coverage should be permitted, as long as adequate safeguards are in place. For loss-sensitive coverage, the safeguards established by the Guidelines are designed to ensure that the contract is exactly what it purports to be: an informed bargain between a willing insurer and a willing PEO to allocate risk between each other, without shifting those risks to third parties. As in the context of other issues, the most essential regulatory requirement in the Guidelines is that the insurer must make and honor an unconditional commitment to cover the clients and the workers.

Likewise, when the client has paid the appropriate fees up front, the PEO is not permitted to hit the client with additional charges down the road if claims experience goes sour. Beyond those restrictions, the focus is on transparency, making sure that all parties have all the information they need to make an informed decision. Transparency extends to regulatory reporting, as well. Subsection 11D of the Guidelines requires specific reporting by all insurers (foreign as well as domestic) in the domestic PEO market, and by domestic insurers on their nationwide PEO business. The content of the report is to be specified by the Commissioner, and a drafting note contemplates that it will include information on the rating methodologies, security arrangements, and reinsurance arrangements used, allowing regulators to evaluate whether PEO arrangements pose any material financial risk to the insurer.

Conclusion

The Guidelines are the result of a lengthy effort by regulators and interested parties to address a number of concerns that have arisen in PEO arrangements over the years. While the PEO industry has been largely successful in providing coverage and other services to many businesses on a long term basis, this record of success has not been universal. It has become apparent that the PEO relationship creates a variety of complications in areas such as proof of coverage, experience rating, and notice — and open up opportunities for abuse that require enhanced regulatory oversight.

Some states have addressed PEO issues more comprehensively than others. Some have adopted systems that work particularly well for them, while others are looking to adopt regulations or revise regulations already in place. The ultimate goal of all of the states is to preserve a workers' compensation system where all workers are properly covered and claims are handled promptly and correctly. Additional goals are to preserve competition in the marketplace in an effort to keep workers' compensation rates affordable and, to the extent possible, continue to move coverage from the residual to the voluntary market. To this end, the Guidelines have sought to provide flexibility while addressing issues that have arisen in the past.

It has become clear that, the issue is not simply the needs of the insurance regulatory agency. Action in each state should include other important stakeholders in the process: the workers' compensation administrative agency and/or adjudicator, the advisory organization or rating agency, the insurance carriers involved in the PEO markets, and the PEOs themselves. All of these stakeholders should be involved in the process of developing the regulations necessary within each jurisdiction, while also striving to ensure some commonality for data-reporting and exchange of information nationwide. Implementation of these Guidelines might take time. They might require legislative efforts. They might require a phased approach over time. However, the Working Group believes that the end result will be a better workers' compensation system for all.

Appendix A

Table of Contents

Section 1. Authority and Purpose

This regulation is adopted pursuant to [insert applicable statutory authority] to ensure that professional employer organizations (PEOs), and their clients, properly obtain workers' compensation insurance coverage for all of their employees, including both direct hire employees and persons employed under PEO agreements; that the premium paid is commensurate with the anticipated claim experience; and that an appropriate procedural framework is in place for the inception, continuation, and termination of coverage.

Drafting Note: These guidelines are presented in the form of a regulation; however, some provisions may be more appropriately enacted as legislation in some states. Agencies promulgating regulations based upon these guidelines should ensure that statutes regulating PEOs or employee leasing arrangements, statutes regulating workers' compensation insurance, or other applicable law grant them adequate rulemaking authority. In states where another agency has regulatory jurisdiction over PEOs, the commissioner should consider jointly promulgating regulations with that agency. Agencies promulgating regulations or drafting legislation based upon these guidelines should also ensure that insurers, PEOs and regulators have adequate resources and infrastructure in place to make compliance feasible, including but not limited to the necessary information systems and the necessary reporting mechanisms for data and proof of coverage.

Drafting Note: The scope of these guidelines is limited to issues related to workers' compensation insurance. It does not provide a comprehensive regulatory framework for the PEO industry. States may wish to consider regulations or legislation based upon these guidelines as part of a more comprehensive registration or licensing regimen for PEOs. In particular, states should take appropriate measures to ensure, to the extent possible, that both a PEO and a client obtaining coverage in compliance with these guidelines are protected by the state's exclusive remedy provisions.

Section 2. Definitions

A. "Client" means an employer whose work force consists in whole or part of PEO co-employees.

B "Designated advisory organization" means the entity designated by the commissioner for the reporting of claims and experience data and for the administration of the workers' compensation experience rating system.

Drafting Note: If state law or practice uses different terminology or an inconsistent definition, make the appropriate substitution. Where the term "commissioner" is used, states should substitute the title of their chief insurance regulator, if different.

C. "Direct hire employee" of a client or a PEO means an individual who is an employee within the meaning of the Workers' Compensation Act and who is not a PEO co-employee as defined in Subsection J.

D. "Direct purchase basis" means an arrangement in which all contractual obligations under the insurance policy run directly between the insurer and the client without the involvement of the PEO, whether the arrangement is negotiated solely between the client and the insurer or is negotiated with the assistance of the PEO on terms that might not be available to the general public.

E. "Full work force PEO agreement" means a PEO agreement under which the PEO agrees to assume specified employment responsibilities for all of the client's employees within the state, except that a full work force agreement may exclude by name one or more owners and/or officers who have demonstrated that they are excluded from state workers' compensation benefits.

Drafting Note: States that permit the "Designated Workplaces Exclusion Endorsement" to be used in a master policy certificate or coordinated policy should add the following sentence: "A full work force PEO agreement may also exclude employees at one or more named workplaces that are subject to a Designated Workplaces Exclusion Endorsement issued in compliance with this regulation and other applicable legal and procedural requirements."

F. "Master policy basis" means an arrangement under which a single policy issued to the PEO provides coverage for more than one client, and provides coverage to the PEO with respect to its direct hire employees. Two or more clients that are insured under the same policy solely because they are under common ownership are considered a single client for purposes of this definition.

Drafting Note: States that prohibit master policies should omit this subsection and all other references to master policies in regulations or legislation based upon these guidelines.

G. "Multiple coordinated policy basis" means an arrangement under which a separate policy is issued to or on behalf of each client or group of affiliated clients but payment obligations and certain policy communications are coordinated through the PEO.

H. ***[Option 1]*** "Professional Employer Organization" or "PEO" means a business entity that enters into agreements with other businesses, whether under a formal contract or otherwise and regardless of the terminology used by the parties to describe the relationship, under which the PEO assumes or shares employment responsibilities for all or a significant number of the worksite employees of the other business. However, "PEO" does not include a business entity that recruits and hires its own employees; assigns them to clients on a temporary basis to support or supplement the client's work force in special work situations such as employee absences, temporary skill shortages and seasonal workloads; and customarily attempts to reassign the employees to other clients when they finish each assignment.

H. ***[Option 2]*** "Professional Employer Organization" or "PEO" means a business entity that is required to be *[insert appropriate term]* pursuant to *[insert reference to state's licensure or registration law for PEOs or employee leasing companies]*.

Drafting Note: Option 1 is for use in those states where these guidelines will not be part of a comprehensive regulatory scheme for PEOs requiring licensure or registration.

I. "Professional employer agreement" or "PEO agreement" means an agreement between a PEO and a client under which the PEO agrees to assume specified employment responsibilities for all or part of the client's work force.

Drafting Note: If the state has an existing comprehensive statutory scheme in place regulating PEOs, these guidelines should be reviewed for consistency with that statutory scheme and revisions should be made if appropriate. This may include revisions to the terminology used in this section if state law uses different terminology, including but not limited to "employee leasing company," to describe some or all of the shared or delegated employer relationships that are the subject of these guidelines. Also, these guidelines presume that the state recognizes some form of employment arrangement under which both the PEO and client are considered employers for purposes of the workers' compensation laws. States should review this definition for consistency with the applicable statutory or common-law definition and make any revisions that might be necessary.

J. ***[Option 1]*** "PEO co-employee" means an individual who is an employee, within the meaning of the Workers' Compensation Act, of both a PEO and a client.

J. ***[Option 2]*** "PEO co-employee" means an individual whose employment responsibilities are shared between a client and a PEO, either by the terms of a PEO agreement or by operation of law.

Drafting Note: Generally, a client's direct hire employees are reported for tax purposes under the name and identification number of the client, while its PEO co-employees are reported for tax purposes under the name and identification number of the PEO. However, the determination whether the PEO is an employer of an individual for workers' compensation purposes is outside the scope of these guidelines because employer status is not governed by insurance laws. Although the PEO agreement should provide a clear process for determining which members of the client's workforce are PEO co-employees and which (if anyone) are direct hire employees, state law must control if the PEO agreement is inconclusive or is inconsistent with the law. If state law does not recognize co-employment, different terminology such as "PEO worksite employee" should be used and the definition should be revised to be consistent with state law.

Section 3. Insurance Coverage on PEO Co-Employees

The following are the methods approved by the commissioner as providing coverage for a client and a PEO that have entered into a PEO agreement, sufficient to meet their statutory obligation for coverage as employers under [insert appropriate statutory reference] of their PEO co-employees:

A. The client obtains a standard workers' compensation policy from an insurer on a direct purchase basis, covering all of the client's PEO co-employees and direct hire employees, subject to the same requirements and conditions as if the client were the sole employer of its PEO co-employees. The policy may name the PEO as an additional insured. If licensed as a producer, and authorized by the insurer, the PEO may negotiate coverage, collect premiums on behalf of the insurer, and otherwise act as an intermediary with respect to direct purchase coverage as permitted by law;

Drafting Note: States whose law uses other terminology such as "agent" or "broker" should modify this provision accordingly.

B. The client obtains authorization from the [insert appropriate state official] pursuant to [insert applicable self-insurance licensure statutes] to self-insure its workers' compensation obligations;

Drafting Note: States that allow a PEO as an entity to self-insure should modify this subsection accordingly. However, states considering allowing PEOs to self-insure should seriously consider basing such authorization upon licensure as an alternative risk-bearing entity, similar to laws allowing licensure for multiple-employer welfare arrangements and group self-insurance pools, and upon compliance with standards substantially similar to those established by these guidelines for insurers issuing master policies.

C. The PEO purchases insurance providing workers' compensation coverage on a multiple coordinated policy basis in compliance with this regulation, with a policy providing coverage to the client and to the PEO with respect to the PEO co-employees at the client; or

D. The PEO purchases a master policy, with a certificate of coverage issued in compliance with this regulation providing coverage to the client and to the PEO with respect to the PEO co-employees at the client.

Section 4. Requirements for PEOs

A. A PEO shall be registered as a professional employer organization with the [insert appropriate state official] pursuant to [insert applicable statutes]. An insurer may not enter into or maintain a multiple coordinated policy agreement with, or issue a master policy to, an unregistered PEO. If a PEO providing multiple coordinated policies, or covered under a master policy, ceases to be registered or has been subject to disciplinary sanctions, the [insert appropriate state official] shall promptly notify the insurer of record.

Drafting Note: Substitute "licensed" for "registered" in states with licensing laws. States that have no formal regulatory framework for PEOs may modify this subsection to impose a requirement for registration with or notice to the commissioner, or may omit this subsection entirely.

B. A PEO may not enter into or remain in a multiple coordinated policy agreement with an insurer or be issued a master policy if it is ineligible for coverage pursuant to [insert appropriate statutory citation here if applicable] as a result of a default on a workers' compensation premium or assessment debt.

C. If the services that a PEO offers to a client do not include securing workers' compensation coverage on a master policy or multiple coordinated policy basis, the PEO shall provide the client with clear and conspicuous written notice, before entering into a PEO agreement with the client, that the client will remain responsible for obtaining its own workers' compensation coverage for both PEO co-employees and direct hire employees, and the written PEO agreement shall also clearly set forth that responsibility.

D. If a PEO offers any client services that include securing workers' compensation coverage on either a master policy or multiple coordinated policy basis, the PEO shall have a written agreement with the client, signed by the client before coverage becomes effective, including clear and conspicuous provisions:

(1) Explaining that insurance coverage does not take effect until the effective date designated by the insurer on the policy or certificate of coverage;

(2) Explaining that while the coordinated policy or certificate of coverage is in force, the PEO will be responsible for paying all premium obligations, including any audit adjustments and policyholder assessments, and will be entitled to any premium refunds. The written agreement shall further explain that although the PEO will charge fees to the client that reflect or include the cost of coverage, these fees are not considered insurance premium obligations of the client. If there is a policy deductible, the written agreement shall further explain that the PEO is responsible for reimbursing the insurer for the deductible and may not seek recovery from the client;

(3) Explaining the procedures by which the client or PEO may terminate the PEO agreement, including any fees or costs payable upon termination, and that except as otherwise expressly provided or required by law, all services provided by the PEO to the client shall cease immediately on the effective date of the termination. The written agreement shall explicitly state that the client's coverage under any workers' compensation insurance shall terminate immediately on the termination date of the PEO agreement, subject to the client's right to receive at thirty (30) days' advance notice before workers' compensation insurance coverage may be terminated involuntarily and to purchase an extension of coverage at the client's expense for the remainder of the notice period if the notice period extends beyond the termination date of the PEO agreement;

Drafting Note: In states where Section 10 is revised to permit shorter notice in some or all situations, this provision should be modified accordingly.

(4) Explaining that the insurer has the right to inspect the premises and records of the client;

(5) Explaining that the client's loss experience will continue to be reported in the name of the client to the designated advisory organization, and will be available to subsequent insurers on request;

(6) If coverage is provided under a multiple coordinated policy arrangement, explaining whether the client may elect to purchase coverage directly from an insurer in lieu of participating in the multiple coordinated policy arrangement;

(7) If the PEO agreement is a full work force PEO agreement, explaining that the policy or certificate will cover all employees of the client within the state who are not excluded from workers' compensation benefits. If the PEO agreement is not a full work force PEO agreement, explaining that the policy or certificate will cover only those employees acknowledged in writing by the PEO to be PEO co-employees, and that the client shall at all times maintain other valid coverage for its direct hire employees and shall provide evidence of coverage satisfactory to the PEO's insurer; and

Drafting Note: States that permit the "Designated Workplaces Exclusion Endorsement" should add the following additional sentence between the first and second sentences. "If the client's policy or certificate is subject to a Designated Workplaces Exclusion Endorsement, the above disclosure shall be modified to reflect the terms of the exclusion and shall expressly state the client's obligation to provide separate coverage for the excluded workplaces."

(8) Explaining that the client may take complaints to the [insert applicable regulator] in accordance with [insert applicable law].

Drafting Note: A state that does not have an established regulatory process for complaints by clients against PEOs should consider adding a provision establishing a complaint process for workers' compensation issues.

E. The PEO shall promptly notify the workers' compensation insurance carrier of the termination of any PEO agreement with a client that is covered on a master policy or multiple coordinated policy basis.

F. The PEO shall not make any materially inaccurate, knowingly or recklessly misleading, or fraudulent representations to the client of the cost of workers' compensation coverage. If the PEO charges the client an itemized amount for workers' compensation coverage, the PEO shall provide the client with a good faith estimate of the actual cost of coverage and an accurate and concise description of the basis upon which it was calculated and the services that are included. Without the prior approval of the commissioner, a PEO may not charge a client an itemized amount for workers' compensation coverage that is:

(1) Materially inconsistent with the actual amounts charged by the insurer or reasonably anticipated loss-sensitive charges;

(2) In conflict with the terms of the uniform classification system; or

(3) Materially in conflict with the terms of the uniform experience rating plan.

G. The PEO shall provide any information requested by the commissioner relating to the provisions of its PEO agreements that relate to or have an impact on workers' compensation benefits or coverage, the methods by which the fees charged to clients are calculated to the extent that they are based upon or attributed to the cost of workers' compensation coverage, and any other information relevant to the PEO's workers' compensation coverage arrangements.

H. The PEO shall not impose any fee increase upon a client based upon the actual or anticipated cost of workers' compensation coverage without giving the client at least thirty (30) days' advance notice and an opportunity to withdraw from the PEO agreement without penalty.

I. If a client receives notice of the termination or nonrenewal of coverage, and the client obtains replacement coverage, the client shall have the right to withdraw from the PEO agreement without penalty even if the PEO's coverage has been reinstated or replaced.

J. Except with prior approval of the commissioner and full written advance disclosure to clients, the PEO shall not impose any fee or other charge upon a client that relates to workers' compensation coverage and could become due after the termination of the PEO agreement, other than:

(1) Fees and charges due and billed while the PEO agreement was in force, and fees for the final period of PEO services to the extent normally and customarily billed in arrears;

(2) Reasonable charges for additional services requested by the former client after termination of the PEO agreement;

(3) The cost to the PEO of workers' compensation coverage, including reasonable administrative expense, during any extension of the coverage period after termination of the PEO agreement;

(4) Reasonable interest on overdue fees and charges; and

(5) Reasonable charges for late payment of fees or early termination of the PEO agreement.

Section 5. Multiple Coordinated Policy Agreement

If a PEO secures workers' compensation coverage on a multiple coordinated policy basis, it shall first enter into a written agreement with the insurer establishing the terms and conditions under which multiple coordinated policies will be issued to the PEO and each client. The agreement may consist in whole or part of an endorsement to the coordinated policy covering the PEO's direct hire employees. The agreement shall include provisions addressing the following issues and such other reasonable provisions as the parties consider appropriate:

A. A copy of the policy form to be used for each coordinated policy issued under the agreement;

B. The premium discount, if any, to be applied to policies issued under the agreement, and any other modifications of the insurer's standard underwriting guidelines and rating plan;

C. The provision of financial and ownership information and coverage history by the PEO to the insurer, the form and amount of security to be held by the insurer, and the conditions under the insurer may draw upon it;

Drafting Note: States with laws limiting an insurer's ability to require prepayment of premium should consider whether it is necessary to clarify that a requirement to post a reasonable level of security under this subsection is not considered a prohibited prepayment requirement.

D. Whether a client may elect to purchase coverage directly from the same or another insurer in lieu of participating in the multiple coordinated policy arrangement;

E. The designation of a third-party administrator, if one is to be used. Any third-party administrator must be licensed by the commissioner;

Drafting Note: Omit second sentence if the state does not license third-party administrators, or if workers' compensation insurance is outside the scope of the state's administrator law. States with third party administrator laws that do not encompass workers' compensation coverage should consider amending them.

F. Provisions for billing and claims reporting and for enforcement of these requirements;

G. Provisions addressing the obligations of the PEO and the insurer when the PEO acquires a new client or terminates a relationship with an existing client, including notice to the insurer and to the [workers' compensation regulator];

H. Procedures for termination and renewal of the multiple coordinated policy agreement. Grounds for cancellation by the insurer and procedures for providing notice of cancellation or nonrenewal to the PEO shall be substantially consistent with the restrictions on policy termination set forth in [insert law regulating cancellation of workers' compensation policies]. Termination of PEO registration and continuing material noncompliance with reporting requirements shall be mandatory grounds for cancellation. The PEO shall have the right to a hearing before the commissioner upon a claim that the insurer has cancelled the agreement unlawfully or has failed to provide proper notice of cancellation or nonrenewal;

I. Provisions establishing the conditions and procedures, if any, under which a specific policy may be cancelled or nonrenewed while the multiple coordinated policy agreement remains in force; and

J. Provisions, if any, for conversion of coordinated policies to direct purchase policies upon termination of a PEO agreement, or upon termination of the multiple coordinated policy agreement between the PEO and the insurer.

Section 6. Coverage in the Residual Market

[Option One]: This version of Section 6 is for use by states where the residual market is an assigned risk plan or pooling mechanism. States should make appropriate revisions to the extent that this section is not consistent with the state's residual market structure.

A. The [residual market manager] shall file with the commissioner a standard multiple coordinated policy agreement that shall be made available to all registered PEOs in good standing. The terms of the standard agreement shall be subject to approval by the commissioner and shall include:

(1) Provisions under which, to the extent feasible, the policies covering all clients of the same PEO within this state shall be assigned to the same servicing carrier, and reasonable efforts shall be made to assign a common servicing carrier on an interstate basis;

(2) Provisions under which any client that is otherwise eligible for coverage may obtain direct purchase coverage with no break in coverage if the coordinated policy covering the client terminates for any reason; and

(3) A premium discount schedule that appropriately reflects any cost savings created by multiple coordinated policy arrangements.

Drafting Note: Omit Paragraph (3) in states where there is no premium discount available to large employers in the residual market.

B. If a PEO is not in good standing, residual market coverage for its clients shall be issued in the name of the client on a direct purchase basis. A PEO is not in good standing for purposes of this section if the residual market manager, subject to the PEO's right of appeal to the commissioner, determines that the PEO, an entity that controls or is controlled by the PEO, or an entity in which the PEO or an entity controlling the PEO directly or indirectly holds a 25% or greater ownership interest or actively manages:

(1) Is in default on an undisputed workers' compensation premium or assessment, either for its own coverage or for its clients' coverage, or otherwise fails to qualify as an eligible employer under the terms of the residual market plan;

Drafting Note: Omit the word "undisputed" in states that allow the denial of coverage while a dispute is pending.

(2) Is unable to demonstrate the financial capacity to comply with its obligations under the multiple coordinated policy agreement;

(3) [Insert appropriate reference here if state has a disciplinary provision in its PEO laws that when triggered would restrict a PEO's ability to provide workers' compensation coverage to clients.]; or

(4) Has, or is owned or managed by persons who have, a history of material noncompliance with the law or with contractual obligations, including but not limited to a felony conviction, multiple criminal convictions, judgments of liability for fraud or material representation, or multiple cancellations of insurance policies or multiple coordinated policy agreements.

C. A master policy may not be issued to a PEO in the residual market.

D. An employer that is a client of a PEO is not eligible for issuance or continuation of a residual market policy, nor is the PEO eligible for issuance or continuation of residual market coverage with respect to PEO co-employees at that client, if there is voluntary market coverage with respect to some other portion of the client's work force. With the approval of the commissioner, the residual market may deny coverage, or may charge rates reasonably designed to reflect the additional risk assumed, to a PEO requesting coverage on a multiple coordinated policy basis for some but not all of its clients in this state, if the PEO has other coverage on a master policy or multiple coordinated policy basis for other clients in this state.

Section 6. Coverage by the [Statutory Carrier of Last Resort]

[Option Two]: This version of Section 6 is for use by states in which the residual market is a competitive state fund or other statutory carrier of last resort. States should make appropriate revisions if this section is not consistent with the powers and duties of the carrier of last resort; for example, if that carrier does not also compete in the voluntary market.

A. [Statutory carrier of last resort] may negotiate master policies or multiple coordinated policy agreements with PEOs on a voluntary basis. [Statutory carrier of last resort] shall file with the commissioner a standard multiple coordinated policy agreement that shall be made available to all registered PEOs in good standing. The terms of the standard agreement shall be subject to approval by the commissioner and shall include a premium discount schedule that appropriately reflects any cost savings created by multiple coordinated policy arrangements.

Drafting Note: Change "shall" to "may" in the last sentence in states where there is no requirement to provide a premium discount to large employers with involuntary coverage, and omit the last sentence entirely where premium discounts are prohibited.

B. If a PEO is not in good standing, coverage for its clients by [statutory carrier of last resort] shall be issued in the name of the client on a direct purchase basis. A PEO is not in good standing for purposes of this section if [statutory carrier of last resort], subject to the PEO's right of appeal to the commissioner, determines that the PEO, an entity that controls or is controlled by the PEO, or an entity in which the PEO or an entity controlling the PEO directly or indirectly holds a 25% or greater ownership interest or actively manages:

(1) Is in default on an undisputed workers' compensation premium or assessment, either for its own coverage or for its clients' coverage, or otherwise fails to qualify as an employer eligible for coverage as of right with [statutory carrier of last resort];

Drafting Note: Omit the word "undisputed" in states that allow the denial of coverage while a dispute is pending.

(2) Is unable to demonstrate the financial capacity to comply with its obligations under the multiple coordinated policy agreement;

(3) [If state has a disciplinary provision in its PEO laws that when triggered would restrict a PEO's ability to provide workers' compensation coverage to clients, insert appropriate reference here]; or

(4) Has, or is owned or managed by persons who have, a history of material noncompliance with the law or with contractual obligations, including but not limited to a felony conviction, multiple criminal convictions, judgments of liability for fraud or material representation, or multiple cancellations of insurance policies or multiple coordinated policy agreements.

C. The terms of any master policy issued or multiple coordinated policy agreement entered into by [statutory carrier of last resort] shall include provisions under which any client that is otherwise eligible for coverage may obtain direct purchase coverage with no break in coverage if the coordinated policy covering the client or the client's coverage under the PEO's master policy terminates for any reason.

D. An employer that is a client of a PEO is not entitled to issuance or continuation of coverage as of right by [statutory carrier of last resort], nor is the PEO entitled to issuance or continuation of coverage as of right by [statutory carrier of last resort] with respect to PEO co-employees at that client, if there is voluntary market coverage with respect to some other portion of the client's work force. With the approval of the commissioner, [statutory carrier of last resort] may deny coverage, or may charge rates reasonably designed to reflect the additional risk assumed, to a PEO requesting coverage on a multiple coordinated policy basis for some but not all of its clients in this state, if the PEO has other coverage on a master policy or multiple coordinated policy basis for other clients in this state.

Section 7. Policy Issuance

A. A master policy or coordinated policy shall unconditionally obligate the insurer to pay all benefits due under the workers' compensation laws, whether or not the PEO and client comply with their obligations under the policy, for all injuries to covered employees occurring while the policy is in force, including any extension of coverage required pursuant to Section 10 of this regulation.

(1) If the PEO agreement with a covered client is a full work force PEO agreement, the policy or certificate shall cover all PEO co-employees and shall also cover any other obligations of the client under [insert appropriate statutory reference] to the same extent as if the client had obtained a direct purchase policy in this state.

Drafting Note: States that permit the "Designated Workplaces Exclusion Endorsement" should add the following language at the end: " ... or subject to the terms of a Designated Workplaces Exclusion Endorsement in a form approved by the commissioner, consistent with all other applicable legal and procedural requirements, that is properly executed, attached to the policy, specifically identified in the PEO agreement and contingent upon the client's obligation to maintain coverage at the designated workplaces and upon the insurer's obligation to give .notice of the exclusion to the [workers' compensation regulator] when filing proof of coverage."

(2) If the PEO agreement is not a full work force PEO agreement, the policy or certificate may exclude coverage for direct hire employees and may specify that only those employees acknowledged in writing by the PEO as PEO co-employees shall be covered, subject to the following conditions and requirements:

(a) A PEO's insurer may not issue or renew coverage with a direct hire exclusion unless it obtains satisfactory evidence demonstrating that the client has coverage for all of its other workers' compensation liabilities under [insert appropriate statutory reference]. A direct hire exclusion is not valid if the insurer issues the policy or certificate without first obtaining evidence of coverage for the client's other workers' compensation liabilities, or if the coverage for the client's other workers' compensation liabilities has terminated and the PEO's insurer has failed to act promptly to cancel the policy or certificate after learning of the termination.

(b) A direct hire exclusion is not valid if the PEO's insurer has provided proof of coverage on behalf of the client to the [workers' compensation regulator]. In lieu of providing proof of coverage, an insurer that issues a coordinated policy or a master policy certificate with a direct hire exclusion shall provide notice to the [workers' compensation regulator] in a form prescribed by the commissioner in consultation with the [workers' compensation regulator].

Drafting Note: States with proof-of-coverage reporting systems that are capable of tracking both primary and secondary coverage should replace this provision with a requirement to report PEO coverage with a direct hire exclusion as secondary coverage for the client in order for the exclusion to be enforceable.

(c) A policy or certificate with a direct hire exclusion shall provide that loss of coverage for direct hire employees is a ground for cancellation, unless the client obtains replacement coverage with no break in coverage.

(d) If a client's insurer has issued coverage for direct hire exposure, and an injured employee is entitled to workers' compensation benefits but there is a dispute as to whether the employee is a direct hire employee or a PEO co-employee, the client's insurer shall pay the benefits, subject to reimbursement of claims costs and loss adjustment expenses by the PEO's insurer if it is determined that the claimant is a PEO co-employee.

(e) A representation that the client has no direct hire employees does not constitute proof of coverage for direct hire employees. A client representing that its PEO agreement is not a full work force agreement but that it has no direct hire employees within the state must maintain a valid policy of insurance written on an "if any" basis.

(f) Upon the termination of separate coverage for PEO co-employees, they shall be considered direct hire employees for purposes of the client's policy, and premium shall be charged accordingly. The client'spolicy may include an endorsement requiring the client to provide prompt reporting of any notice of termination by the PEO's insurer and advance notice of any voluntary termination, and, if issued in the voluntary market, may provide that termination of the PEO coverage is a ground for cancellation of the client's policy.

(g) If the PEO and its client have obtained separate policies in compliance with this subsection, and one of the insurers becomes insolvent, coverage obligations shall be allocated between the solvent insurer and the [guaranty association] in the same manner as if both insurers were solvent.

B. A master policy shall be issued in the name of the PEO, and shall provide that all clients holding certificates of coverage are additional insureds to the extent provided in the certificate of coverage.

C. A master policy may cover only one PEO or one PEO group. For a master policy to be issued to a PEO group, all covered PEOs must be combinable for experience rating purposes, each member of the group shall execute a cross-guarantee of the premium payment obligations of the other members, and each covered PEO shall be expressly named as an insured PEO before the effective date of coverage. A PEO, employee leasing company, temporary service agency or other entity in the business of employment services outsourcing may not be covered as a client under a master policy or coordinated policy. Each client's coordinated policy or certificate of coverage, and any policy issued to a PEO for the sole purpose of covering its direct hire employees, shall include a Labor Contractor Exclusion Endorsement or similar provision excluding coverage for employees furnished by the client to other entities or with respect to whom the client acts as a PEO.

Drafting Note: If applicable state law regulates PEO groups, this subsection should be revised as necessary for consistency, and if applicable should include a provision requiring the PEO group to be registered or licensed as such.

D. The insurer or its authorized representative shall issue a certificate of coverage to each client covered under a master policy.

(1) The certificate shall specify the effective date of the client's coverage and the expiration date of the underlying master policy. A renewal certificate shall be issued to each client each time the policy is renewed.

(2) The certificate of coverage shall provide that coverage shall continue as long as the master policy and the PEO agreement between the PEO and the client both remain in force, or shall expressly set forth any exceptions.

(3) The certificate of coverage shall provide that the client is entitled to thirty (30) days' notice before coverage may be cancelled or nonrenewed without the client's consent, except:

(a) When replacement coverage is provided by the PEO with no break in coverage; or

(b) When the insurer has notified the client and the [workers' compensation regulator] at the time the certificate is first issued that the master policy will be cancelled or nonrenewed in less than thirty (30) days.

Drafting Note: In states where Section 10 is revised to permit shorter notice in some or all situations, this provision should be modified accordingly.

E. Coordinated policies, except for the policy covering the PEO's direct hire employees, shall be issued in a manner that clearly specifies the identities of the PEO and client and clearly describes the scope of coverage:

(1) Coverage may be issued in the name of "[PEO] and [client] as co-employers," or substantially similar language, as long as the policy clearly indicates which named insured is the PEO and which named insured is the client.

(2) Coverage may be issued in the name of "[PEO] as labor contractor for [client]," or substantially similar language, as long as the policy clearly provides coverage for the client's obligations as employer under the workers' compensation laws.

(3) Coverage may be issued in the name of "[client], for employees co-employed with [PEO]," or substantially similar language, or in the name of the client with the PEO as an additional insured, as long as the policy clearly provides coverage for the PEO's obligations as employer under the workers' compensation laws.

(4) If a client participates in more than one PEO agreement, employees affiliated with different PEOs shall be covered under different policies unless both PEOs, and both PEOs' insurers, agree to the issuance of a single policy providing comprehensive coverage to the client's entire workforce, comprising direct hire employees and PEO co-employees from all sources.

Drafting Note: If applicable state law specifies a different procedure for designating the named insureds on the policy, this Subsection should be omitted or revised accordingly. States that require coordinated policies to be issued in the name of one of the parties to the PEO agreement should take appropriate measures to ensure that the other party is also adequately protected, particularly on the employer's liability side of the policy.

F. A coordinated policy shall be issued on a standard workers' compensation policy form, with an endorsement or endorsements clearly describing all variations from the terms of the insurer's direct purchase policy, consistent with the terms of the multiple coordinated policy agreement and this regulation, including without limitation provisions establishing that premium payment is the sole obligation of the PEO and clarifying the client's rights and obligations with respect to policy cancellation and, if applicable, policy conversion.

G. All policies for clients issued under a multiple coordinated policy agreement with a PEO shall have the same termination date. If a client enters into a PEO agreement during a policy period, the initial policy will be written for less than a twelve-month period. Subsequent policies shall be written with the same effective date as the policies for other clients. Termination of the PEO agreement between the PEO and client shall be grounds for cancellation of the client's coordinated policy or, if agreed between the insurer and the client, for conversion to a direct purchase policy.

H. The insurer shall send each coordinated policy to the PEO, and shall send the client a certificate adopting by reference the policy form attached to the multiple coordinated policy agreement together with any amendments that may be expressly set forth in the certificate, and providing a method by which the client may obtain a copy of the entire policy on request.

I. The insurer shall use its standard underwriting and rating rules for coordinated policies, except as modified by the terms of the multiple coordinated policy agreement.

J. Regardless of the basis on which coverage is provided, the insurer shall report payroll and claims data for each client to the designated advisory organization in a manner that identifies both the client and PEO, and experience modification factors shall be calculated for each client as if the client were the sole employer of all PEO co-employees. The designated advisory organization may also establish rules for the calculation of an experience modification factor for PEOs which may be used by agreement between a PEO and an insurer in accordance with Section 12A.

K. Policies for clients issued on either a direct purchase or multiple coordinated policy basis shall be issued with a Labor Contractor Endorsement limiting coverage under the policy to PEO co-employees and those direct hire employees who are not covered under a separate policy.

L. An insurer, directly or through an advisory organization authorized to act on its behalf, shall file all applicable master policy forms, master policy certificate of coverage forms, multiple coordinated policy agreement forms and coordinated policy forms with the commissioner at least thirty (30) days before issuing master policies or multiple coordinated policies subject to this regulation, or no later than the effective date of this regulation for forms already in use. If a master policy or a multiple coordinated policy agreement is written on a manuscript basis or materially varies from the forms on file with the commissioner, the insurer shall file the contract as soon as practicable, and no later than ten (10) days after the effective date.

Section 8. Premium Payments

A. The PEO is responsible for payment to the insurer of any premiums, policyholder assessments or deductible reimbursement charges under a master policy or coordinated policy, whether or not the PEO has received timely payment from the client. A client's failure to pay fees when due to the PEO does not constitute nonpayment of premium within the meaning of [insert reference to law regulating cancellation of workers' compensation policies and law or residual market operating rule requiring denial of coverage to employers with outstanding premium debt]. Unless the PEO and client are under common ownership, a client may not be denied coverage pursuant to [insert reference to law or residual market operating rule requiring denial of coverage to employers with outstanding premium debt] on the ground that its PEO has failed to pay premium to the insurer when due.

B. A master policy or multiple coordinated policy agreement shall include provisions requiring the insurer to take prompt action to cancel a client's coverage or convert it to direct purchase coverage, at the carrier's option, if notified by the PEO that the PEO agreement has terminated.

C. An insurer may not issue a master policy or multiple coordinated policies with deductibles or with retrospective or other loss-sensitive rating unless the insurer has applicable program policy forms on file with the commissioner.

Drafting Note: If state law prohibits deductibles, omit reference to deductibles.

D. The client's direct hire employees, if any, shall be included in the client's payroll for rating and classification purposes unless the policy or certificate was issued with a direct hire exclusion pursuant to Section 7A(2).

E. If a coordinated policy is converted to or replaced with a direct purchase policy, the insurer shall provide clear and timely notice to both the PEO and client explaining when the PEO's premium payment obligations end and the client's premium obligations begin. The insurer shall conduct a premium audit within 120 days to determine the PEO's final premium obligation under the policy. Unless otherwise agreed between the insurer and the former PEO client, a converted policy shall have no deductible and shall be rated according to the insurer's generally applicable rating plan.

Drafting Note: If applicable state law provides a different time frame for premium audits, states may consider modifying this provision accordingly.

F. If a client's negligence or fraud results in a substantial understatement of the estimated premium for coverage of the client under a master policy or coordinated policy, or if the PEO's negligence or fraud results in a substantial understatement of the estimated premium for a client's direct purchase policy, the PEO and client are jointly and severally liable to the insurer for the premium actually owed.

Section 9. Verification of Classifications and Payroll

A. At least annually, and more often if reasonably requested by the insurer, a PEO shall furnish to the insurer a complete payroll record of all PEO co-employees covered pursuant to a master policy or multiple coordinated policy agreement, itemized by policy or certificate number and by workers' compensation class code. The insurer may visit the client to review ledger records or may request copies of payroll information from the client to determine the actual amounts paid to PEO co-employees, and to direct hire employees if the direct hire employees are not covered under a separate policy.

B. An insurer shall be permitted access to inspect the client's workplace to determine the proper classifications for insurance purposes. If either the PEO or client disagrees with the insurer's classification assignment, it may ask the designated advisory organization to do an inspection to determine the proper classification, subject to a further right of appeal to the commissioner. This subsection does not limit the insurer's or PEO's right to conduct safety inspections as appropriate.

Section 10. Policy Cancellation or Nonrenewal

A. A master policy or a coordinated policy may be cancelled or nonrenewed by the insurer on the same grounds and subject to the same conditions as any other workers' compensation insurance policy. In addition, the insurer shall cancel or nonrenew a coordinated policy covering a client, or may at its option convert it to a direct purchase policy, if the multiple coordinated policy agreement is cancelled or nonrenewed, voluntarily or involuntarily, or if the PEO agreement between the PEO and the client terminates for any reason. The termination or conversion of coverage shall be concurrent with the termination of the multiple coordinated policy agreement or PEO agreement if adequate advance notice can be given in compliance with this regulation and applicable contractual provisions.

Drafting Note: The lawful termination of any essential component of the tripartite agreement among the insurer, the PEO purchasing the coverage, and the client should be a ground for policy termination, especially where the insured risk no longer conforms to the description in the policy. However, in some states the grounds for termination described in this subsection may be prohibited by statute or public policy, and these states should either amend the law or revise this subsection to mandate conversion to direct purchase coverage in lieu of cancellation, and should also make corresponding revisions to subsections 4(D)(3), 7(D)(2) and (7H).

B. Cancellation or nonrenewal of a PEO's or client's coverage at the initiative of the insurer without the written consent of that party is not effective as to that party unless the insurer has given at least thirty (30) days' advance notice to that party and the [workers' compensation regulator] in compliance with [insert citation to law regulating cancellation of workers' compensation policies].

Drafting Note: If applicable state law permits involuntary termination of workers' compensation coverage upon shorter notice in some or all situations, states may consider modifying this provision accordingly.

C. Cancellation or nonrenewal of coverage under a master policy or coordinated policy at the initiative of the PEO or client shall be governed by the applicable contractual provisions, except as otherwise provided in this regulation.

D. Cancellation or nonrenewal of a client's coverage at the initiative of the PEO without the written consent of the client is not effective as to the client unless either:

(1) The insurer has given at least thirty (30) days' advance notice to the client and the [workers' compensation regulator];

(2) The PEO has given at least thirty (30) days' advance notice by certified mail to the insurer, the client and the [workers' compensation regulator]; or

(3) Coverage for all covered clients has been replaced with no break in coverage, and the PEO has given advance notice to the insurer, the clients, and the [workers' compensation regulator].

Drafting Note: If applicable state law permits involuntary termination of workers' compensation coverage upon shorter notice in some or all situations, states may consider modifying this provision accordingly.

E. A request for termination of coverage by a client, or a client's or PEO's consent to waiver of notice under Subsection B or D of this section, is not effective:

(1) If the request or consent is executed in blank without specifying the termination date at the time of execution, or is executed in advance as security for a future obligation;

(2) If the request is made or the consent is given pursuant to a power of attorney that was executed in advance or by an attorney that was not chosen solely by and acting in the sole interest of the party on whose behalf the request is purportedly being made or on whose behalf the waiver is purportedly being given; or

(3) If the request or consent is received by the insurer after the specified termination date, unless the insurer also receives satisfactory evidence demonstrating that coverage has been replaced with no break in coverage.

Section 11. Statistical Reporting and Experience Rating

A. All loss reporting for injuries to PEO co-employees and all payroll reporting for PEOs shall be conducted in a manner that identifies both the PEO and the client and enables the calculation of experience modification factors in accordance with this section.

B. The experience modification factor for the client shall be based on all experience of both PEO co-employees and direct hire employees during the experience period.

C. If some or all of the client's experience is unavailable or unreliable because relevant experience was not reported in the name of the client during all or part of the experience period or in some or all of the states where the client had operations, an experience modification factor shall be calculated in accordance with procedures established by the designated advisory organization and approved by the commissioner.

D. All domestic insurers providing workers' compensation coverage to PEOs and all foreign insurers providing workers' compensation coverage to PEOs registered in this state shall file an annual report with the commissioner on the coverage provided in this market sector, at a time and in a format specified by the commissioner.

Drafting Note: The information to be collected may vary from state to state according to their respective regulatory needs, and states may wish to specify the information to be collected in more detail when promulgating regulations or drafting legislation based upon these guidelines. The information to be collected could include the following: the number of PEOs and number of clients covered; premium and loss information; the rating methodologies, security arrangements, and reinsurance arrangements used; and cancellations and replacements of coverage.

Section 12. Rating Methodology

The premium an insurer charges a PEO for a client's operations shall be rated using the client's experience modification factor, with the following exceptions:

A. If an experience modification factor has been calculated for the PEO in accordance with procedures established by the designated advisory organization and approved by the commissioner, the insurer and PEO may agree to use that experience modification factor or, with the approval of the commissioner, a formula that takes into account both the PEO's and the various clients' experience modification factors.

B. If coverage is rated on the basis of the client's experience and some of the client's operations are to be covered under one or more policies issued by a different insurer, the insurer may, as one of the terms under which it offers to issue or renew coverage and separate from any other applicable credits or surcharges, either:

(1) Use an experience modification factor based on the portion of the client's operations that are covered by that insurer if such a factor can be calculated with reasonable accuracy; or

(2) Adjust the premium in a manner that in the insurer's reasoned underwriting judgment appropriately reflects the difference in risk between the insured operations.

Drafting Note: Section 12 is not appropriate for jurisdictions that have not adopted Section 11, since Section 12 presupposes the existence of an effective mechanism for implementing experience rating at the client level and is not intended as an exemption from the requirements of Section 11. Also, since Section 12 permits the use of a negotiated alternative rating formula, it is not appropriate in jurisdictions that require insurers to adhere to a uniform rating plan.

Section 13. Interstate Coverage

A. If the PEO or client has its *bona fide* principal place of business outside this state, the insurer may request that the commissioner grant a variance from one or more requirements of this regulation to enable the PEO's or client's interstate operations to be covered under a single policy or multiple coordinated policy arrangement. The commissioner shall have the discretion to grant a variance upon a determination that the coverage arrangement preserves the statutory rights of employees and clients and offers protections substantially equivalent to those required by this regulation, that the risk is appropriately rated and that the loss experience of individual clients in this state is accurately reported.

B. If the client has operations in multiple states, an interstate experience modification factor shall be used for the client if the client would be subject to interstate modification if it were the sole employer of its PEO co-employees and an accurate loss history is available for the client's interstate operations.

Section 14. Confidentiality

If any information filed with or provided to the commissioner pursuant to this regulation is a trade secret or otherwise exempt from public disclosure under the [insert citation to applicable open records law], the commissioner shall withhold it from public disclosure if the person or entity providing the information makes a written request for confidential treatment that specifies with particularity why the document should be exempt from disclosure under the [insert citation to applicable open records law]. PEO client lists or other information from which the identity of clients may be inferred are presumed to be trade secrets and may not be disclosed to the public except on a finding by the commissioner that the specific information sought to be disclosed is not a trade secret or that failure to disclose the information would tend to conceal fraud or otherwise work injustice.

Drafting Note: In states where residual market employer lists are published, add the following sentence: "If a PEO is covered in the residual market, it shall not be named in the published listing of employers with residual market coverage at any time, and its clients shall not be named until residual market coverage has been in force for sixty (60) consecutive days and shall not be designated as clients of the PEO."

Section 15. Remedies

A. Violations of this regulation by a PEO, client or insurer are subject to penalties as provided in [insert citation to general disciplinary law or other applicable law]. Disputes involving a PEO, client or insurer arising out of a claimed violation of this regulation may be resolved by an adjudicatory hearing before the commissioner.

Drafting Note: In states where another agency has regulatory jurisdiction over PEOs, there should either be a provision specifying procedures for referring disciplinary actions for PEOs to that agency, or provisions under which regulations are jointly promulgated by the agency regulating PEOs and establishing remedies under that agency's regulatory authority.

B. It is a deceptive practice in the business of insurance within the meaning of [insert appropriate citation to unfair trade practices act] for a PEO to represent to clients or prospective clients that they have or will have workers' compensation coverage except when a coordinated policy or certificate of coverage is issued in compliance with this regulation or a duly authorized agent of the insurer has issued a valid temporary binder; for a PEO to purport or threaten to terminate workers' compensation coverage except in accordance with this regulation; or for a PEO to knowingly or recklessly fail to provide the notices or disclosures required by this regulation. If the violation is knowing or willful, it is a fraudulent insurance act within the meaning of [insert appropriate citation to insurance fraud act].

Section 16. Effective Date

The effective date of this regulation is [insert appropriate lead time], except that no later than [one month earlier], the [statutory carrier of last resort or residual market manager] shall file its proposed standard multiple coordinated policy agreement with the commissioner, pursuant to Section 6 of this regulation, and the designated advisory organization shall file proposed state special modifications to its experience rating plan if any are required. This regulation applies to all policies issued or renewed and any applications submitted on or after the effective date of this regulation.

Appendix B

NCCI Alternatives and Technical Supplement on Data Reporting

Purpose of Proof of Coverage (POC) and Experience Rating Data

Workers' compensation administrators and insurance regulators rely on POC and statistical data to enforce and monitor the workers' compensation system. For states that recognize the PEO and their clients as co-employers, compliance programs and regulations need to consider the impact of insurance coverage as it relates to the PEO and the client employer. Regardless of the existence of a PEO or employee leasing arrangement, the integrity of experience rating and POC programs must be effectively maintained with statistical data that is:

- Sufficient to enable the state's compliance administrator to efficiently track and identify whether an employer within the state has the coverage required by law to ensure that injured employees' claims will be processed and the required benefits paid. At a minimum, POC data must identify the worksite employer's name, location, covered work units, and date of inception/cancellation/termination of coverage.

- Detailed enough to allow for the accurate reporting and tracking of payroll and losses attributable to the worksite employer, and enabling the calculation of experience modification factors at the client level.

Master Policy Considerations

The Guidelines support the master policy model when the following conditions are met:

- Client-specific notice requirements and payroll, loss, and other data reporting requirements give the client a status similar to that of an individual insured employer while insured under a master policy;

- Current insurance statistical and data reporting structures have the ability to track client experience and produce client experience ratings using all of the client employers' past experience, whether or not that experience is from the master policy;

- The insurer or the PEO cannot terminate or materially alter coverage without reasonable advance notice to the client;

- Insurers maintain and report data in sufficient and accurate detail to permit the calculation of meaningful client-specific experience ratings and verification of POC on the client level;

- Experience ratings are produced on an ongoing basis for every client that is eligible for experience rating;

- Ability to identify each covered client's workforce as a discrete unit of coverage under the master policy;

- The master policy adopts a "certificate of coverage" requirement, under which each client is issued a coverage document outlining its rights and obligations under the master policy and clearly establishing both the identity and status of the client and the inception and termination dates of coverage.

Considering these conditions, the Master Policy could be issued using the following structure:

- Standard workers' compensation policy (master policy) is issued to the PEO, as the primary named insured;

- Each client company of the PEO is listed as an additional named insured (as provided in Subsection 7(B) of the Guidelines);

- Information page schedules are attached to the master policy to identify each client company's name, FEIN, and job location;

- Each client company is issued a "certificate of insurance" coverage document outlining its rights and obligations under the master policy that clearly establishes both the identity and status of the client, and the inception and termination dates of coverage;

- Each client workforce is identified as a discrete unit of coverage, and corresponding endorsements are attached to specify notice requirements, and policy conditions for each client company covered under the master policy;

- Experience modification factor applicable to the master policy would include the combined experience of the PEO and each client company, including any past experience;

- Pricing and experience rating rules may be adjusted to allow for the combinability of experience and combination of premiums and eligibility for discounts, such as large deductible programs, retrospective rating, and group modification factor.

Data Reporting Options for the Master Policy

The root of the technical problems with obtaining client-level data under a master policy is that present industry standards for the reporting and collection of data are based on the issuance of a separate policy for each employer. These standards support the constant exchange and use of data from carriers' systems to data collection organizations, and subsequently, to many states' compliance systems. The existence of a separate policy identifies the employer as a potential candidate for experience rating and results in the submission of unit statistical data that provide the payroll and losses of the employer used in the experience rating calculation. While some industry standards have changed to assist in the complex reporting of PEO-related data, the ability to make significant changes to the current system is limited both by cost considerations and the need to preserve current capabilities for exchanging data. Adding requirements or changing industry standards is only meaningful if compliance is technically feasible.

Following are two Master Policy options for the reporting of client-level detail. To consider coding changes and system implementation, an 18 to 24 month industry lead time would be required. Should any of these alternatives be considered (or possibly others), it is important to take into account the full range of data reporting and experience rating challenges presented by the Master Policy when client-level detail is required. Both options require the reporting of unit reports for each client that can be linked together for experience rating purposes; the major difference between the options relates to how policy (and POC) data is reported. A third option presented is to convert the current manual reporting system to electronic form. This would support reporting under the 1991 NAIC Model Regulation, but would not be consistent with the Guidelines.

Option 1: Single master policy issued with the reporting of separate client policy and unit data

Data Reporting Requirements

Option 1 sets up a data reporting system for master policy situations that parallels the multiple coordinated policy framework. Separate policy data for each client company and the PEO would be reported as if separate client policies were issued. Separate unit data (payroll and loss) for each client would also be reported, thereby allowing for the reporting and maintenance of client level experience, in addition to the calculation of a group modification factor based on the combined experience of the PEO and its clients. This option would require the reporting of data in sufficient detail to permit the calculation of meaningful client-specific experience ratings, upon termination of a PEO agreement, and verification of POC at the client level. Additionally, policy reporting would need to be sufficient to identify the connection between all the client level policies to ensure that the separate unit data would also be rolled up to the PEO master policy level.

Option 2: Single master policy issued with the reporting of single policy data and separate client-level unit data (Multiple Coordinated Units)

Data Reporting Requirements

Option 2 attempts to support the continuation of reporting a single master policy, but requires the reporting of separate unit data (payroll and loss) for each client. It utilizes the single PEO Master policy and requires multiple coordinated units to be reported. With Option 1, both client-level policy and unit data would be reported; however, with Option 2, only client-level unit data would be reported. As a result, Option 2 would require more detailed policy reporting requirements and the expectation of multiple unit reports for a single master policy. This option would call for significant changes to industry standards, including operating and reporting systems, and might be difficult to implement and costly to the industry.

Option 3: Electronic Reporting of Former Client Experience Rating Data

Currently, when a client leaves a master policy, the PEO carrier reports the client's payroll and loss data to NCCI for experience rating purposes on a hard copy form through a manual process. Option 3 automates the current experience rating manual process, so that carriers would be able to electronically report and collect the individual data of former client companies to NCCI. This option supports the 1991 NAIC Model Regulation, which requires submission of client-level data only after the termination of an employee leasing arrangement; however, it would require changes in industry standards, additional costs, and may prove inadequate if business limitations exist for accurate and timely maintenance and reporting of client-level payroll and losses. This option does not address the maintenance of client-level data while the client is part of the master policy, and therefore is not consistent with the Guidelines.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

2007 Proc. 2nd Quarter, Vol. I 100, 111, 129-135, 219, 425, 627, 647 (adopted).
2007 Proc. 4th Quarter, Vol. I 116, 125, 141-142, 167-169, 403-405, 438-440, 484-488 (amended).
2010 Proc. 2nd Quarter, Vol. I 103, 124, 270-315 (amended).

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

NAIC MEMBER	RELATED ACTIVITY
Alabama	ALA. CODE § 25-1409 (2006).
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	ARK. CODE ANN. § 23-92-409 (2003/2019); BULLETIN 12-2009 (2009).
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	HAW. REV. STAT. §§ 373L-1 to 373L-8 (2010/2013).
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

NAIC MEMBER	RELATED ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	LA. REV. STAT. ANN. § 1768 (2001).
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	MASS. GEN. LAWS ch. 149, § 197 (2018).
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	MO. ANN. STAT. § 285.740 (2018).
Montana	MONT. CODE ANN. § 39-8-207 (1995/2007).
Nebraska	NEB. REV. STAT. § 48-2709 (2010/2012).
Nevada	NEV. REV. STAT. §§ 616A.465 to 616D.120 (2009/2013).
New Hampshire	BULLETIN 2008-079-AB (2008); BULLETIN 2010-024-AB (2010); BULLETIN 10-008-AB (2010).
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	N.C. GEN. STAT. ANN. § 58-89A-110 (2004/2005).
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	OHIO ADMIN. CODE § 4123-17-15 (1997/2019).
Oklahoma	OKLA. STAT. ANN. tit. 40, § 600.7 (2002).

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS

NAIC MEMBER	RELATED ACTIVITY
Oregon	NOTICE 6-10-2013 (2013).
Pennsylvania	43 PA. STAT. ANN. § 933.303 (2012).
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	R.I. GEN. LAWS § 5-75-9 (2004/2006).
South Carolina	S.C. CODE ANN. § 40-68-60 (1993/2005).
South Dakota	NO CURRENT ACTIVITY
Tennessee	TENN. CODE ANN. § 62-43-110 (2012).
Texas	TEX. LAB. CODE ANN. § 91.042 (1995/2013).
Utah	UTAH ADMIN. CODE r. 31A-40-101 to 31A-40-402 (2008/2017); UTAH ADMIN. CODE r. 612-400-2 (2013).
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	16 VA. ADMIN. CODE §§ 30-100-10 to 30-100-80 (2001).
Washington	NO CURRENT ACTIVITY
West Virginia	W.VA.CODE § 3-46A-7 (2008); W. VA. CODE R. §§ 85-31-1 to 85-31-7 (2000/2008).
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY – 2010

GUIDELINES FOR REGULATIONS AND LEGISLATION ON WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS (#1950)

1. Background

In 1991 the NAIC adopted an Employee Leasing Model Regulation and an Employee Leasing Registration Model Act. However, because of the evolution of this market over the intervening years, the Model Law Review (C) Working Group of the Workers' Compensation (C) Task Force had recommended in 2003 that these models be discontinued, noting that very few states had ever adopted them, and they had become considered seriously out of date. It was believed that only a complete rewrite should be considered. Therefore, during the NAIC 2003 Winter National Meeting, these two 1991 models were discontinued.

The Workers' Compensation (C) Task Force formed the Professional Employer Organization Model Law (C) Working Group[1] during the NAIC 2003 Winter National Meeting to consider the development of new model laws that would be appropriate for this market. Through this working group the *Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements* (PEO Guidelines) were drafted to serve as a replacement for the 1991 models. The PEO Guidelines were adopted by Executive/Plenary during the NAIC 2007 Summer National Meeting.

The PEO Guidelines were developed to ensure that professional employer organizations (PEOs) and their clients properly obtain workers' compensation insurance coverage for all their employees, including both direct hire employees and persons employed under PEO agreements; that the premium paid is commensurate with the anticipated claim experience; and that an appropriate procedural framework is in place for the inception, continuation, and termination of coverage.

2. Drafting Group Formed

During the Professional Employer Organization Model Law (C) Working Group's June 10, 2006, meeting, it was suggested that a paper be developed to complement the anticipated adoption of the PEO Guidelines. The paper would be drafted to serve as a companion document to assist states, professional employer organizations, and the insurance industry in implementing a regulatory framework consistent with the PEO Guidelines.

The PEO Guidelines Implementation Paper Drafting Group (Drafting Group) was therefore formed during the June 2006 Working Group meeting for that purpose and was composed of the following regulator and interested party members: Bob Wake (Chair—ME), Alan Wickman (NE), Mona Carter (National Council on Compensation Insurance), and Bill Schilling (National Association of Professional Employer Organizations).

3. Parent Committee Charge Authorizing Project

The following is the Workers' Compensation (C) Task Force 2010 charge that pertains:

> Appoint a Professional Employer Organization Model Law Working Group to complete development of a paper to be of assistance to states in the implementation of the NAIC Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950); to coordinate with other NAIC groups on issues relating to professional employer organizations; and to follow changes in the professional employer organization marketplace. The Working Group is to report the results of their ongoing charge at each national meeting.

4. General Description of Drafting Process

The Drafting Group held its first conference call on Nov. 26, 2007, to review a draft outline of the proposed paper. The Drafting Subgroup's next conference call was held March 25, 2008, in which a number of specific drafting assignments were made to address identified issues. Subsequent Drafting Group conference calls were held on the following dates: Dec. 1, 2008; Feb. 19, 2009; March 17, 2009; April 14, 2009; May 12, 2009; June 1, 2009—in which drafting was completed.

[1] Name changed Sept. 22, 2005, from the Employee Leasing Model Laws (C) Working Group to the Professional Employer Organization Model Law (C) Working Group.

The Working Group first reviewed the draft, now titled "Implementation Commentary: Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements" (Implementation Commentary) during the NAIC 2009 Fall National Meeting. The Working Group determined in a Nov. 6, 2009, conference call that the draft Implementation Commentary should be moved to the Workers' Compensation (C) Task Force during the NAIC 2009 Winter National Meeting—to receive greater exposure.

During the Dec. 6, 2009, Workers' Compensation (C) Task Force meeting the draft "Implementation Commentary" was transferred to the Task Force's purview, with comments on it requested by Feb. 24, 2010. The exposure draft, dated Sept. 22, 2009, continued to remain[2] on the NAIC website under Committee & Activities/White Papers during this period and the draft was also distributed for any final comments to members, interested regulators, and interested parties of the NAIC/IAIABC Joint (C) Working Group and the Professional Employer Organization Model Law (C) Working Group.

Few comments were received during the comment period expiring Feb. 24, which were reviewed and considered, but no material changes made to the draft from that of its Sept. 22, 2009, version. Therefore, the Sept. 22, 2009, version was presented for consideration of adoption to the Workers' Compensation (C) Task Force during the NAIC 2010 Spring National Meeting, at which time the Task Force adopted the draft "Implementation Commentary" without changes. The Sept. 22, 2009, draft was next presented for consideration of adoption to the Property & Casualty Insurance (C) Committee on March 28, 2009—also adopted without change. The draft next is to go before the Executive/Plenary for consideration of adoption during the NAIC 2010 Summer National Meeting.

5. Project Description

The draft Implementation Commentary provides a framework for considering the PEO Guidelines and provides additional information concerning:

- The historical background of the PEO Guidelines, including an overview of PEO arrangements;
- Presents differences between the PEO Guidelines and earlier regulatory approaches;
- Discusses statutory and structural considerations for implementation; and
- Considers key issues that might be essential for successful implementation.

Each of its section titles alludes to the information found within. The section titles are the following:

- Executive Summary
- Section I: Historical Background of the Guidelines
- Section II: Some Legal Issues Relating to Implementation (existing law; key issues beyond the scope of the guidelines)
- Section III: Specific Issues Related to the Guidelines (see "Issues Identified" below)
- Conclusion
- Appendices (The PEO Guidelines; National Council on Compensation Insurance "Alternatives and Technical Supplement on Data Reporting")

6. Issues Identified

Among issues identified which were addressed in Section III of the draft "Implementation Commentary" were the following:

- ✓ Statutory-Regulatory Framework for PEOs
- ✓ Master Policies and Client-Level Experience Rating
- ✓ Lack of Coverage, Gaps in Coverage, and Proof of Coverage
- ✓ Notice and Cancellation of Coverage for PEOs and Clients
- ✓ Policy Forms
- ✓ Data Reporting
- ✓ Exclusive Remedy
- ✓ Residual Market Issues
- ✓ Pricing
- ✓ Improper Extensions of Coverage (Piggybacking)

[2] The Sept. 22, 2009, version of "Implementation Commentary" was originally placed on the NAIC website shortly after its drafting date.

- ✓ Self-Insurance
- ✓ Loss-Sensitive Coverage

7. Other Pertinent Information

The PEO business model for employment services outsourcing has continued to expand nationwide. Presently, there is a broad disparity among the states as to how PEO arrangements are being regulated. The existing statutory frameworks in some states might not directly or adequately address issues related to workers' compensation, while other states are devoid of any significant statutory provisions.

The PEO Guidelines are designed to provide the states with a possible regulatory framework for addressing the most significant workers' compensation issues that have arisen to date in PEO relationships, with an emphasis on a clear allocation of the respective rights and responsibilities of PEOs, clients, and insurers. The purpose of the "Implementation Commentary" is to provide additional insight from the work group that developed, through its drafting group, the guidelines.

The "Implementation Commentary" is to be a lead document, with the PEO Guidelines included as Appendix A. In this way it is believed the PEO Guidelines will be properly introduced and that the additional information provided may prove useful for successful implementation and oversight.

PROJECT HISTORY – 2007

WORKERS' COMPENSATION COVERAGE FOR PROFESSIONAL EMPLOYER ORGANIZATION ARRANGEMENTS MODEL REGULATION

1. Background

In 1991 the NAIC adopted an Employee Leasing Model Regulation and an Employee Leasing Registration Model Act. However, because of the evolution of this market over the intervening years, the Model Law Review (C) Working Group of the Workers' Compensation (C) Task Force had recommended in 2003 that these models be discontinued, noting that very few states had ever adopted them, and they had become considered seriously out of date. It was believed that only a complete rewrite should be considered. During the NAIC 2003 Winter National Meeting these two 1991 models were discontinued.

2. Working Group Formed

The Workers' Compensation (C) Task Force formed the Employee Leasing Model Laws (C) Working Group during the NAIC 2003 Winter National Meeting to consider the development of new model laws that would be appropriate for this market. On Sept. 22, 2005, the Workers' Compensation (C) Task Force changed the name of the Employee Leasing Model Laws (C) Working Group to the Professional Employer Organization Model Law (C) Working Group, since the term "employee leasing" was considered outdated in most states and the more contemporary term for these services was professional employer organization (PEO).

The following jurisdictions are currently members of the Professional Employer Organization Model Law (C) Working Group, chaired by Bob Wake (Maine): Arkansas, California, Connecticut, Florida, Kansas, Kentucky, Minnesota, Missouri, Nebraska, Nevada, Oklahoma, Oregon, South Carolina, Utah, West Virginia, and Wisconsin.

3. Parent Committee Charge Authorizing Project

The following is the Workers' Compensation (C) Task Force 2004 charge that pertains:

> Appoint an Employee Leasing Model Law Working Group to develop new employee leasing/professional employer organization model laws that address issues presented in the June 2002 NAIC "Report on Employee Leasing and Professional Employer Organizations" in addition to later credible concerns. The new model laws are to be designed to replace the previous two NAIC model laws on this subject adopted by the NAIC in 1991: Employee Leasing Model Regulation; Employee Leasing Registration Model Act. Make final recommendations for adoption of the new model laws by the NAIC 2005 Fall National Meeting. Report the results of this ongoing charge on a quarterly basis.

4. General Description of Drafting Process

The Professional Employer Organization Model Law (C) Working Group began to assess current PEO regulatory issues during its first conference call, held Feb. 10, 2004. In developing the new model regulation, the Working Group frequently referenced the "Report on Employee Leasing and Professional Employer Organizations," which was developed through the NAIC/IAIABC Joint (C) Working Group and adopted by the NAIC in June 2002.

The Report on Employee Leasing and Professional Employer Organizations dealt primarily with the ramifications of the "master policy" framework for workers' compensation insurance coverage. A master policy arrangement is typically characterized by an insurer issuing a single policy covering the employees of all of its clients (employers), including the internal employees of the master policyholder. In most states, the voluntary market allows for master policies to be written at the insurer's discretion. However, in the residual market each client is required to be insured under a separate insurance policy, referred to as a "multiple coordinated" policy arrangement. A multiple coordinated policy arrangement is characterized by having an insurer issue separate policies, with common policy administration and renewal date, to each client company. The multiple coordinated policy approach raises fewer regulatory problems, but places more administrative burden on insurers and PEOs.

The 1991 models were considered out-of-date by the Professional Employer Organization Model Law (C) Working Group primarily because of their emphasis on residual market issues with only secondarily attention to master policy concerns. The Working Group reviewed the two discontinued models for areas in need of improvement. The Working Group made the decision that the new model should pertain only to workers' compensation, rather than including other insurance lines or non-

insurance issues. In developing the draft model, the Working Group obtained information (e.g., charts; surveys; other organization model acts) and comments from a wide number of sources, which included most notably the following: interested insurance regulators that were not members of the Working Group; the International Association of Industrial Accident Boards & Commissions; the National Association of Professional Employer Organizations; and the National Council on Compensation Insurance (NCCI). Additionally, industry responses to PEO questions asked by the Working Group were obtained through an informal ad hoc gathering of various trade associations under the leadership of the Property Casualty Insurers Association of America.

Because of the volume of comments and the importance and complexity of the issues, the Working Group did not adopt the PEO Model Regulation, to be titled the "Workers' Compensation Coverage for Professional Employer Organization Arrangements Model Regulation," until the NAIC 2006 Winter National Meeting held in San Antonio, Texas. The draft model regulation required some significant changes from status quo in regard to how coverage is documented under master policies, how some statistics are to be reported, including those for proof-of-coverage, and how experience rating might be utilized. However, the Working Group believed that dynamic changes were needed to find a way to effectively regulate PEOs in today's marketplace, which encompasses master policies and multiple coordinated policies.

The Workers' Compensation (C) Task Force also considered the PEO Model Regulation for adoption during the NAIC 2006 Winter National Meeting but determined that more time was needed for public exposure, due to revisions to the draft shortly before its Working Group adoption. However, the Task Force and the Property and Casualty Insurance (C) Committee did adopt the March 11, 2007, draft PEO Model Regulation, without changes, during the NAIC 2007 Spring National Meeting.

General Description of Due Process

The Working Group held 17 conference calls and/or meetings since it conducted its first conference call on Feb. 10, 2004. All conference calls and meetings were open, except for one executive session meeting held on Dec. 5, 2004. Additionally, from Feb. 20, 2004, through March 11, 2007, a dozen drafts of the PEO Model Regulation had been circulated at different times to members and interested parties for comment.

5. Project Description

The draft NAIC PEO Model Regulation was developed to ensure that the following occurs:

- PEOs and their clients properly obtain workers' compensation insurance coverage.
- Premiums paid are to be commensurate with anticipated claims experience.
- Coverage would need to be obtained for all employees—including both direct hire employees and persons employed under PEO agreements.
- Appropriate procedural frameworks would be in place for the inception, continuation, and termination of coverage.

Each of its section titles alludes to the comprehensive information found within. The section titles are the following:

- Section 1: Authority and Purpose
- Section 2: Definitions
- Section 3: Insurance Coverage on PEO Co-Employees
- Section 4: Requirements for PEOs
- Section 5: Multiple Coordinated Policy Agreement
- Section 6: [Option One] Coverage in the Residual Market
- [Option Two] Coverage by the [Statutory Carrier of Last Resort]
- Section 7: Policy Issuance
- Section 8: Premium Payments
- Section 9: Verification of Classifications and Payroll
- Section 10: Policy Cancellation or Non-renewal
- Section 11: Statistical Reporting and Experience Rating
- Section 12: Interstate Coverage
- Section 13: Confidentiality
- Section 14: Remedies
- Section 15: Effective Date

6. Significant Issues Raised

Among key issues identified were the following:

- Experience rating, including but not limited to modification laundering. The primary issues motivating the old model laws continued to be identified as a significant problem both by regulators and the NCCI.

- The need for certainty regarding who is insured, who is the insurer, when coverage begins and ends, and how this is verified with the appropriate regulators.

- Ensuring that all affected parties receive the information they need, and that there is due process before coverage is terminated and adequate opportunity to shop for replacement coverage. Affected parties are PEOs, clients, insurers, statistical organizations, claimants, insurance regulators, and workers' compensation regulators.

- Appropriate procedures in place to deal with insolvencies and the threat of insolvency, and to minimize the risk of harm to claimants and PEO clients.

- Piggybacking: A situation where several PEOs are listed as clients on another PEO's policy and coverage is provided through a master policy.

- Coverage for Direct Hire Employees. A "direct hire employee" of a client or a PEO means an individual who is an employee within the meaning of the Workers' Compensation Act and who is not a PEO co-employee as defined in Section 2, Subsection J of the draft.

- Responsible Party for the Premium. Should the client pay the PEO a fee in exchange for the PEO being responsible for payment of the insurance company premium that provides the client coverage?

- The "unknown employee" exposure. This exposure exists when the client does not have any coverage of its own because it intended to cover its entire workforce through the PEO. However, someone unexpectedly files a claim as an employee of the client—either because the claimant was a new employee who has not yet established a documented relationship with the PEO, or because the claimant was regarded by the client as an independent contractor.

7. Other Pertinent Information

- National Conference of Insurance Legislators (NCOIL) Draft PEO Model Act

NCOIL has been developing its own PEO Model Act. However, the NCOIL model is not expected to be as broad in scope as the draft PEO Model Regulation produced by the Professional Employer Organization Model Law (C) Working Group. During the NAIC 2007 Spring National Meeting the Workers' Compensation (C) Task Force formed the NCOIL PEO Model Focus Group, composed of members who were most involved with PEO activities. The purpose of the NCOIL PEO Model Focus Group was to provide comments regarding the recent NCOIL draft for delivery to that organization by its deadline date of March 30, 2007. The comments were submitted by that date. NCOIL next plans to make a decision on its model during the NCOIL Summer Meeting, to be held in Seattle, Washington from July 19—22, 2007. NCOIL is an organization of state legislators whose primary focus is insurance legislation and regulation.

- Complementary Paper

During the Professional Employer Organization Model Law (C) Working Group's June 10, 2006, meeting, a suggestion was made for a paper to be developed to complement an adopted NAIC PEO Model Regulation. The intent of the paper (not anticipated to be a white paper) would be to help states determine law changes that need to be made and to indicate whether insurers, bureaus and PEOs are ready to handle the data and other needs addressed in the model. The Working Group agreed to develop such a paper and therefore plans to continue meeting after adoption of the model.

GUIDELINES FOR THE FILING OF WORKERS' COMPENATION "LARGE DEDUCTIBLE" POLICIES & PROGRAMS

Background: For an exhaustive treatment of large deductible workers' compensation insurance, see the NAIC/IAIABC white paper, *Workers' Compensation Large Deductible Study*. The intent of these guidelines is to give states suggested approval guidelines for large deductible policies and programs that are consistent with that detailed study, and to give a few comments on the reasoning behind some of them. Unfortunately, the *Large Deductible Study* has become dated in some respects (TPA-related matters being the prime example), which means that the reader should supplement that background material with a review of relevant NAIC activity since then.

Status of these "Guidelines": During the time that these guidelines were under development, the NAIC decided that issues previously being addressed through the adoption of model laws and regulations would instead be addressed by the adoption of "guidelines" if there was not a widespread feeling among NAIC membership that the NAIC should strongly encourage adoption by the states of the law or regulation on a uniform basis. Accordingly, many items that were previously under development as model laws or regulations were reclassified as "guidelines." This document, however, was never intended for adoption as a regulation or law ("model" or otherwise). Rather, it was (and is) intended to be adapted by the individual state to its laws and then to become part of the state's (often informal) set of published approval standards. While parts of this document may cause a state to consider law changes, no attempt is contained herein to draft any suggested statutes or regulations.

Conformance to State Laws: As referenced in the preceding paragraph, the suggested requirements will need to be modified by individual states as necessary to conform to specific state laws. For instance, some states have laws that restrict the eligibility of some employers for these programs, or that prescribe deductible amounts, or that require specific forms, or that require or prescribe collateralization. Particularly in light of the disfavor with which so-called "desk drawer rules" are viewed, individual states are encouraged to add or delete material from this document in order to make their own review guidelines consistent with the individual state's laws. Each state is then encouraged to make its version of this document freely available through whatever means that the state uses to communicate its approval standards.

Situations in which these guidelines are most likely to require amendment include (a) if state law requires the employer to post collateral in order to obtain large deductible coverage; (b) if state law allows insured employers to self-administer claims or to have any formal right to deny or protest claims; (c) if state law includes PEO provisions that may require amendment of these guidelines where they refer to a PEO; (d) if state law restricts the sale of large deductible coverage to employers of a minimum size or has other requirements of a similar nature, (e) if state law has rate filing requirements or restrictions on allowable rates, and (f) if state law has provisions relating to TPAs, which are likely to vary from state to state especially as/if/when TPA-related laws are revised to recognize workers' compensation. This list is not intended to be all-inclusive. Typically, states are well aware of unique provisions in their laws that would give rise to exceptions.

Deductible size: These approval standards and other requirements have only been written to apply to so-called "large" deductibles, not to small deductibles allowed (or required in some cases) as an option by some states' laws. While there is no attempt in this document to distinguish these "small" deductibles from "large" deductibles, there is generally a clear distinction in the marketplace. "Small" deductibles are typically no more than $5000 or $10,000 and may be for medical losses only. "Large" deductibles are typically at least $100,000 (although some states have approved "large" deductibles as low as $25,000), and $1,000,000 deductibles are not uncommon. They will always or almost always apply to combined medical and indemnity losses.

Rates & statistical reporting: These guidelines do not address rate filing requirements. Each state will need to review its own laws to determine applicable rate filing standards and requirements. These guidelines do, however, recognize that accurate statistical reporting is essential to the integrity of the ratemaking process, and one of the objectives of these requirements is to ensure that experience incurred under these policies can be reported to the NCCI or other state bureau on a basis that preserves information on classifications, payroll and total losses.

– Suggested Filing Requirements –

(1) Insurers are neither obligated to offer large deductible policies, nor to offer them to all customers in all amounts that the insurer might file or that these guidelines might allow.

(2) Under a large deductible policy, the insurer (or TPA on its behalf) must handle the defense and settlement of all claims as if no deductible applies. The policy must provide that the insurer shall pay all deductible amounts directly to the person or health care provider entitled to the benefit pursuant to the law, with deductible amounts paid by the insured employer to the insurer or its TPA. The insurer's obligation to pay claims shall not be eliminated if the employer fails in its obligations to reimburse the insurer or its TPA. Termination of the policy only terminates the insurer's obligation for injuries incurred after the policy period, and shall not affect obligations for injuries prior to the cancellation or expiration of the policy.

(3) All costs borne by the employer must be in the form of payments to the insurer or its TPA. The employer must not pay anything to claimants, doctors, attorneys or any entity other than the insurer or its TPA to settle workers' compensation obligations or to pay for associated settlement costs. (*State exceptions may occur with "first aid" costs or in the occasional instance where the policyholder is a hospital or has the capability to provide emergency on-site treatment for injuries.*)

(4) Rights of the employer to contest, control, approve or disapprove claim settlements must be consistent with those allowed by state insurance and workers' compensation laws. In many or most states, such rights are limited or do not exist. Provisions that appear to give the employer additional rights to control, approve or disapprove payments or settlements should not be allowed when they conflict with state law, either in policies or in TPA agreements. (*Explanation: Applicability of these statements will depend upon state law. In a number of states, the workers' compensation law gives the employer some ability to dispute a workers' compensation claim that its insurer intends to pay. Even in such states, however, an endorsement to this effect is usually unnecessary as this right vests to the employer without any policy endorsement being necessary. As such, provisions of this nature are generally discouraged because, if they are not illegal, then they are probably unnecessary.*) The comments in this section are not intended to preclude an insurer or TPA from agreeing with the policyholder to provide detailed or extensive claim reporting or notification procedures, as long as those procedures are not inconsistent with state law. It is not unreasonable to expect large policyholders to want more frequent reporting with greater detail than is common with small policyholders that only have infrequent claims.

(5) Given the likelihood that many policyholders will not have a detailed knowledge of state law and interpretations thereof, it is strongly advisable that contracts include specific language complying with items (2), (3) and (4), to ensure that these items are clearly understood, rather than relying on the statutory obligations of the insurer or a generic conformance clause.

(6) Prompt payment of all amounts owed to the insurer is one of the policyholder's most important contractual obligations. Some of the states that allow relatively quick (e.g., ten days) cancellation for nonpayment of premium explicitly recognize nonpayment of a deductible reimbursement as a ground for accelerated cancellation on the same basis. In states without explicit provisions in their laws to address nonpayment of deductible reimbursements, this should be viewed as a ground for cancellation under laws permitting cancellation for "substantial breach of contractual duties" or similar statutory language. It is also recommended that states allow the insurer to have the right to offset unpaid deductible amounts against unearned premiums, if any, in the event of cancellation of the policy.

(7) Coverage written under these forms is customarily considered workers' compensation coverage for Annual Statement reporting, workers' compensation law, and insurance laws. It is not necessary that these items be mentioned in a manual page for the insurer, but nothing should be approved that states or suggests otherwise.

(8) Typically, large deductible policies will be developed by the attachment of a large deductible endorsement to an otherwise standard workers' compensation policy. Large deductible policies are still considered statutory policies (as opposed to excess workers' compensation policies, which are written for approved self-insureds, and are typically not considered statutory policies), so the large deductible endorsement must not purport to negate any statutorily required provisions. Should an insurer file an entire large deductible *policy form*, instead of an endorsement, the regulator must take care to see that all statutory provisions are included.

(9) The policy must specify the nature of the losses for which the employer must reimburse the insurer, or reimburse the TPA on the insurer's behalf. The deductible amount may be any one of the following:

(a) Benefits only;

(b) The sum of benefits and actual LAE or ALAE; or

(c) Benefits only, but the employer is liable to reimburse actual LAE or ALAE in addition to the deductible applying to the benefits.

(d) Any reasonable pro-ration of LAE or ALAE between the insurer and the employer is acceptable.

Employers' liability coverage may be included with any of the above. (*Some state laws may not allow all of these options and this language will then need to be restricted accordingly.*)

(10) The policy must specify whether the deductible is per-person or per-accident. The most common form of deductible (per-accident for accidental injury and per-person for disease) is acceptable; unique proposals should be considered on their merits.

(11) Even in states that otherwise exempt large deductible workers' compensation insurance from rate filing requirements, manual pages and/or other documentation should be filed to assure that policies are written in accordance with these guidelines and any specific state laws. Individual risk filings should not be necessary and are not recommended.

(12) Some states have laws, regulations or other practices that exempt policyholders of a certain size or premium from various aspects of form or rate regulation. In these states, it is likely that most or all large deductible policyholders will qualify. When exemptions from form approval apply, care should be taken that these exemptions may not be used to evade or alter the statutory requirements for workers' compensation policies. In particular, policyholders and insurers may not be given the ability to reduce benefits in any way, and employers may not be given rights to adjust or administer claims, nor to control a TPA or adjuster, except to the limited extent as may be permitted under Items 25 and 26.

This recommendation is not intended to imply that that states should limit large risk flexibilities otherwise granted for workers' compensation rates or premium payment provisions. To the contrary, Item 21 in these guidelines recommends that states grant policyholders and insurers considerable flexibility in the negotiation of collateral and deposit arrangements.

(13) Policy rating must preserve and use usual payroll and classification information and require the use of audited payrolls after policy expiration. In other words, rating that does not use standard workers' compensation rating classifications and actual audited payrolls should not be allowed. The reason for this is to preserve data and data quality associated with these policies. Although it is typically not necessary for the large deductible endorsement or manual pages to mention this, all deductible losses, including those that are reimbursed by the employer, are still reported to the bureau and used for experience rating purposes. Anything in a filing that appears to allow the non-reporting of losses should be disapproved.

(14) An insurer may offer an endorsement to limit the aggregate amount to be reimbursed by the employer under the deductible provision due to claims arising during the policy period. This coverage must be included on the same policy as the rest of the workers' compensation coverage, and not offered as a separate policy.

The reason for this recommendation is that this separate policy would probably be reported as liability insurance and not as workers' compensation, and various assessment bases for residual markets and other compensation-specific assessments would be adversely and unfairly affected. It follows that exceptions to this recommended disapproval policy could be considered if RMLs are minimal or not applicable for a state, and the state has assessment mechanisms for workers' compensation that use something other than net premiums. Exceptions might also be considered for so-called "basket aggregate" policies when the rules filed with the program provide assurance that the net workers' compensation large deductible premium will be much larger than the charge for expected workers' compensation losses under the "basket aggregate" policy.

(15) If aggregate stop-loss protection is provided, the policy must provide for proration of any aggregate retention limits in the event of cancellation by the insurer unless the aggregate limits are a function of the audited exposure. However, the policy may state that proration of the aggregate retention limit will not occur in the event of cancellation due to nonpayment or other serious breach of contract. These "serious breaches" would need to be detailed in the cancellation provisions. (*Explanation: Without this provision, an insurer that cancels a policy mid-term, as it neared the aggregate limit, would avoid providing the coverage that the employer had paid for when it purchased an aggregate maximum limit.*)

(16) The manual rules must state that coverage is to be provided only when the financial impact of the retention amount (that is, the effect of the deductible, subject to any aggregate provided on the policy) will remain uninsured by the policyholder. That is, anything that appears to involve so-called "deductible reimbursement policies" or that otherwise insures these same exposures should be questioned and not approved. "Deductible reimbursement policies" applying to workers' compensation insurance should also be disapproved, but fully addressing this problem goes beyond the scope of the workers' compensation form approval process, as insurers in the past have used surplus lines or health insurers to write this coverage to avoid this prohibition. The application of this section is not, however, intended to prohibit:

(a) An employer from procuring unreinsured deductible reimbursement insurance from a valid captive insurance arrangement,

(b) A bona fide loss portfolio transfer policy, where an insurer picks up a book of unpaid past incurred claims on a one-time basis, or

(c) A surety bond purchased at arms' length from an unaffiliated insurer used to guarantee reimbursement of claims paid by the insurer under a large deductible arrangement. (A surety bond of this nature purchased from an affiliated insurer would not be a meaningful transfer of credit risk and could be used to "play games.")

(*Explanation: The story here is a bit complex, but the primary reason for this guideline is to avoid arbitrage, where an insurer and/or employer may be able to obtain a more favorable treatment for taxes or assessments by using the large deductible policy as a façade. Other reasons for disapproval of this practice includes the harm that this practice can have on financial and statistical reporting, and the potential use of this device as a means to avoid regulation. Readers who are not familiar with the reasons why these situations need to be avoided are advised to read the relevant sections of the full Study.*)

(17) Provisions that would allow the insurer to cancel the large deductible endorsement, but otherwise keep the policy in force and cause the policy to revert to a "guaranteed cost" contract, should be unacceptable unless there is agreement from the employer. However, provisions similar to retro provisions dealing with employer insolvency may be included in the policy, and can be extended to nonpayment situations. Such provisions could allow an insurer to value all claims on an incurred basis for the purpose of making a claim against a financially distressed employer's LOC, surety bond, or receiver.

(18) (This section only applies to states that utilize loss-based assessments.) Difficulties are likely to arise when an insurer wishes to recoup loss-based assessments from the policyholder on a dollar-for-dollar basis. While this is fair in principle, it can become very complicated to apply correctly, especially if such assessments are not uniform percentages collected year after year. For an assessment on paid losses that is levied on a sporadic basis, a proper assessment technique would require:

(a) The insurer would wait until after the end of each year – which would be after the time that it would have otherwise billed for most of the losses,

(b) The insurer would then determine whether a loss-based assessment is being made,

(c) The insurer would then apply the tax rate to all paid losses during the prior year and,

(d) Then, long after the policyholder has reimbursed the insurer for the losses, the insurer would bill for the tax.

Thus, for states where assessments on paid losses are not the same percentage year after year, it would be much easier to simply add an additional amount to the premium for an average amount of loss-based assessments and not charge for actual assessments. In addition to being reasonably fair, this procedure will also be far simpler from a billing and statistical reporting standpoint.

(19) The premium tax status of policyholder payments (i.e., whether they are considered taxable as premiums or not) is the subject of state law or interpretations of state law, and should typically not be part of a rate or form filing. Accordingly, reviewers should be alert to anything in a filing that appears to be an attempt to shelter payments by the policyholder from premium taxes or workers' compensation assessments. The total cost to the policyholder of the set of agreements constituting the large deductible arrangement is premium, except to the extent that the law clearly provides that certain payments may legally be considered as something other than premiums. This exception will almost always include reimbursements for losses paid. In some states, it may also apply to loss adjustment and other administrative expenses paid to the TPA, but it will rarely, if ever, include payments such as reimbursements of taxes or assessments by the policyholder. Reports have been received, however, of policyholders seeking to shelter other payments, and analysts should be aware of this possibility within the context of their specific state's laws.

(20) A few states require insurers to obtain collateral from policyholders to assure that the insurer will eventually be reimbursed as losses are paid. Even in states without such requirements, however, it is an unusual account where the insurer does not require collateral of some nature to assure that it will be reimbursed for loss payments. The reason for these requirements and practices is that, if the policyholder becomes bankrupt, the insurer will still be obligated to provide full statutory benefits to injured workers, even if it will not be reimbursed for those claim payments. Thus, it is only prudent for an insurer to protect itself against the possibility of policyholder insolvency or noncompliance.

Collateral and prefunding arrangements, when they exist, are a substantial part of the total agreement between the policyholder and the insurer. A collateral agreement makes no sense without an accompanying coverage agreement, and the insurer will usually not agree to provide coverage without an accompanying collateral agreement. It can therefore be argued that the entirety of such collateral agreements should be considered part of the insurance policy and thus be subjected to state laws requiring the filing of insurance policies and all endorsements and amendments thereto.

Deeming the collateral agreements to be subject to filing requirements would, however, be awkward. Collateral agreements will often involve a third party (e.g., a bank) and may sometimes relate to more than a single workers' compensation policy written for a period of one year. The same statement is true for prepayment arrangements.

It is therefore recommended, instead of applying state form filing laws to the collateral or prepayment agreements themselves, that when such arrangements exist, a reference to the insurers' collateral or prepayment requirements should be a required part of the large deductible endorsement. The primary reason for this recommendation is practicality, and not a lack of regulatory authority in this area. This recommendation differs from the *Large Deductible Study,* which would have applied form filing laws to collateral agreements, though frequently subject to large risk exemptions.

While the non-filing of collateral agreements should generally cause few problems, the situation would be very different if an insurer attempted to change premium calculations or to amend cancellation or other policy provisions through provisions contained in collateral agreements – or in any other side agreement, for that matter. The policy should constitute the entire contract of insurance between the policyholder and the insurer, and an allowance for separate collateral agreements can only be acceptable if insurers keep these agreements limited to the details of handling the policyholder's collateral.

In summary, as long as no problems arise to cause the regulator to change this approach, this document recommends:

(a) Exempt the collateral agreement from form filing requirements, regardless of the size of risk, but only if the scope of the collateral agreement is narrowly confined to the handling and maintenance of collateral. If the insurer wants the collateral agreement to cover more than that, then it will need to be filed.

(b) When collateral is required, the large deductible endorsement must refer to the existence of the collateral agreement and provide that collateral must be maintained in accordance with that agreement.

At this writing, problems and abuses in this area do not appear to be a subject of significant complaints. Should problems develop in the future, or should states have requirements or limitations regarding collateral agreements that they wish to apply, then the best recourse may be a requirement for these to be mentioned in the insurer's accompanying manual pages. Rulemaking authority may be another possible alternative to the application of form filing laws.

(21) As just discussed, it is common and prudent for an insurer to require collateral when writing a large deductible policy. The amount, adequacy, and especially any lack of collateral are important concerns for actuaries and financial examiners that are evaluating the liabilities of an insurer. Notwithstanding the importance of collateral, this document recommends that states not require insurers' large deductible filings to include a requirement that collateral be posted unless the state has a law to this effect. Presumably, an insurer would only write a large deductible account without collateral in return for a higher price or for accounts (e.g., a governmental entity) where the chance of default was believed to be remote. This is not to discourage an insurer's filing from including a requirement for collateral, only to note that such a requirement should not be a condition for approval unless the state has a law to this effect.

(22) Even when not required by state law, states may wish to consider minimum standard premium size, payroll, net worth, or other provisions of this nature for risks to be written on a large deductible policy. If states implement such minimums, it is recommended that they also consider accompanying exceptions for policyholders that post adequate collateral (e.g., no less than the amount of the deductible, although insurers may routinely require greater amounts of collateral).

(23) If the insurer making the large deductible filing is owned or controlled by a large employer in the state, then careful consideration should be given to disapproving any large deductible filing for the insurer unless its manual rules include a provision that it will not write large deductible coverage for that employer or an affiliated entity without adequate, high-quality security. The reason for this admonition is that it would otherwise be possible for the insurer and the employer or affiliated entity to accumulate substantial unfunded liabilities and, should the employer become bankrupt, then the affiliated insurer would likely become bankrupt as well, leaving the state's guaranty fund to pay the losses. This potential concern may be especially strong if the entity involved is a PEO, as the exposure of a PEO can change significantly on short notice when clients are added, a bankrupt PEO's assets are likely to fall well short, and the client employers will typically not be (and should not be) obligated to reimburse the guaranty funds for obligations of the PEO's estate.

(24) As referenced above, unique issues arise when the policyholder on a large deductible policy is a PEO. While agreements between the PEO and its clients are beyond the scope of a policy filing or the filing of manual rules, nothing contained in the policy or in the manual rules should permit or imply that, in the event that the PEO becomes unable to reimburse losses paid by the insurer, that the clients of the PEO will then become liable to reimburse these losses. This would not be appropriate because of the nature of the PEO-client relationship and because individual clients of the PEO are typically not going to be of sufficient size that they can assume the size of losses that are involved with a large deductible.

(25) Policies written for a policyholder with a contract or agreement with a TPA must be endorsed to reflect the existence of this agreement. At a minimum, this endorsement must: name the TPA; include the responsibility (if any) of the policyholder to pay the TPA; identify the insurer's ability to terminate the TPA agreement; state that the policyholder cannot switch TPAs without the prior consent of the insurer; and provide for actions in case of nonpayment or policyholder default.

(26) The insurer must still be responsible for setting claims handling standards if it uses a TPA or an independent adjuster to handle claims. Except in states that provide that insured employers may adjust claims, a large deductible policy should not be used to give the employer the ability to adjust its own claims. (Limited exceptions may be considered with the agreement of the state's workers' compensation commission, but it is unlikely that state workers' compensation commissions will have much interest in approving exceptions. A possible exception may involve policyholders that had recently been approved self-insurers, but are now purchasing insurance. The workers' compensation commission may approve such an exception to ease the transition for the formerly self-insured employer.)

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2008 Proc. 3rd Quarter, Vol. I 127, 140-145, 167-172, 599-510 (adopted).

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES AND PROGRAMS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES AND PROGRAMS

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES AND PROGRAMS

NAIC MEMBER	RELATED ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIVITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES AND PROGRAMS

NAIC MEMBER	RELATED ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY – 2008

GUIDELINES FOR THE FILING OF WORKERS' COMPENSATION "LARGE DEDUCTIBLE" POLICIES & PROGRAMS (#1970)

1. Background

The Workers' Compensation Large Deductible Study was developed through the NAIC/IAIABC Joint (C) Working Group. The Study was adopted by the NAIC in March 2006. The purpose of the Study was to inform regulators on current workers' compensation large deductible issues and provide findings and recommendations in regard to these issues. There were 17 Findings and Recommendations identified.

Finding and Recommendation No. 5 stated that insurance departments should review their large deductible approval standards and procedures to assure that undesirable practices are not allowed owing to regulatory loopholes, shortcomings in regulatory oversight, or a lack of clarity in the applicable law. The white paper therefore recommended that the Workers' Compensation (C) Task Force be charged to develop approval guidelines for large deductible policies.

Large deductible policies came into existence during the workers' compensation market crisis in the late 1980s and early 1990s. Today, large deductible policies are a major factor in the workers' compensation marketplace. Large deductibles represent an intermediate economic strategy between self-insurance and complete loss transfer to an insurer. Above a deductible threshold, the large deductible policy protects the employer from catastrophic losses. Below the threshold, the policy protects workers from the risk that the employer will default on its share of claims obligations.

The insurer of a large deductible policy makes the same unconditional promise made by all workers' compensation insurers—that all valid claims arising out of injuries occurring within the policy period will be paid according to state benefit laws. This "first-dollar liability" of the insurer distinguishes deductible policies from excess policies. Workers' compensation excess policies are intended for use only by authorized self-insurers, in which the insurer is only liable (to the employer, not the employee) for claims in excess of a specified attachment point.

The distinction between large deductibles and small deductibles is hypothetically only a difference of degree. Usually, however, the marketplace does draw a line because the two products are geared to different markets and, where permitted by state law, large deductibles tend to be very large (i.e., $100,000 often is the low end of the range).

2. Formation and Charge of Working Group

The Large Deductible Study Implementation (C) Working Group was formed by the Workers' Compensation (C) Task Force during the NAIC 2006 Spring National Meeting. The following Task Force charge encompassed the Working Group's activities:

> Appoint a Large Deductible Study Implementation (C) Working Group to assure that the charges presented in the Findings and Recommendations of the NAIC Workers' Compensation Large Deductible Study are properly completed.

As part of this charge, the Working Group held its first conference call on April 19, 2006, to consider how best to fulfill Recommendation No. 5 of the Workers' Compensation Large Deductible Study by developing approval guidelines for large deductible policies.

3. Working Group Members

The following states are currently members of the Working Group, with Nebraska serving as its chair: Alaska, Arkansas, California, Illinois, Kansas, Maine, Massachusetts, Missouri, Nevada, New York, Oklahoma, and West Virginia.

4. General Description of Drafting Process

The meetings and conference calls of the Working Group have all been open. Drafts of the study were regularly circulated to members and interested parties for comment. The intent of the guidelines was to give states suggested approval guidelines for large deductible policies and programs that are in general consistent with the Workers' Compensation Large Deductible Study.

The suggested requirements were drafted with the intent to allow individual states to modify, when necessary, to conform to specific state laws. The guidelines were to neither address nor propose rate filing requirements, nor propose that rating plans be filed. The suggested filing requirements therefore pertain to large deductible form filings. However, a primary objective of these requirements is that experience incurred under these policies be reported to the statistical agent on a basis that preserves information on classifications, payroll and total losses.

5. Project Description

The final draft of the Guidelines for the Filing of Workers' Compensation "Large Deductible" Policies & Programs (Large Deductible Guidelines) consists of introductory material followed by 26 Suggested Filing Requirements.

The introductory material mentions that during the time these guidelines were being developed, the NAIC decided that issues previously being addressed through adoption of model laws and model regulations will instead be addressed by the adoption of guidelines if there is not a widespread feeling among NAIC members that the NAIC should strongly encourage adoption by the states on a uniform basis. This document, however, was never intended for adoption as a model law or regulation, but rather was intended as a set of guidelines for use by the individual states. While parts of this document may cause a state to consider law changes, no attempt was made to draft any suggested statutes or regulations. Additionally, this document encourages each state to make its version of the Large Deductible Guidelines freely available through whatever means that the state uses to communicate its approval standards.

Below are some excerpts from the Suggested Filing Requirements:

- Insurers are neither obligated to offer large deductible policies, nor to offer them to all customers in all amounts that the insurer might file or that these guidelines might allow.

- Typically, large deductible policies will be developed by the attachment of a large deductible endorsement to an otherwise standard workers' compensation policy. Large deductible policies are still considered statutory policies, so the large deductible endorsement must not purport to negate any statutorily required provisions. Should an insurer file an entire large deductible policy form, instead of an endorsement, the regulator must take care to see that all statutory provisions are included.

- Policies written for a policyholder with a contract or agreement with a third party administrator (TPA) must be endorsed to reflect the existence of this agreement.

- The insurer must still be responsible for setting claims handling standards if it uses a TPA or an independent adjuster to handle claims.

6. Issues Raised

The Working Group discussed in detail a number of the suggested filing requirements before final changes were made. In particular, much discussion centered on how best to handle collateral requirements, professional employer organization (PEO) issues, and TPA issues pertinent to large deductible filings.

A number of jurisdictional approaches for workers' compensation large deductible filing review were examined, which included those applied in the following states: Kansas, Missouri, Oklahoma, and Texas. The Working Group also consulted with the International Association of Industrial Accident Boards and Commissions (IAIABC) regarding various aspects of the document—primarily in regard to TPA large deductible concerns.

7. Group Adoptions

The May 16, 2008, draft Large Deductible Guidelines was unanimously adopted by the Working Group during its May 22, 2008 conference call. Both regulators and interested parties present expressed satisfaction with the final draft. The Workers' Compensation (C) Task Force and the Property & Casualty Insurance (C) Committee adopted the Large Deductible Guidelines during the NAIC 2008 Summer National Meeting held in San Francisco, California.

8. Other Pertinent Information

In further fulfillment of its charge, the Working Group is currently drafting TPA Guidelines, which revise the current NAIC model covering this same subject, except the revision will allow states to include workers' compensation within the scope of the law.

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

Table of Contents

Drafting Note: Having the necessary statutory authority specific to large deductible workers' compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC *Insurer Receivership Model Act* (#555—IRMA), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Large Deductible Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state's ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options generally complement each other, except for conflicting provisions regarding the issue of the ultimate ownership of, and entitlement to, the deductible recoveries and large deductible collateral as between the estate and the guaranty association. The issue is whether the guaranty associations, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty associations and the uncovered claimants.

As of the drafting of this Guideline, the NCIGF model approach has been adopted by several states using varying language. However, the NCIGF model has evolved over time based on additional experiences from insolvencies and the NCIGF continues to modify its model as warranted. The NAIC has developed the following Guideline based largely on the principles and structure of the NCIGF model with certain modifications made by the NAIC Large Deductible Workers' Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force. The following statutory language is not an amendment to the NAIC receivership models but is intended as a Guideline for use by states as an alternative to IRMA Section 712, Administration of Loss Reimbursement Policies.

This Guideline shall apply to workers' compensation large deductible policies issued by an insurer subject to delinquency proceedings under [insert cite to state's receivership statute]. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with this Guideline. This Guideline does not apply to policies where the insurer has no liability for the portion of a claim that is within the deductible or self-insured retention.

Section 1. Definitions

For purposes of this Guideline:

A. "Large deductible policy" means any combination of one or more workers' compensation policies and endorsements and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

(1) Pay directly the initial portion of any claim covered under the policy up to a specified dollar amount which the insurer would otherwise be obligated to pay, or the expenses related to any claim; or

(2) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term "large deductible policy" includes policies which contain an aggregate limit on the insured's liability for all deductible claims, a per-claim deductible limit or both. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer, and the insurer remains liable to claimants in the event the insured fails to fulfill its payment or reimbursement obligations.

Drafting Note: States may wish to establish a minimum dollar deductible threshold for application of this statute based on local conditions. Because the payment of the entire amount of the claim remains the unconditional obligation of the insurer, the insured's loss reimbursement obligation should not be treated as a "deductible" for the purpose of any applicable exclusion from guaranty association coverage, even though these policies are commonly referred to as "large deductible policies."

Large deductible policies do not include policies, endorsements or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insurer shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such reinsurance arrangements or agreements are put in place as security for the policyholder's large deductible obligations.

B. "Deductible claim" means any allowed claim, including a claim for loss and defense and cost containment expense (unless such expenses are excluded), under a large deductible policy to the extent it is within the deductible.

C. "Large deductible collateral" means any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Large deductible collateral may also secure an insured's obligation to reimburse or pay to the insurer as may be required for other secured obligations.

D. "Commercially reasonable" means to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter.

E. "Other secured obligations" means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations the performance of which is secured by large deductible collateral that also secures an insured's obligations under a large deductible policy.

Section 2. Handling of Large Deductible Claims

Unless otherwise agreed by the responsible guaranty association, all large deductible claims that are also "covered claims" as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling.

A. If a deductible claim is not covered by any guaranty association, the receiver shall draw on available large deductible collateral to pay the claim; or make other arrangements with the insured to ensure the timely payment of the claim. The receiver shall pay the claim promptly from the large deductible collateral unless the insured pays the claim directly or there is no available large deductible collateral.

B. Deductible claims paid by the insured or by the receiver in accordance with this Guideline shall not be treated as distributions of estate assets under [insert cite to state's liquidation priority distribution statute]. To the extent the insured, or a third-party administrator on behalf of the insured, pays the deductible claim, pursuant to an agreement by the guaranty association or otherwise, the insured's payment of a deductible claim in whole or in part will extinguish the obligations, if any, of the receiver and/or any guaranty association to pay that claim or that portion of the claim. No credit or charge for an imputed or constructive distribution of any kind shall be made against the receiver or a guaranty association on the basis of an insured's payment of a deductible claim.

Drafting Note: This provision addresses so called "orphan claims," which are situations where, because of variations in state law or for other reasons, claims generally covered by the guaranty fund system are not provided such protection. States should take steps, through statutory revision or otherwise, to avoid orphan claims, especially for workers' compensation insurance. However, if such claims do exist, this provision permits the receiver to utilize available large deductible collateral, or other funds provided by the employer, to ensure that they continue to be paid. Alternative language that states may consider is as follows: "In cases where a deductible claim is not a guaranty association covered claim and the claimant has no other remedy either from the employer or other resources available in a state, the receiver may pay the claim to the extent of the deductible with available Large deductible collateral as described in subsection E(2) below."

Section 3. Deductible Claims Paid by a Guaranty Association

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the amount of the reimbursement, and available large deductible collateral as provided for under subsection E to the extent necessary to reimburse the guaranty association. Such amounts shall be paid to the guaranty association net of any of the receiver's collection costs as described in subsection F. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [insert cite to state's

liquidation priority distribution statute] or as early access payments under [insert cite to state's early access statute].

To the extent that a guaranty association pays a deductible claim that is not reimbursed either from large deductible collateral or by an insured's payments, or incurs expenses in connection with large deductible policies that are not reimbursed under this subsection, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding, except as provided Section 4(E).

Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses, such as those provided for pursuant to [insert cite to state's guaranty association net worth provision], or existing under similar laws of other states.

Section 4. Collections

A. The receiver shall take all commercially reasonable action to ensure that the large deductible collateral remains adequate to secure the insured's obligations, and to collect reimbursements owed for deductible claims as provided for herein:

(1) Paid by the insurer prior to the commencement of delinquency proceedings;

(2) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments;

(3) Paid or allowed by the receiver; or

(4) Approved by the receiver for payment.

B If the insured does not make payment within the time specified in the large deductible policy, or within sixty (60) days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

C. Neither the insolvency of the insurer, nor the receiver's or insurer's inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured's reimbursement obligation under the large deductible policy.

D. An allegation of improper handling or payment of a deductible claim by the insurer, the receiver and/or any guaranty association shall not be a defense to the insured's reimbursement obligations under the large deductible policy.

E. If the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured for a large deductible obligation and there is no available large deductible collateral, a guaranty association may, after notice to the receiver, seek to collect the reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured. The guaranty association shall report any amounts so collected from each insured to the receiver. The receiver shall provide the guaranty association with available information needed to collect a reimbursement due from the insured. The receiver shall notify all other guaranty associations that have paid large deductible claims on behalf of the same insured. Amounts collected by a guaranty association pursuant to this paragraph shall be treated in accordance with subsection C. The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority, except as a agreed by the receiver at or before the time the expenses are incurred; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

Section 5. Large Deductible Collateral

A. Subject to the provisions of this subsection, the receiver shall utilize large deductible collateral, when available, to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to large deductible collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any payments made to a guaranty association pursuant to this subsection shall not be treated as distributions of estate assets under [Insert cite to state's liquidation priority distribution statute] or as early access payments under [Insert cite to state's early access statute]. Such payments shall extinguish the receiver's obligations to the guaranty association with respect to any claim or portion of a claim that has been reimbursed from large deductible collateral.

B. All claims against the large deductible collateral shall be paid first to reimburse claim payments made by the insurer, the receiver, or the guaranty associations to reimburse their deductible claim payments on large deductible policies. After these obligations are satisfied, remaining claims shall be paid in the order received and no claim of the receiver, except in accordance with this subsection, shall supersede any other claim against the large deductible collateral.

C. Notwithstanding any agreement between the insured and the insurer, the receiver shall draw down large deductible collateral to the extent necessary in the event that the insured fails to:

(1) Perform its funding or payment obligations under any large deductible policy;

(2) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty (60) days after the date of the billing if no time is specified;

(3) Pay amounts due the estate for pre-liquidation obligations;

(4) Timely fund any other secured obligation; or

(5) Timely pay expenses.

D. Excess large deductible collateral may be returned to the insured when deemed appropriate by the receiver after a periodic review of claims paid, outstanding case reserves, and allowance for adverse development and claims incurred but not reported as determined by the receiver.

Section 6. Administrative Fees

A. The receiver is entitled to recover through billings to the insured or from large deductible collateral all reasonable expenses that the receiver incurred in fulfilling its collection obligations under this Guideline. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.

B. To the extent the receiver cannot collect such expenses pursuant to paragraph (1), the receiver is entitled to deduct from the large deductible collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the large deductible collateral and deductible reimbursements.

C. To the extent such amounts are not available from reimbursements or large deductible collateral, the receiver, or guaranty associations if provided under an agreement with the receiver under subsection D(5), shall have a claim against the estate as provided pursuant to [insert cite to state's liquidation priority distribution statute].

Drafting Note: State policymakers should decide whether this provision, when enacted, should apply to existing liquidations.

Chronological Summary of Action (all references are to the Proceeding of the NAIC)

2021 Spring National Meeting (adopted).

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIV ITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP

NAIC MEMBER	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2021

GUIDELINE FOR ADMINISTRATION OF LARGE DEDUCTIBLE POLICIES IN RECEIVERSHIP (#1980)

1. Description of the Project, Issues Addressed, etc.

In 2018, the Receivership Large Deductible Workers' Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force was given charges in response to issues arising out of the *2016 Workers' Compensation Large Deductible Study* by the NAIC/International Association of Industrial Accident Boards and Commissioners (IAIABC) Joint (C) Working Group to recommend possible enhancements to the U.S. receivership regime.

In 2018, the Working Group heard presentations from the National Conference of Insurance Guaranty Funds (NCIGF) and nine states/insurers with experience with a receivership involving large deductible workers' compensation. The Working Group also conducted a survey of states' laws, practices and recommendations, to which 27 states responded. It was clear through this work that having statutory authority specific to large deductible workers' compensation products in receiverships was key to the successful resolution of these insurers. As a result of its work, on Nov. 16, 2018, the Working Group presented the Task Force with its recommendation regarding statutory authority.

The Working Group recommended state adoption of clear statutory authority that articulates the respective rights and responsibilities of the various parties in large deductible workers' compensation business receiverships. Having clear statutory authority in place can avoid much of the confusion, and sometimes expensive and prolonged litigation, for both the receiver and the guaranty funds. Clear statutory authority can also avoid collections delays that dilute recoveries.

Based on the study, the Working Group recommended that states adopt statutory authority regarding large deductible workers' compensation products in receiverships. Prior to the development of the new guideline, there were two options available:

1) *Insurer Receivership Model Act* (#555—IRMA) Section 712—Administration of Loss Reimbursement Policies; or
2) NCIGF Model Large Deductible Legislation.

Twelve states have adopted the NCIGF model using varying language (California, Florida, Indiana, Illinois, Louisiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, Utah and West Virginia). Most of these states follow the NCIGF approach and have amended their insurance liquidation acts to clarify the following when to secure competing claims such as deductible amounts owed the insurer and retroactive premium balances: 1) the ownership of the deductible reimbursements or collateral drawdowns; 2) claims-handling matters; 3) collection responsibility; and 4) allocation of collateral.

After recommending to the Task Force that states adopt clear statutory, the Working Group discussed differences between Model #555 and the NCIGF model during 2019 and 2020. While Section 712 is part of Model #555, it was the opinion of the Working Group that the alternative language to Section 712 should be drafted as a guideline because it does not meet the two-pronged test to be a model law. Therefore, the Working Group agreed to draft a new model guideline for the Administration of Large Deductible Policies in Receivership as an alternative to Model #555, Section 712—Administration of Loss Reimbursement Policies. The new model guideline is based largely on the principles and structure of the NCIGF model with certain modifications.

2. Name of Group Responsible for Drafting the Model and States Participating

The Receivership and Insolvency (E) Task Force is responsible for Model #555. The 2020 members of the Task Force are: Texas (Chair), District of Columbia (Vice Chair), Alaska, American Samoa, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee and Utah.

The Receivership Large Deductible Workers' Compensation (E) Working Group evaluated the issues and drafted the draft model guideline relating to Section 712 of Model #555 based on the NCIGF principles from the NAIC model (available on the NCIGF website).

The 2020 members of the Working Group are: Pennsylvania (Co-Chair); Oklahoma (Co-Chair), Alaska, Arkansas, Florida, Georgia, Illinois, Maine, Missouri, Nebraska, New Jersey, New Mexico and Texas.

An informal drafting group was formed in 2020 consisting of Donna Wilson (OK), Toma Wilkerson (FL), Robert Wake (ME), James Kennedy (TX), Barbara Cox (NCIGF) and Rowe Snider (Locke Lord LLP).

3. Project Authorized by What Charge and Date First Given to the Group

The Receivership Large Deductible Workers' Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force was given the follow charge beginning in 2018:

"Study states' receivership laws and practices regarding receivership of insurers with significant books of large deductible workers' compensation business, and evaluate the need for a model act/rule, or amendments to existing models, that governs the rights and duties of the various parties regarding large deductible business in insolvencies, including, but not limited to, consideration of a provision that expressly permits the collection of large deductibles from insureds during an insolvency proceeding. Provide any other recommendations for possible enhancements to the U.S. receivership regime based on this study."

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Receivership Large Deductible Workers' Compensation (E) Working Group, chaired by Donna Wilson (OK) and Laura Lyon Slaymaker (PA), drafted the model guideline. Open conference calls were held where interested parties participated. The information drafting group included four state insurance regulators and two industry volunteers.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

a. The Working Group held five open conference calls between August 2018 and November 2018 where it: 1) heard presentations from the NCIGF; 2) heard presentations from nine states and insurers with experience with a receivership involving large deductible workers' compensation; and 3) reviewed survey results from 27 states regarding their laws, practices and recommendations.

b. The Working Group began by amending the NCIGF model as an alternative approach to Section 712 of Model #555. The Working Group held five open meetings between February 2019 and December 2019. During its Dec. 2, 2019, meeting, the Working Group exposed a new draft model guideline for a 60-day public comment period ending Jan. 31, 2020. The guideline is an alternative approach to Model #555, Section 712 based on the NCIGF model and amended to reflect administrative fees, a state-specific citation for the definition of "large deductible" and the guaranty association entitlement to the net amount of the reimbursement. In conjunction with the model guideline, NAIC legal staff drafted a memorandum explaining the difference between a guideline and a model law.

c. The Working Group received two comment letters during the exposure period from Maine and the NCIGF.

d. The Working Group met via open meeting March 2, 2020 and formed a drafting group to further amend the draft guideline to address comments received. The drafting group met four times between March 2020 and September 2020.

e. On Sept. 30, 2020, via open meeting, the Working Group exposed a revised draft Guideline for Administration of Large Deductible Policies in Receivership for a 30-day period ending Oct. 30, 2020. The revised guideline was re-drafted based largely on the principles and structure of the NCIGF model with certain modifications. It is based on the principles rather than the NCIGF model because the NCIGF model approach has been adopted by several states using varying language. The NCIGF model has evolved over time based on additional experiences from insolvencies and continues to be modified as warranted by the NCIGF.

f. All exposure drafts were distributed to more than 120 interested parties and posted to the Working Group's public web page. Barbara Cox (NCIGF) and Rowe Snider (Locke Lord LLP) actively participated in the drafting group.

g. The Working Group adopt the guideline on Nov. 5, 2020.

h. The Receivership and Insolvency (E) Task Force adopted the guideline on Nov. 19, 2020.

i. The Financial Condition (E) Committee adopted the guideline at the Fall National Meeting on Dec. 8, 2020.

j. The Executive (EX) Committee and Plenary adopted the guideline at the Spring National Meeting on Apr 14, 2021.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

Deductible Reimbursements and Collateral

The primary distinction between the NCIGF and Model #555, Section 712—Administration of Loss Reimbursement Policies, is the issue of deductible reimbursements and collateral. Twelve states have adopted large deductible policy laws based on the NCIGF model principles using varying language. It should be noted that no state has enacted the reinsurance approach described below in Model #555. Therefore, it was the decision of the Working Group to include the NCIGF approach to collateral within the Guideline.

- The NCIGF model "secured claim" approach: Claims within the deductible are primarily the obligation of the policyholder. Under this approach, deductible reimbursements are earmarked to pay those claims, and any collateral posted by or on behalf of the policyholder is held to ensure that those claims are paid. Accordingly, when the guaranty association takes pays a claim within the deductible, it earns the benefit of the reimbursement due from the policyholder and the right to draw on the collateral, if necessary, or to initiate a draw by the receiver, for the benefit of the guaranty fund.

- Model #555 Section 712 "reinsurance" approach: The insurer's obligation to pay all covered claims and the policyholder's obligation to reimburse the insurer are unconditional and each is independent of the other. Under this approach, deductible reimbursements are a general asset of the estate and the guaranty fund only benefits from the deductible reimbursements in proportion to its share as a creditor of the estate. The receiver has the right to collect all deductible reimbursements, drawing on collateral as necessary. Any reimbursements paid to the guaranty association are treated as early access distributions and offset from future recoveries from the estate.

7. Any Other Important Information (e.g., amending an accreditation standard).

None

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

Drafting Note: The receivership laws of most states address the coordination of receiverships involving multiple states. Typically, these laws provide that a domiciliary receiver appointed in another state has certain rights and protections, such as the following:

- The domiciliary receiver is vested with the title to the insurer's assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

In many states' laws, these provisions may apply only if the domiciliary state is a "reciprocal state." Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago. These definitions may be inconsistent with laws in other states, and they may be more prescriptive than the Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws. As a result, the assets of a receivership estate might not be protected outside of the domiciliary state, and the receiver may be forced to defend litigation in multiple forums.

The provisions described above are intended to promote judicial economy, which benefits all participants in the receivership process. This guideline provides a statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of these provisions. Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Definition of Reciprocal State for Receivership

"Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2021 Summer National Meeting (adopted).

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

What are the state pages?

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC guideline. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered.

How do you use them?

States and territories are listed alphabetically in the chart. Locate the state or territory you are interested in to find a citation; to perform further research, use the citations to locate state laws.

Who do I speak to if I have questions?

If you have questions or believe information related to a state should be updated, please contact Jennifer Neuerburg at jneuerburg@naic.org.

Disclaimer: *This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.*

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

NAIC MEMBER	RELATED ACTIVITY
Alabama	NO CURRENT ACTIVITY
Alaska	NO CURRENT ACTIVITY
American Samoa	NO CURRENT ACTIVITY
Arizona	NO CURRENT ACTIVITY
Arkansas	NO CURRENT ACTIVITY
California	NO CURRENT ACTIVITY
Colorado	NO CURRENT ACTIVITY
Connecticut	NO CURRENT ACTIVITY
Delaware	NO CURRENT ACTIVITY
District of Columbia	NO CURRENT ACTIVITY
Florida	NO CURRENT ACTIVITY
Georgia	NO CURRENT ACTIVITY
Guam	NO CURRENT ACTIVITY
Hawaii	NO CURRENT ACTIVITY
Idaho	NO CURRENT ACTIVITY
Illinois	NO CURRENT ACTIVITY
Indiana	NO CURRENT ACTIVITY
Iowa	NO CURRENT ACTIVITY
Kansas	NO CURRENT ACTIV ITY
Kentucky	NO CURRENT ACTIVITY
Louisiana	NO CURRENT ACTIVITY
Maine	NO CURRENT ACTIVITY

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

NAIC MEMBER	RELATED ACTIVITY
Maryland	NO CURRENT ACTIVITY
Massachusetts	NO CURRENT ACTIVITY
Michigan	NO CURRENT ACTIVITY
Minnesota	NO CURRENT ACTIVITY
Mississippi	NO CURRENT ACTIVITY
Missouri	NO CURRENT ACTIVITY
Montana	NO CURRENT ACTIVITY
Nebraska	NO CURRENT ACTIVITY
Nevada	NO CURRENT ACTIVITY
New Hampshire	NO CURRENT ACTIVITY
New Jersey	NO CURRENT ACTIVITY
New Mexico	NO CURRENT ACTIVITY
New York	NO CURRENT ACTIVITY
North Carolina	NO CURRENT ACTIVITY
North Dakota	NO CURRENT ACTIVITY
Northern Marianas	NO CURRENT ACTIVITY
Ohio	NO CURRENT ACTIVITY
Oklahoma	NO CURRENT ACTIVITY
Oregon	NO CURRENT ACTIVITY
Pennsylvania	NO CURRENT ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY
Rhode Island	NO CURRENT ACTIVITY
South Carolina	NO CURRENT ACTIVITY
South Dakota	NO CURRENT ACTIVITY

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

NAIC MEMBER	RELATED ACTIVITY
Tennessee	NO CURRENT ACTIVITY
Texas	NO CURRENT ACTIVITY
Utah	NO CURRENT ACTIVITY
Vermont	NO CURRENT ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY
Virginia	NO CURRENT ACTIVITY
Washington	NO CURRENT ACTIVITY
West Virginia	NO CURRENT ACTIVITY
Wisconsin	NO CURRENT ACTIVITY
Wyoming	NO CURRENT ACTIVITY

PROJECT HISTORY - 2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS (#1985)

1. Description of the Project, Issues Addressed, etc.

The Receivership and Insolvency (E) Task Force has an active and ongoing charge, which was adopted in each year of this project by the Executive (EX) Committee and Plenary, that reads as follows:

> Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

In 2020, the Task Force finalized its Macroprudential Initiative (MPI) study, which began in 2019, and addressed the referral from the Financial Stability (EX) Task Force to evaluate receivership and guaranty fund laws and practices in the context of the MPI. The Task Force surveyed state insurance regulators and interested parties on each of the key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receivership of insurers operating in multiple states. While a receivership of a multi-jurisdictional insurer would not likely have a material impact on financial stability or the broader financial markets, this project highlighted areas of the receivership process that may need attention, including laws related to full faith and credit of stays and injunctions.

The Task Force discussed the effect of whether a stay or injunction entered into a receivership court is honored in another state. This has been the subject of a lot of litigation, and receivers have expressed concern about this issue. The receivership laws of most states address the coordination of receiverships involving multiple states. However, in many states' laws, these provisions may apply only if the domiciliary state is a "reciprocal state." Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago.

The Task Force drafted this Guideline as an alternative to address how states define "reciprocal state." This Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership and Insolvency (E) Task Force was responsible for drafting the Guideline. The 2020 and 2021 members of the Task Force were:

2020: Texas (Chair); District of Columbia (Vice Chair); Alaska; American Samoa; Arkansas; California; Colorado; Connecticut; Florida; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; North Carolina; Oklahoma; Pennsylvania; Rhode Island; South Carolina; Tennessee; and Utah.

2021: Texas (Chair); Louisiana (Vice Chair); American Samoa; Arizona; Colorado; Connecticut; Florida; Hawaii; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; New Mexico; North Carolina; Northern Mariana Islands; Oklahoma; Pennsylvania; Rhode Island; South Carolina; and Utah.

3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1, on its Oct. 7, 2020, meeting, the Task Force agreed to draft a guideline to address this issue, which was identified through the results of the MPI study and the subsequent survey regarding key provisions of receivership and guaranty fund laws that states should consider adopting into their laws.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Guideline was drafted by Task Force members: Florida; Maine; Texas; and Patrick Cantilo (Cantilo and Bennett LLP), an interested party. This drafting group met Oct. 19, 2020, and considered language contained in both the Florida and Maine laws. Rather than identifying a list of specific key provisions in law that would be required for a state to be defined as "reciprocal," the drafting group agreed to use the same criteria used by the NAIC Financial Regulation Standards and Accreditation Program. Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws, which requires a state to have a "receivership scheme," will be treated as a reciprocal state. The definition recognizes the diversity of

existing state receivership laws, and it should avoid unnecessary litigation regarding the recognition of a state as a reciprocal state.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On Nov. 19, 2020, the Task Force met to release the draft Guideline for a 42-day public comment period ending Dec. 31, 2020. The exposure was distributed by email to members, interested state insurance regulators, and interested parties of the Task Force; and it was posted to the NAIC website.

The Task Force did not receive any comments.

The Task Force adopted the Guideline on March 12, 2021.

The Financial Condition (E) Committee adopted the Guideline on April 13, 2021.

The Executive (EX) Committee and Plenary adopted the Guideline on August. 17, 2021.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

There were no issues of significance raised during the exposure periods or during meetings.

7. List the key provisions of the model (sections considered most essential to state adoption).

The Guideline provides the following definition, as well as an explanatory drafting note:

> "Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

8. Any Other Important Information (e.g., amending an accreditation standard).

The Guideline will not be considered for any accreditation standard.

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit **www.naic.org**.